Why eating disorder treatments only work half the time, according to a psychologist

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Credit: AI-generated image (disclaimer)

No single treatment will work for all people with eating disorders. Even the most highly researched evidence-based treatment may work for some people, but less so for others. When such treatments do not work, it can provoke anxiety.

As part of our research, we spoke with one mother who was supporting her teenage daughter through anorexia nervosa. When current treatments were not working, the mother told us:

"We don't really know what else we can do."

But there may be other treatment options for people like her daughter. The issue is they're not always available on Medicare.

Medicare provides a menu of options

In Australia, changes to Medicare mean people diagnosed with an eating disorder may be eligible for up to 40 sessions with a psychologist and up to 20 sessions with a dietitian a year.

This is a remarkable recognition of how eating disorders such as anorexia, bulimia or binge eating impact people's lives, and for those who care for them.

This also recognizes how difficult it can be to recover from an eating disorder. This is particularly when aspects of the eating disorder are acceptable to the person, and become their way of dealing with the slings and arrows of life.

Medicare provides several options for psychological interventions to treat eating disorders that are backed by research evidence.

These treatments include family-based treatment for adolescent eating disorders and cognitive behavioral therapy for adult eating disorders.

Such interventions work in the long term for around half of people.

So what about the other half?

It's not just about evidence

Think about psychotherapy—also known as talking therapy—as a three-legged stool.

One leg of the stool is the research evidence. Another is the clinician's expertise. The third leg is preferences of the person having treatment. We need all three if the stool is to stay upright and the psychotherapy has a chance of working.

The current Medicare system allows clinicians to draw from the first leg —the research evidence. This works for some.

Then there's the second leg, the clinician's expertise. One welcome development is through the Australian & New Zealand Academy for Eating Disorders credential for professionals treating eating disorders.

What is less recognized in the current Medicare system, however, is the importance of the therapeutic relationship, such as whether the clinician works in a person-centered way that takes into consideration the person's preferences.

This could be tailoring treatment to the person's unique needs, instilling hope for their recovery, and seeing the person as more than just the eating disorder. Think of these as the third leg of the stool.

These second and third legs help explain why even gold-standard, research evidence-based treatments do not work for everyone.

What else could work?

There are many psychological treatments for eating disorders that don't

have research evidence to back them. We cannot necessarily dismiss them as not working. They may have not yet been extensively researched. These emerging treatments need more research evidence, including which treatments work, for whom, and when.

Emerging treatments include those based on mindfulness. These may involve people learning not to judge their thoughts and feelings as right or wrong, or good or bad. Instead, this therapy allows them to observe these thoughts and feelings by focusing on the present moment.

Others include therapies that address both the eating disorder and adverse and traumatic life events, including the experience of the eating disorder itself.

We are also interested in, and are currently researching, narrative therapy. This explores aspects of the person that have been lost to the eating disorder, such as a valued sense of oneself. Reclaiming these aspects can give the person freedom to live a life no longer dominated by the eating disorder.

Until emerging treatments have more extensive research evidence, the Medicare system needs to mention them as valid treatment pathways when facilitated by experienced practitioners. This is particularly important if the most widely researched interventions do not work for someone.

Including emerging therapies, however, does not mean anything goes. To work out which of these emerging therapies might be eligible for Medicare funding in the future, we need greater consultation with people living with eating disorders, and the clinicians who treat them, to learn which emerging treatments work in practice.

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