

Eating disorders: new insights and developments


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1

Outline


- Brief recap of Eating disorders
- How have eating disorders changed?
- Unmet needs
- Psychotherapy treatment for more common EDs:
 - How can we improve treatment for youth?
 - Optimizing BED treatment



2

Feeding and Eating Disorders (DSM-5)


- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Other specified Feeding and eating disorder (OSFED):
- Avoidant Restrictive Food Intake Disorder (ARFID)
- Pica
- Rumination



3

Anorexia Nervosa

Food restriction
Low body weight for age/sex and dev stage
Intense fear of weight gain or behaviours aimed at weight loss or interfering with weight gain




4

Bulimia Nervosa


-Binge eating (eating a large amount of food with loss of control)
-Compensatory behaviours (purging, etc.)
At least once a week for 3/12

Weight and shape concern




5

Binge eating disorder

Binge eating
At least once a week for 3/12
Distress
 No regular use of inappropriate compensatory behaviours

The binge-eating episodes are associated with >three of the following:

1. eating much more rapidly than normal
2. eating until feeling uncomfortably full
3. eating large amounts of food when not feeling physically hungry
4. eating alone because of being embarrassed by how much one is eating
5. feeling disgusted with oneself, depressed, or very guilty after overeating




6

Other Specified Feeding and Eating Disorder (OSFED)

Disorders of eating that do not meet the full criteria for any specific Eating Disorder. Examples include:


- 1. Atypical AN** All the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
- 2. Sub-threshold BN** All the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than once a week or for a duration of less than 3 months.
- 3. Sub-threshold BED** All the criteria are met except that the binge eating occurs at a frequency of less than once a week or for a duration of less than 3 months.
- 4. Purging Disorder** Recurrent purging behaviour (such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications) in the absence of binge eating



7

Avoidant and Restrictive Food Intake Disorder (ARFID)

Restricted amount and/or range of food	+	Severe Consequences	ARFID
Not explained by... X Weight or shape concerns, anorexia nervosa, or bulimia nervosa X Lack of food or cultural practices X Another mental or somatic disorder		<ul style="list-style-type: none"> • Significant weight loss (failure to gain weight, faltering growth) • Nutritional deficiency • Dependence on enteral feeding or nutritional supplements • Marked interference with psychosocial functioning 	

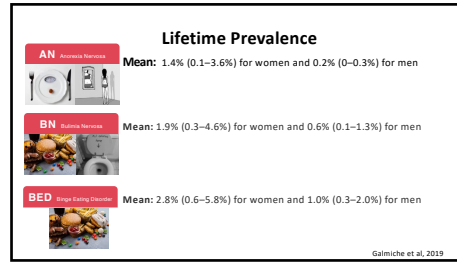


8

Recap of FED

AN Anorexia Nervosa	BN Bulimia Nervosa	BED Binge Eating Disorder	ARFID Avoidant & Restrictive Food Intake Disorder
Low energy intake → Low weight physical complications Distorted body image LOW BMI	Binge eating + Compensatory behaviours Distorted body image NORMAL BMI	Binge eating Distress (Shame etc.) No compensatory behaviours NORMAL BMI/ OVERWEIGHT/OBESITY	Avoidant & restrictive eating Severe consequences No ED If there is a comorbidity presentation goes over and above ANY BMI

9

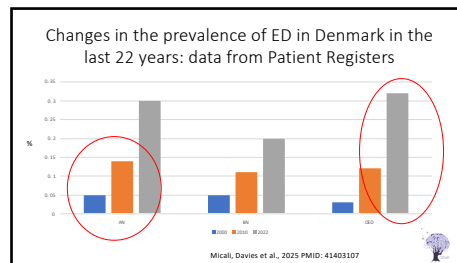


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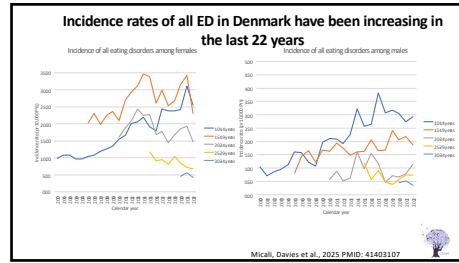
Eating Disorders are increasing in incidence & prevalence

- This rise is mostly seen post-pandemic in young people
- Other EDs are the most common ED coming to services

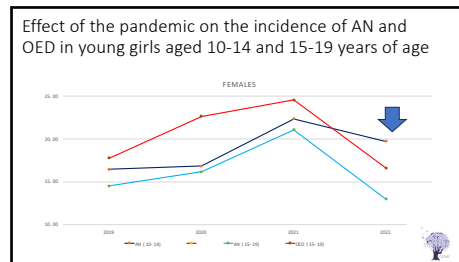
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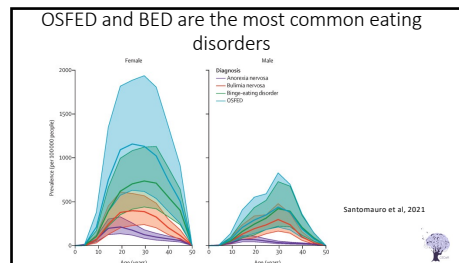
12



13







14



15

Impact of changes in prevalence/incidence


-  Increase in new onset ED in adolescents following the pandemic
-  Binge eating disorder starting to be seen/treated in public healthcare
-  Improving access to healthcare



16

Unmet treatment need


- Demand for ED services exceeds capacity to supply evidence-based treatments
- Demand-capacity gap exacerbated by the pandemic (ED services have seen almost a doubling in the number of referrals)



17

How do we target:

- waiting lists
- EDs that are not necessarily treated in secondary/tertiary services (Other eating disorders/ Other Specified Eating Disorder (OSFED))
- youth
- common EDs such as BED



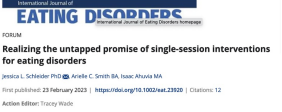
18

Many examples in the recent literature

[Early Interv Psychiatry, 2018 Apr;12\(2\):250-257, doi: 10.1111/eip.12382, Epub 2016 Sep 13.](#)


The FREED Project (first episode and rapid early intervention in eating disorders): service model, feasibility and acceptability

Amy Brown ¹, Jessica McClelland ², Elena Rosten ², Victoria Mountford ^{1, 2}, Danielle Glennon ², Ulrike Schmidt ^{1, 2}



International Journal of
EATING DISORDERS
Official Journal of the Association for Eating Disorders Research

FORUM
Realizing the untapped promise of single-session interventions for eating disorders

Jessica L. Schneider PhD , Arielle C. Smith BA, Isaac Ahuvia MA

First published: 23 February 2023 | <https://doi.org/10.1002/eat.23920> | Citations: 12

Article Editor: Tracy Wood

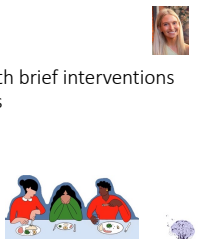
19

Targeting more common EDs (particularly in youth)




20

Reaching more youth with brief interventions & targeting common EDs



21

One way to increase access to psychological treatment is through the use of less resource-intensive interventions that are scientifically supported, accessible and scalable




22

Low intensity psychological interventions

Low intensity psychological interventions are modified, brief versions of evidence-based therapies that have a primary focus on teaching self-management skills to patients or their carers

- Can be delivered using a range of flexible delivery formats (e.g., books, digital platforms)
- Require less therapeutic input than conventional treatments
- Can be delivered by paraprofessionals

'Low intensity' from the provider's perspective, and does not reflect low engagement from the patient



23



Systematic review & meta-analysis

To systematically assess the evidence-base for the use of low intensity psychological interventions for the treatment of feeding and eating disorders compared to both active and inactive comparators

Findings:

- Low intensity psychological interventions can successfully treat ED symptoms
 - Superior to waitlist controls with moderate effects
 - Generally comparable to high intensity psychological therapies, except for remission/recovery
- Limited evidence for young people

Davey et al, 2023




24

Guided self-help treatment for Children and YP with EDs:
pilot study
Short Psychological Intervention for Children and adolescents with Eating disorders (SPICE)

- 6 participants (aged 13-17)
- Transdiagnostic (2 AN, 3 BN, 1 OSFED)
- GSH: 8 modules
- 1 session/week

Davey et al., 2024



25

Results

European Eating Disorders Review

International Journal of Eating Disorders

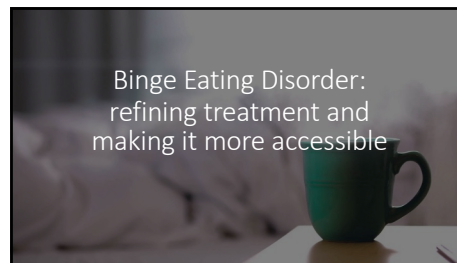
Guided Self-Help Treatment for Children and Young People With Eating Disorders: A Proof-Of-Concept Pilot Study

Journal of Child Psychology and Psychiatry

- Reduction in ED psychopathology and impairment
- The intervention was feasible to deliver, with all participants completing at least six modules and six support sessions
- Quantitative and qualitative feedback suggested the intervention was acceptable.

Davey et al., 2024

26



27

CBT for eating disorders: most studied treatment

- Recent systematic review and meta-analysis by examined CBT vs. controls (absolute effects) in 36 trials, n = 2809 with EDs
 - 22 trials on BED
 - 11 trials on BN
 - 3 trials on AN and mixed disorders

Culpers et al. (20)

28

CBT for eating disorders

- Key findings:
 - Abstinence rate CBT: 36% (95% CI: 31%; 43%);
Abstinence rate control Treatment: 10% (95% CI: 8%; 12%)
 - No significant difference between BED and BN outcomes
 - Moderate to large effect ($g = 0.88$, 95% CI: 0.71; 1.04)
 - Clinical implications: CBT is effective for BN and BED, but a large group of patients do not achieve sufficient response

Culpers et al. (20)

29

Treatment for BED (Darvariu et al., submitted)

- Systematic review with meta-analysis
- Trial Sequential Analysis and GRADE assessment of quality
- Focused on CBT for BED (relative effects)
- RCTs included: 30

Culpers et al. (20)

30

Treatment for BED: Key findings

- CBT reduced BE frequency 5X more than control treatment
- BE abstinence rates: CBT: 45%; Control: 22%
- CBT also significantly outperformed control treatment in:
 - Reducing global ED psychopathology and depressive symptoms
 - Enhancing self-esteem

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31

Treatment for BED: Key findings

- Delivery mode did not impact effectiveness
- No significant difference between group or self-help CBT (only 1 study investigated individual therapy)

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Limitations

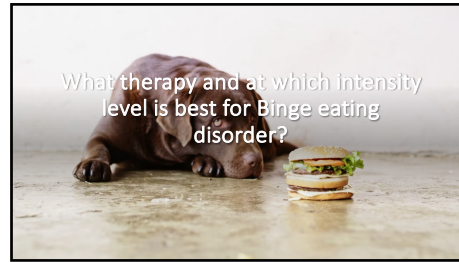
- High risk of bias in 66.6% of trials

Quality of evidence

- Overall, low quality of evidence but preliminary evidence supports the use of CBT over other treatments

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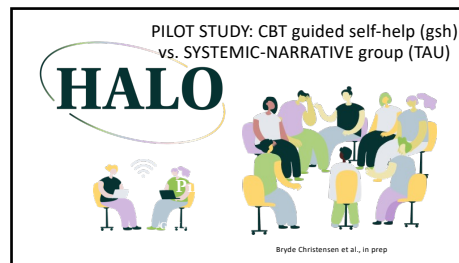
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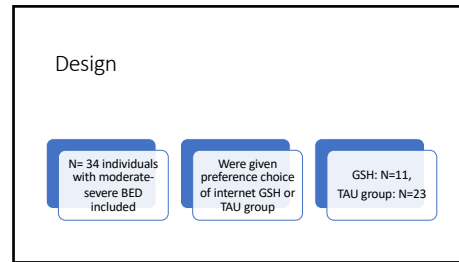
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35



36



37

Characteristics at Baseline	Guided Self Help	TAU Group
N	11	23
Age	35 (27, 37)	39 (30, 50)
Sex	64% W, 36% M	83% W, 17% M
Psychiatric Comorbidity	55%	35%
Previous ED treatment	56%	17%
BED-Q score	19	20
Depression score MDI	29	27
Readiness for Psychotherapy score RPI	29	30

38

Results total BED-Q: Between groups and time points

- Pre-post treatment: moderate effect size
- Group BED-Q score: not significantly different (p = 0.896)
- Interaction between group and time not significantly different


39

The HALO trial


- Biggest psychotherapy RCT for BED
- Four-armed, assessor-blinded, randomized clinical trial
- 320 patients (80 in each arm)
- Testing 4 psychotherapy programs: CBT-E in 3 intensities + TAU
- First study to directly compare the 3 main therapy intensities (internet-based, group and individual)

40


Aims




To assess the efficacy of four psychotherapy programs for BED



To explore 'what works for whom'

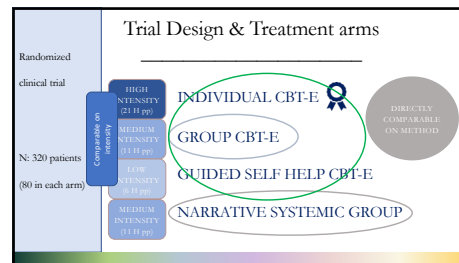


To investigate patients' experiences



To investigate direct and indirect costs associated with the population


41




42

Main Hypothesis

High intensity individual CBT will be more effective in reducing binge eating episodes compared to medium- and low intensity psychotherapy



43




Digital Psychiatry

Psykiatri

44

Conclusions

- More (and newer) ED need healthcare
- We need more 'tools in our toolbox' for more common EDs and to deal with unmet treatment needs
- More common EDs will need different psychotherapy approaches: low intensity treatments are promising but will need testing



45

CEDaR



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46

Any questions?

Thank You!

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47
