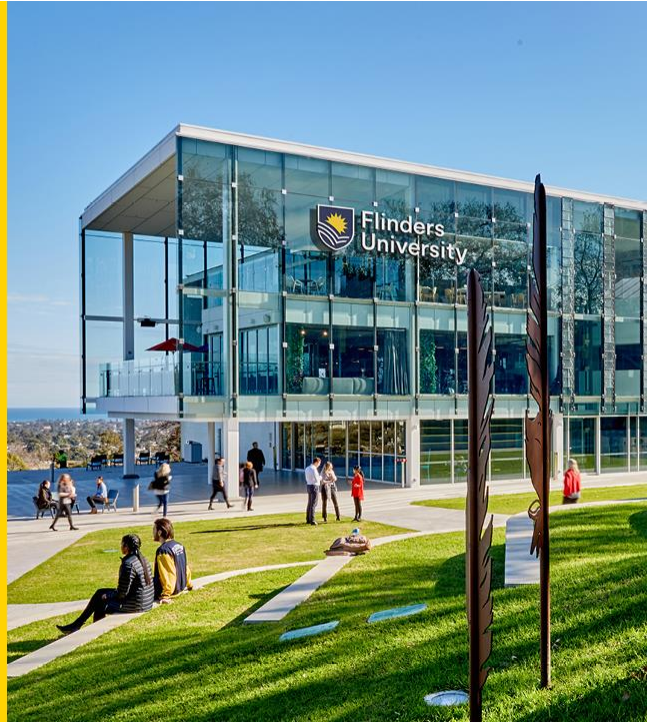


**Matthew Flinders Distinguished
Professor Tracey Wade**

EATING DISORDERS: ASSESSMENT AND TREATMENT



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Topics covered over this seminar

Assessment

- Screening tools
- Self-report
- Diagnostic
- Making the most of it

Evidence-based treatment approaches and outcomes

- Across eating disorders
- Across age groups

Monitoring progress

- Evidence related to monitoring
- What to use and how

2

Screening tools

Why screen?

- Eating disorders are highly prevalent



3

ED prevalence

82% of eating disorders emerge before age 25, when 18% of females will have met criteria for an eating disorder, and 2.4% of males

In females	
Anorexia nervosa	6.2%
Bulimia nervosa	2.4%
Binge eating disorder	0.6%
Other specified feeding and eating disorders (OSFED)*	4.5% AAN - 2.1%; PD - 1.3%; low frequency BN/BED - 0.7%
Unspecified FED*	4.5%

* Impairment caused is the same as other eating disorders

Silén, Y., et al. (2020). *International Journal of Eating Disorders*, 53(5), 520–531. doi:10.1002/eat.23236

Solmi, M., et al. (2022). *Molecular Psychiatry*, 27(1), 281–295. doi:10.1038/s41380-021-01161-7

Wilkop, M., Wade, T. D., Keegan, E., & Cohen-Woods, S. (2023). *Clinical Psychology Review*, 101, 102267. doi:10.1016/j.cpr.2023.102267

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Screening tools

Why screen?

- Eating disorders are highly prevalent
- Eating disorders have high levels of comorbidity



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Comorbidity

- At least one lifetime DSM-IV disorder is present in most adults with anorexia nervosa (56.2%), bulimia nervosa (94.5%), and binge-eating disorder (78.9%)
- The most frequently co-occurring DSM-5 diagnoses with these three eating disorders are mood and substance use disorders (half to two-thirds) and anxiety disorders (nearly half)
- In addition to co-occurring disorders, other common comorbid features including affect regulation difficulties, negative affect, perfectionism, cognitive-behavioural inflexibility, impulse control difficulties, and deliberate self-harm
- Around two-thirds of people receiving treatment for an eating disorder report at least one traumatic event

Hudson, J. I., et al (2007). *Biological Psychiatry*, 61(3), 348–358.
doi:10.1016/j.biopsych.2006.03.040

Udo, T., & Grilo, C. M. (2019). *International Journal of Eating Disorders*, 52(1), 42–50.
doi: 10.1002/eat.23004

Halmi, K. A. (2018). In W. S. Agras (Ed.) *The Oxford Handbook of Eating Disorders* (p. 229–243). Oxford University Press.

Warne, N., et al. (2021). *Journal of Affective Disorders*, 282, 386–390.
doi:10.1016/j.jad.2020.12.053

Kjaersdam Tellús, G., Lauritsen, M. B., & Rodrigo-Domingo, M. (2021). *Frontiers in psychology*, 12, 687452.
doi:10.3389/fpsyg.2021.687452

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Screening tools

Why screen?

- Eating disorders are highly prevalent
- Eating disorders have high levels of comorbidity
- Eating disorder symptoms are commonly minimised



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Minimisation of symptoms predicts less help-seeking

- *I don't believe I have a problem; The problem will get better without help*
- A GP simply inquiring about a person's mental health (as opposed to diet or eating) was likely to result in a mental health referral for people with eating disorders



In the early phase, disordered eating becomes the solution: the structured and predictable refuge that creates a sense of control or security, simplifies the problems associated with a more complex life, and can win admiration from others including health professionals

Radunz, M., Ali, K., & Wade, T. D. (2023). *International Journal of Eating Disorders*, 56(2), 314–330. doi: 10.1002/eat.23845
 Hay, P., et al. (2020). *International Journal of Eating Disorders*, 53(1), 61-68. doi: 10.1002/eat.23174

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Screening tools

Why screen?

- Eating disorders are highly prevalent
- Eating disorders have high levels of comorbidity
- Eating disorder symptoms are commonly minimised
- Disordered eating interferes with therapy



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Functional nutrition



- Scientists tell us our brain is evolving over our lifetime, called **BRAIN NEUROPLASTICITY**.
- Your genes are like instructions for how your body works - these instructions can change based on what's happening around you. This is called epigenetics.
- We can promote neuroplasticity and helpful epigenetic instructions by having adequate nutritional intake.
- Eating foods with complex carbs, like whole grains or vegetables, release glucose (which is like fuel) into your bloodstream, which is good for your brain, emotion and learning new behaviours. They also help your gut stay healthy, which is important because a healthy gut can support brain chemicals that make you feel good, like tryptophan.

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Screening tools

Tool	Name
EDE-Q7	Eating Disorder Examination Questionnaire https://hub.eatingdisordersresearch.org.au/tools/EDE-QS
EDE-Q V6	
EDE-QS	
EDE-Q8	
EDE-QS12	
EDE-Q18	
EDS-PC	Eating Disorder Screen for Primary Care
SDE	Screen for Eating Disorders
SCOFF	Sick Control One stone recent weight loss Fat Food
IOI-S	Inside Out Institute Screen https://insideoutinstitute.org.au/assets/insideout-institute-screener-2018-.pdf

Example

Screen for Disordered Eating (SDE)

Do you often feel the desire to eat when you are emotionally upset or distressed?

Do you often feel you can't control what or how much you eat?

Do you sometimes make yourself throw up (vomit) to control your weight?

Are you often preoccupied with the desire to be thinner?

Do you believe yourself be fat when others say you are thin?

Issues to consider

- “Whilst over the last 35 years a body of research has been conducted to examine the validity and reliability of various screening instruments for eating disorders, there is recognition that SCOFF, and variants of later screening tools with less examination of validity, are equally “good enough” but inadequate for detecting the broad array of eating disorders that present in primary practice settings.”
- Ability to screen for the broadening range of EDs is essential, so more recent screening tools are advised
- Language is also important; none suitable to date for Indigenous peoples

Self-report questionnaires



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Binge Eating Scale (BES; Gormally et al., 1982).	16 items, 2 factors: 3- and 4-point Likert scales.
Body Checking Questionnaire (BCQ; Reas et al., 2002).	23 items, 3 factors: 5-point Likert scale.
Body Image Acceptance & Action Questionnaire (BI-AAQ; Sandoz et al., 2013). Body image flexibility.	12 items, 1 factor: 7-point Likert scale.
Body Image Avoidance Questionnaire (BIAQ; Rosen et al., 1991).	19 items, 4 factors/behavioural themes: 6-point Likert scale, higher scores indicated greater body image avoidance.
Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987). Concerns about body shape.	34 items, 1 factor: 6-point Likert scale. Two 16-item "alternative forms" (Evans & Dolan, 1993) and a 14-item version (Dowson & Henderson, 2001).
Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008). Impact of ED y on psychosocial functioning.	16 items, 1 factor: 4-point Likert scale. Provides a global impairment score (≥ 16 indicative of an eating disorder): https://www.credo-oxford.com/7.2.html
Dutch Eating Behaviour Questionnaire (DEBQ; Van Strien et al., 1986)	33 items, 3 subscales: 5-point Likert scale. A children's version (DEBQ-C) is also available (Van Strien & Oosterveld, 2008).
Eating Disorder Diagnostic Scale (EDDS; Stice, Telch, & Rizvi, 2000). Brief diagnostic tool for eating disorders.	22 items: based on EDE-Q, scoring algorithms derive DSM-IV diagnosis for AN, BN, and BED. https://qxmd.com/calculate/calculator_562/eating-disorder-diagnostic-scale-edds
Eating Disorder Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 2008). Symptoms during the past month.	22 items: cognitive symptoms using 7-point Likert scale, 6 items for diagnostic symptoms. Can derive proxy DSM-IV and DSM-5 diagnoses: https://www.credo-oxford.com/7.2.html
Eating Disorder Questionnaire (EDQ; Mitchell, Hatsukami, Eckert, & Pyle, 1985): eating, psychiatric, social, and medical history.	16 sections with varying item numbers and response formats in each. Algorithms for DSM-IV diagnoses are available (Uttinger & Mitchell, 2016).
Night Eating Questionnaire (NEQ; Allison et al., 2008). Screens for Night Eating Syndrome (NES).	13 items, 4 subscales: 5-point Likert scale. An additional two items assess distress and impairment (Allison, 2015).
ED-15 (Tatham et al., 2015)	10 items measuring eating, weight and shape concerns and 5 behavioural items over the last week: https://cbt-t.sites.sheffield.ac.uk/resources with sessional progress tracker.

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Diagnostic tools



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Freely Available Diagnostic Interview Schedules Specific to Eating Disorders

Name	Brief description and where it can be found
Eating Disorder Examination (EDE) 17.0D	A semi-structured interview for DSM-5 eating disorder diagnoses http://www.credo-oxford.com/7.2.html
The Structured Inventory for Anorexic and Bulimic Eating Disorders (SIAB-EX)	A structured clinical interview for experts http://www.klinikum.uni-muenchen.de/Klinik-und-Poliklinik-fuer-Psychiatrie-und-Psychotherapie/de/forschung/forschungsfelder/essstoerungen/evaluation/index.html
The Eating Disorder Assessment for DSM-5 (EDA-5)	For feeding or eating disorders or related conditions according to DSM-5 criteria https://modeleda5.wordpress.com/

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avoidant/restrictive food intake disorder (ARFID)

apparent lack of interest in food, avoidance based on sensory characteristics of food, concern about aversive consequences of eating

Treatment of ARFID

Bryant-Waugh R. ARFID Avoidant Restrictive Food Intake Disorder. A Guide for Parents and Carers

Thomas J, Eddy K. Cognitive Behavioural Therapy for avoidant/restrictive intake disorder.

PARDI-AR-Q self-report measure for 4+ (parent) and 14+ (32 questions yes/no or on a 7-point scale)

<https://www.feedingmatters.org/pardi-ar-q/>

e.g., Over the past month have you avoided eating situations because you were worried something bad might happen, like being sick, choking, having an allergic reaction, or being in pain while eating (for example, because you might be served something you usually avoid for these reasons, or because you have had a bad experience in the past)?

Making the most of assessment



Motivational issues need consideration

Use of a motivational enhancement style throughout assessment. This includes a respectful curiosity pertaining to the patient's perception of the problem, greater reliance on open than closed questions, consideration of the functions of the eating disorder, the benefits of changing and the barriers to be overcome to change; moving from the here and now to the future by envisioning key values and future goals.

- Talk less than your client does
- Your most common response to what your client says should be a reflection
- On average, reflect twice for each question you ask
- When you reflect, use complex reflections more than half the time
- When you do ask questions, ask mostly open questions
- Never ask three questions in a row
- Avoid getting ahead of your client's level of readiness

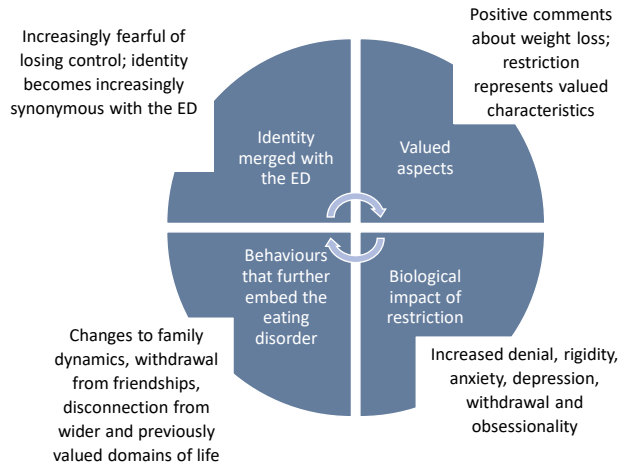
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Advantages of Change	Fears of Change	Responses to Fears
Getting better food Less focussed on food Free up the mind to focus on what really matters Less shame, guilt Exercise for fun Feel more visible Feeling less like I need to hide my body and myself Be more open to others Feel less lonely Less physical and emotional pain	Not lose weight Won't be able to maintain change Will slip back to old habits I will not be successful at changing None of this will fix anything I will find worse ways of coping with stress, guilt, shame	It is not about weight, or fixing anything, it is about stability If I continue to work on my skills, then based on previous history, it is unlikely that I will slip back into old habits I have been successful in almost everything I have set my mind to as long as I continue to work at it and keep my expectations in check It could also be possible that I will find other, less harmful ways to cope
Putting it all together: What summary statement I can use to help myself move forward in overcoming the eating disorder when times get tough? Despite my fears I have made changes in many areas of my life – I can choose to rinse and repeat or to make changes. In comparison to giving up drugs, alcohol and self-harm, excelling at University, working towards stable and healthy eating and exercise is likely to be very achievable and likely to be liberating.		

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Develop a collaborative understanding

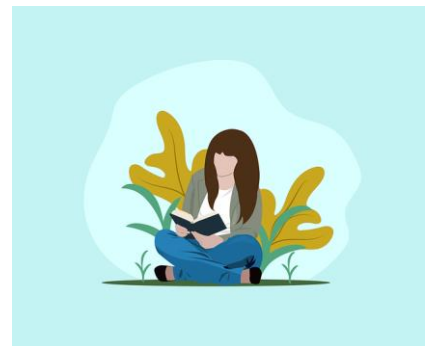
- Collaborative understanding of the vicious cycle and self-perpetuating nature of eating disorders is usually established at the end of assessment in some form of formulation or conceptualisation.
- The form of this conceptualisation can be specific to the nature of the therapy to be used subsequently or generic.



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Give patients something to focus on between assessment and treatment

- Even basic psychoeducation about functional nutrition results in patients being significantly more likely to complete treatment
- A carefully-constructed single session intervention (pdf) on behavioural activation results in 64% of patients significantly decreasing dietary restriction (first step of CBT-ED) before treatment commences – available on <https://www.flinders.edu.au/institute-mental-health-wellbeing/blackbird-initiative/nourished-mind>



Keegan, E., Waller, G., Tchanturia, K., & Wade, T. D. (2024). *Cognitive Behaviour Therapy*, 53(6), 608–620. doi:10.1080/16506073.2024.2351867
 Wade, T. D., & Waller, G. (2025). *Cognitive Behaviour Therapy*, doi:10.1080/16506073.2025.2547977

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Evidence-based treatment approaches and outcomes



Overview

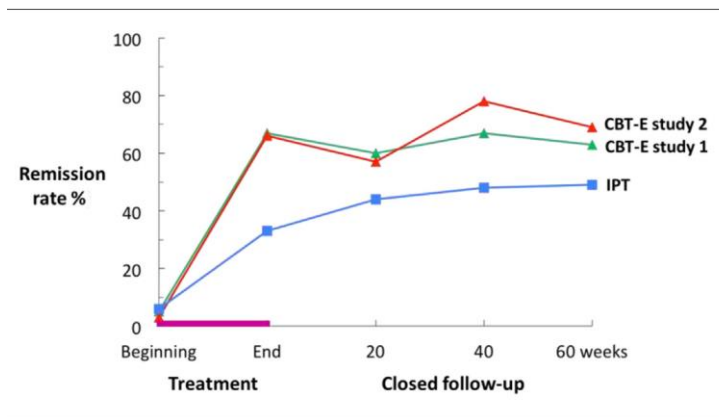
- See: Eating disorders: recognition and treatment. NICE Guideline NG69 [Internet]. 2017. Available from: <https://www.nice.org.uk/guidance/ng69>
- Disorder-focused psychological therapies are the first-line treatment of choice for most EDs, with medications having a mainly adjunctive role, with remission rates between 30 to 60%.
- Antidepressants are not particularly effective when people are underweight. Low dose olanzapine can support weight gain in adolescents or adults with AN, with the impact on psychopathology less clear.
- Pharmacotherapies for bulimic disorders include fluoxetine and topiramate as adjunctive treatments for BN, and lisdexamfetamine and topiramate for BED. It is too early to know whether GLP-1 receptor agonists have a role in the treatment of bulimic disorders in people with obesity.

Adults

Eating disorders that manifest binge-eating – bulimia nervosa and binge eating disorder

Treatment	Degree of evaluation	Magnitude of effect
SSRIs	Moderate	Moderate
CBT-ED	Moderate	Substantial
GSH-CBT	Moderate	Substantial
IPT	Some	Substantial
Psychodynamic psychotherapy	Some	none

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CBT-E
versus IPT

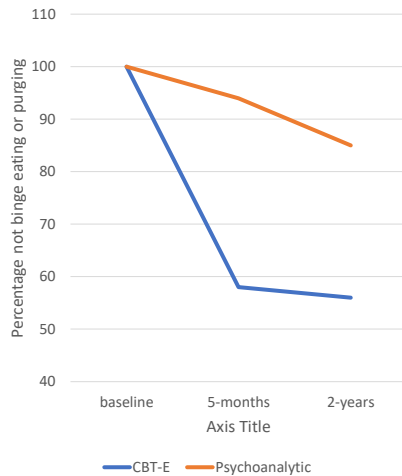
BT-E study 1 - Focused CBT-E. (Data from the original transdiagnostic study (Fairburn et al., 2009) analysed using the statistical approach em present study).

BT-E study 2 - Focused CBT-E. (Data from present study).

PT - Interpersonal psychotherapy. (Data from present study).

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Psychodynamic therapy NOT indicated



- Patients with BN received 20 sessions of CBT-E over 5 months, or weekly sessions over 2 years of psychoanalytic psychotherapy
- The latter did not impact much on behaviour
- By the end of both treatments, substantial improvements in global eating psychopathology but changes took place more rapidly in CBT

Poulsen et al., 2014, *Am J Psychiatry*

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Adults

Anorexia nervosa

Doing something is better than doing nothing:

There is consensus on the need for specialist care that includes nutritional rehabilitation and weight restoration in addition to psychotherapy

Therapy	Degree evaluated	Magnitude of effect
CBT-E	Moderate	Moderate
Focal psychoanalytic therapy	Low	Moderate
Interpersonal psychotherapy	Low	None
Refeeding or dietetic advice alone	Low	Low
MANTRA	Moderate	Moderate
Specialist supportive clinical management (SSCM)	Moderate	Moderate

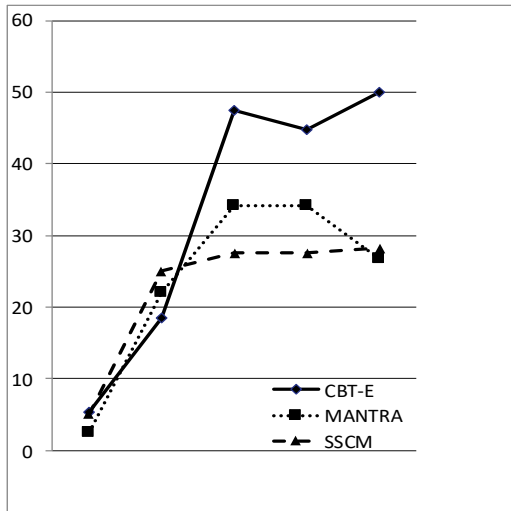
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Anorexia nervosa

Graph: Percentage of participants achieving a healthy weight (BMI > 18.5) at each time point

No difference in proportion of participants in remission at 12-month follow-up (BMI > 18.5, Global EDE < 1.81; cessation of binge eating and purging)

- *SSCM* = 27.5%
- *CBT-E* = 23.1%
- *MANTRA* = 14.6%



Byrne, S., Wade, T., et al. (2017). *Psychological Medicine*, 47(16), 2823–2833. doi:10.1017/S0033291717001349

Children and adolescents

Family-based treatment (FBT) is the dominant treatment

It emphasizes the active involvement of parents in the recovery process, allowing young individuals to receive treatment at home while focusing on nutritional restoration and behavioural management.

- It can require parents to give up employment for a while
- The caregivers need to be robust and be able to agree on strategies and work collaboratively
- It does not work for everyone
- Concerns about poorly specified protocol for handing over autonomy to the young person

Children

Bulimia nervosa

Randomised trials comparing family-based therapy with:

- Cognitive Behaviour Therapy Guided Self Care
Schmidt et al, Am J Psychiatry, 2006
- Supportive Psychotherapy
Le Grange et al, Arch Gen Psychiatry, 2007

Conclusion

- Only 2 RCTS
- CBT (GSH or CBT-E) likely to be the preferred treatment – more rapid reductions in symptoms, greater acceptability
- There are differences of opinion on this in the treatment guidelines

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Children

Anorexia nervosa

Family Based Treatment (FBT) is Tx of choice

- 22% - 42% of children with AN receiving FBT have poor outcome at 12-month follow-up

Lock et al., 2010; Eisler et al., 2016

- Parent-focused and multi-family group therapy looks as useful

Eisler et al., 2016

- Modified FBT vs CBT-E (17-24 years) with AN showed
 - 28% vs 53% drop out
 - 81% vs 89% in remission at follow-up

Nymann-Carlsson et al., 2019

Non-randomised trial

Le Grange et al., 2021

- Participants (N = 97) aged 12–18 years, with a DSM-5 eating disorder diagnosis (largely restrictive, excluding Avoidant Restrictive Food Intake Disorder), and their parents
- Chose between FBT and CBT-Ea - older and less well participants opted for CBT-E
- At follow-up, no difference between the groups in terms of weight gain or EDE global
- CBT-E is a viable treatment for adolescents with an eating disorder

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Monitoring progress



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Focus on (and respond to) session-by-session progress in therapy.

- Measurement of, sharing of, and response to, progress (or the lack of it) in therapy *in each session of therapy*.
- Requires use of a brief measurement tool immediately before each session to identify whether the problematic symptoms that brought the patient to therapy are indeed changing.
- The results from these tools are shared in session with the patient, preferably in a graphical format, to communicate the message about progress, and to discuss ways in which the patient has worked to change, and how to do more to enhance progress going forward.

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Evidence

- Meta-analyses show that measuring sessional symptom change and sharing it with the client is associated with:
 - reduction in therapy drop-out
 - improved treatment outcomes
 - making less effective (or below average) therapists more effective – they know rather than assume what is going on with their client
 - reductions in therapy duration due to better progress

[de Jong et al., 2021](#); [Delgadillo et al., 2018](#); [Delgadillo et al., 2022](#); [Janse et al., 2020](#)

ED-15 – also youth and parent version

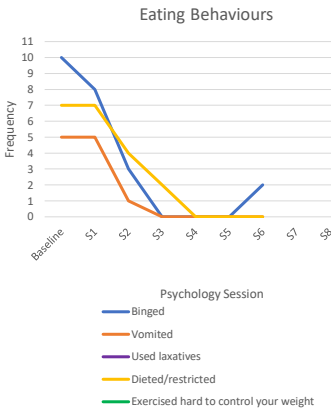
- Worried about losing control over my eating.
- Avoided activities or people because of the way I look
- Been preoccupied with thoughts of food and eating
- Compared my body negatively with others'
- Avoided looking at my body (e.g., in mirrors; wearing baggy clothes) because of the way it makes me feel
- Felt distressed about my weight
- Checked my body to reassure myself about my appearance (e.g., weighing myself; using mirrors)
- Followed strict rules about my eating
- Felt distressed about my body shape
- Worried that other people were judging me as a person because of my weight and appearance.

10 x 7-point scales, “not at all” to “all the time” assessing weight and shape concern, and eating concern

5 items assessing eating disorder behaviours over previous week

2 replicable factors (more robust factor structure than EDE-Q)

The brevity and psychometric robustness of the ED-15 in a clinical group makes it a preferable measure to the EDE-Q for sessional assessment of progress in treatment



Over the last week, how often have you	Baseline	S1	S2	S3	S4	S5	S6	
1 Worried about losing control over your eating	5	4	3	1	0	0	0	
2 Avoided activities or people because of the way I look	5	5	5	5	4	4	4	
3 Been preoccupied with thoughts of food and eating	5	4	3	1	1	1	0	
4 Compared your body negatively with others'	5	5	5	5	6	6	6	
5 Avoided looking at your body]	5	5	5	5	6	6	6	
6 Felt distressed about your weight	5	5	6	6	6	6	6	
7 Checked your body to reassure yourself about your appearance	5	5	5	5	5	4	4	
8 Followed strict rules about your eating	5	3	3	0	0	0	0	
9 Felt distressed about your body shape	5	5	5	5	5	5	5	
10 Worried that other people were judging you	5	5	5	5	5	5	5	
(0, not at all - 6, all the time)	Mean	5	4.6	4.5	3.8	3.8	3.7	3.6