FOR MENTAL HEALTH CLINICIANS AND COMMUNITY PROFESSIONALS

CLINICAL PRACTICE POINT

WORKING WITH YOUNG PEOPLE EXPERIENCING EATING DISORDERS

THIS RESOURCE WILL HELP YOU

- **Understand eating disorders and their presentation in different cohorts of young people.**
- **Identify potential eating disorders through screening and assessment tools.**
- **Engage young people in treatment for eating disorders.**
- **Understand the different specialised approaches used in eating disorder treatment.**
- **Collaborate better with families and external agencies to support the young person.**

WHAT ARE EATING DISORDERS?

Eating disorders are complex mental health conditions that typically emerge during childhood or early adolescence.(1) A person has an eating disorder when their attitudes to food, weight, body size or shape lead to marked changes in their eating or exercise behaviours. This interferes with the person's life and relationships and can have significant impacts on their physical health and psychological wellbeing. People with current or former eating disorders have increased mortality and a reduced quality of life.(2) Therefore, early identification and intervention is highly important in supporting people with eating disorders in the long-term.(3)

Not all mental health professionals will be able to provide specialist treatment for eating disorders. However, all professionals working in youth mental health will likely encounter young people impacted by eating disorders, either as a primary concern or co-occurring with other mental health challenges. Understanding how to recognise, assess, and provide support for eating disorders is essential for all youth mental health clinicians.

TYPES OF EATING DISORDERS

The term "eating disorder" serves as an umbrella term for a group of related mental health conditions. While all eating disorders involve disturbances in eating behaviour and a preoccupation with food, weight, or body shape, they differ in their specific presentations and diagnostic criteria. Table 1 below outlines the various eating disorder diagnoses.

Many people will move from one eating disorder diagnosis to another over their lifetime, or they may not always fit neatly into one category. This tendency for symptoms and behaviours to change over time makes diagnosing eating disorders challenging. All young people exhibiting signs of a disordered eating pattern should be offered support and treatment.

Table 1. Eating disorder diagnoses

DIAGNOSIS	CHARACTERISTICS
Anorexia nervosa (AN)	Characterised by the restriction of energy intake relative to an individual's requirements (e.g. a reluctance or refusal to eat). This can lead to significantly low body weight, and intense fears and thoughts about body size and weight. The average onset of AN is 16-17 years old but it can also impact younger people.(4)
Bulimia nervosa (BN)	Characterised by recurrent episodes of binge eating (overeating with a sense of no control), followed by compensatory behaviours, like self-induced vomiting, misuse of laxatives, fasting or excessive exercise. People with BN don't typically appear low weight and are instead usually in the 'normal' or 'overweight' body mass index (BMI) category.
Binge eating disorder (BED)	Characterised by recurrent and rapid episodes of binge eating. This often manifests as overeating when not physically hungry combined with a sense of no control over what or how much is eaten. The person experiences distress due to their binge eating and it may be associated with feelings of disgust, shame, or guilt. Compensatory behaviours seen in BN are not present in BED. People with BED don't typically appear low weight and are instead usually in the 'normal' or 'overweight' BMI category.
Avoidant/restrictive food intake disorder (ARFID)	Characterised by a failure to meet nutritional and/or energy requirements due to disturbances in eating. Distinct from anorexia nervosa, individuals with ARFID are not characterised by disturbances in the way they perceive their body or weight. Young people with ARFID may present as underweight, within expected body weight range or in a bigger body. Disturbances in eating may be related to sensory characteristics, lack of appetite or interest in food/eating and anxiety about possible aversive consequences of eating, such as fear of choking. Emerging research suggests an increased prevalence of ARFID in Autistic populations.(5)
Other specified feeding or eating disorder (OSFED)	Characterised by many symptoms of another eating disorder but the full criteria for a diagnosis is not quite met. This category includes atypical anorexia nervosa, where weight is within or above the normal range, and purging disorder, which is engaging in a recurrent behaviour to influence weight or shape in the absence of binge eating.
Unspecified feeding or eating disorder (UFED)	Like OSFED, UFED is characterised by many of the symptoms of another eating disorder, but these do not meet full diagnostic criteria. It is used as a diagnosis in situations where the clinician chooses not to specify the reason why another eating disorder was not met, including when there is insufficient information for a more specific diagnosis.

YOUNG PEOPLE EXPERIENCING EATING DISORDERS

Eating disorders are common in young people and can lead to significant interference with day-to-day life. Young people of all genders can become excessively concerned with body image, size, weight, shape, perceived defects, and fitness.(1) The Butterfly Foundation suggests that up to 90% of young people report being concerned about their body image.(6) This preoccupation can change a young person's behaviour, disrupting key developmental processes and identity formation.

Eating disorders can affect every system of the body, having enduring impacts on an individual's physical health, quality of life and close relationships. Malnutrition and starvation in young people can lead to deteriorating mood and complications such as growth stunting, changes in brain structures, cardiac problems, osteoporosis, amenorrhea, and infertility. Purging behaviours can also lead to physical health dangers, such as electrolyte imbalances, heart arrhythmias and cardiomyopathy, and dental problems.

There are a multitude of factors that can increase vulnerability to and perpetuation of an eating disorder, however dieting is the single biggest predictor for the development of an eating disorder.(7) It is important that young people have access to early intervention to help assist with recovery and planning for education, physical health, work and relationships. Early identification and intervention can result in better long-term outcomes, with treatment in the first two or three years of onset significantly increasing the chance of recovery.(8,9)

UNDERSTANDING THE DEVELOPMENT OF AN EATING DISORDER

Eating disorders are multifaceted, with the development of an eating disorder dependent on several variables. These include sociocultural, biological, genetic, and psychological factors.(7,10) While this is the case, several key risk factors exist which may lead to the development of an eating disorder. These are described in Table 2 below.

Table 2. Key eating disorder risk factors (7)

RISK FACTOR	CHARACTERISTICS
Genetics	• Genomic variations • Family history of eating disorders • Gender
Biological	• Gastrointestinal microbiota variations • Intestinal infections • Chronic inflammation • Autoimmune diseases
Childhood and development	• Childhood weight status • Relationship with parents and perception of weight • Neglect and abuse • Trauma and post-traumatic stress disorder
Personality traits	• Perfectionism • Impulsiveness • Obsession
Social and environmental	• Exposure to and internalisation of the 'thin ideal' • Body dissatisfaction • Peer pressure or bullying • Food insecurity • Problematic social media use • Involvement in elite sports • Education level

Adapted from: Barakat et al. 2023. Risk factors for eating disorders: Findings from a rapid review.(7)

BODY IMAGE AND SOCIAL MEDIA

With the rise of social media, young people are spending an increasing amount of time in online spaces. Australian data indicates that two-thirds of young people spend more than two hours per day on social media.(11) High social media use has repeatedly been linked to mental and physical health challenges, including disordered eating behaviours.(11)

Much of the content marketed to young people takes the form of "fitspiration" and "thinspiration", but it often depicts idealised, excessively thin or overly lean bodies. These types of bodies are presented as desirable or attainable, even when they are unrealistic.(12) Research shows that exposure to image-centric content is associated with higher levels of eating disorder symptoms in those that are already at risk of developing an eating disorder.(12) Problematic or excessive internet use has also been found to increase shape and weight concerns, affecting both men and women equally.(13,14) Social media algorithms can intensify these effects: when a young person engages with body-idealising content, similar material is more likely to be subsequently delivered to them. This compounds the impact and reinforces related anxieties.(12)

Finally, the growing popularity of weight loss medications (e.g. Ozempic) has led to increased advertising and influencer marketing from around the world where different advertising regulations apply. This wider exposure is a further concern for young people who are vulnerable to eating disorders and body dissatisfaction. It can normalise pharmacological weight loss, glamourise rapid results, and potentially fuel demand for unsupervised or off-label use.(15)

IDENTIFICATION AND ASSESSMENT

Young people with an eating disorder may try to hide or disguise their behaviour. For others, the eating disorder is ego-syntonic and linked to things like control, perfectionism, and identity. In these cases, the young person may simply not recognise that there is anything wrong or problematic with their behaviour. All of this can result in a delay in accessing treatment and support, making long-term physical health, mental health and relationship issues more likely. It is important that young people have access to early identification and intervention to help assist with recovery and positive long-term outcomes. When physical health is a concern, this should also include a referral to a medical professional to carry out further physical health assessments such as blood tests.

Regardless of the reason why a young person is presenting for mental health support, it is important that professionals listen for eating disorder concerns. Young people may experience barriers to disclosing disordered eating thoughts and behaviours. They may also oscillate between different symptoms, and experience co-occurring mental health or neurodevelopmental conditions. This makes identifying an eating disorder difficult; however, a short screening measure may be helpful for identifying young people with eating disorder concerns. The SCOFF questionnaire displayed below is validated for young people aged 12 years and older.(16)

A comprehensive assessment may also help to identify if a young person has or is at risk of developing an eating disorder. Questionnaires are not diagnostic but can assist with identifying if a more detailed assessment is needed. There are several tools available, including:

- The Eating Attitudes Test (EAT-26).(17)
- The Eating Disorder Examination Questionnaire (EDE-Q) for use with adolescents 14 years and older.(18)
- The Children's Eating Attitudes Test (ChEAT) for use with younger children 8 – 15 years old.(19)

Table 3. SCOFF Questionnaire

ONE POINT IS GIVEN FOR EACH 'YES' ANSWER. A SCORE OF ≥2 WARRANTS FURTHER ASSESSMENT.		
Do you ever make yourself **Sick** because you feel uncomfortably full?	Yes	No
Do you worry you have lost **Control** over how much you eat?	Yes	No
Have you recently lost **Over** 6kg in a three-month period?	Yes	No
Do you believe yourself to be **Fat** when others say you are too thin?	Yes	No
Would you say that **Food** dominates your life?	Yes	No

PSYCHIATRIC COMORBIDITIES

Most people with an eating disorder will also have another mental health diagnosis or neurodevelopmental disorder. This is important to consider when understanding the eating disorder and potential treatment outcomes. The most common co-occurring conditions are:

- anxiety disorders
- major depressive disorder and other mood disorders
- post-traumatic stress disorder and complex trauma
- obsessive compulsive disorder
- personality disorder
- substance abuse disorders
- deliberate self-harm behaviours and suicidal ideation/suicidality
- autism spectrum disorder and attention-deficit/hyperactivity disorder
- chronic illness where care is linked to diet monitoring (e.g. diabetes, IBD, etc.) (20)

A note on risk: Suicide is a leading cause of death for young people experiencing an eating disorder.(21) Suicidal ideation and behaviour can be linked to an eating disorder diagnosis and the presence of other comorbidities. This risk is heightened for young people experiencing social exclusion, for example due to their ethnicity or being transgender.(20) Therefore, a thorough assessment of risk and eating disorder behaviours should be included in mental health assessments at frequent time points as required.

BIASES IN IDENTIFICATION

There are strong stereotypes that exist about eating disorders and the types of people who experience them. Often the people who are represented as having an eating disorder are young, white, underweight and cisgender females.(1,7) These stereotypes are common within the general population, but they can also impact the beliefs and behaviours of healthcare providers, leading to an under-diagnosis of eating disorders in males, those who are not underweight, and young people from culturally diverse backgrounds.(1,22,23)

GENDER

Population studies suggest that men could make up 1/4 of people experiencing an eating disorder, with AN, BN, and BED being most common.(1,23,24) While this is the case, often young men will not receive a diagnosis or will not engage in treatment. This is often due to stigma but also the different symptom presentations in men.(1,23) For example, young men may experience a preoccupation with building muscle, a fixation on a high protein diet, or may engage in compulsive exercise. This is markedly different to what's indicated in most eating disorder research which is done on female populations.(23)

Likewise, LGBTIQA+ communities experience higher rates of eating disorders compared to their cisgender and heterosexual peers. It has also been suggested that there may be a relationship between gender dysphoria and eating disorders, leading to increased disordered eating risk in these populations.(1,25) This, in combination with considerable healthcare access barriers, means LGBTIQA+ young people may experience significantly higher rates of undiagnosed and untreated eating disorders.(22)

YOUNG PEOPLE IN BIGGER BODIES

People in bigger bodies are at an increased risk of developing an eating disorder.(7,22) They are also more likely to seek and receive treatment for weight loss as opposed to appropriate treatment for their eating disorder. Research has found that adolescents who both have a history of being overweight and have developed a restrictive eating disorder, take longer to be identified and may consequently have poorer long-term outcomes.(7,26)

It's important that mental health professionals are aware of the biases that exist in both the community and the broader healthcare sector. This may influence how the young person presents in session, including their own beliefs and what they have been told by other healthcare professionals.

ENGAGING YOUNG PEOPLE IN TREATMENT

Young people may find it hard to disclose or discuss their eating disorder thoughts and behaviours. There are several strategies that mental health professionals can implement to better enhance engagement. Key strategies that can be implemented are detailed in Table 4.

Table 4. Engagement strategies (27,28)

STRATEGY	FEATURES
Building therapeutic rapport	• Be non-judgmental, taking a curious approach. • Try to identify concerns such as shame, fear, secrecy. • Identify the young person's values and future goals (outside of health and weight). • Validate the young person's feelings, rather than the thoughts or behaviours related to the eating disorder. • Be understanding about any ambivalence towards change – exploring both what the eating disorder provides (e.g. comfort, control, etc.) and what it costs. • Respect the young person's autonomy while maintaining safety. • Develop goals which may mean working on other issues first (e.g. anxiety) before exploring eating disorder behaviours.
Addressing ambivalence and resistance	• Normalise the young person's ambivalence – especially when the eating disorder is linked to things like control or perfectionism, the young person may not see their behaviour as problematic. • Externalise the eating disorder and name it as just one part of the young person. • Consider the stages of change model.
Developmental considerations	• Involve families, carers, and supporters when appropriate. • Consider confidentiality and support emerging autonomy. • Consider peer influence and support.
Trauma-informed approaches	• Avoid re-traumatisation. • Understand the function of trauma in the presentation. • Engage in active listening and prioritise trust-building. • Understand control in the eating disorder behaviours.
Holistic care	• Aiming discussions at recovery in both body and mind. • Individualising strategies for the young person. • Offering peer support when available.

PSYCHOTHERAPY APPROACHES

At different stages of illness, different treatments are likely to be beneficial for young people. Recovery requires a multidisciplinary approach as well as a significant commitment from the young person's entire family. A multidisciplinary team will involve a range of health professionals, including medical teams for things like refeeding and bone health, as well as dietetic input. Mental health care teams play an important role in working with the young person and their family to support recovery and rehabilitation in the long-term.

YOUNG PEOPLE UNDER 18 YEARS OLD

Family-Based Treatment (FBT) is the recommended first-line treatment for adolescents with anorexia nervosa, with emerging evidence supporting its use for bulimia nervosa and other eating disorder presentations.(29,30) FBT is grounded in the understanding that parents and carers are the young person's most important resource for recovery. The treatment empowers families to actively support nutritional rehabilitation and interrupt eating disorder behaviours. This recognises that the eating disorder itself impairs the young person's capacity to recover independently.(30,31)

Central to FBT is the concept of externalising the eating disorder – helping families understand that the eating disorder is an illness affecting their child, not a choice the young person is making.(30,31) Treatment for anorexia nervosa typically follows three phases: Phase One focuses on parental control of refeeding and weight restoration (where needed); Phase Two involves gradually returning control of eating to the young person; and Phase Three addresses broader adolescent issues and relapse prevention. FBT typically takes 6-12 months and requires commitment from both the young person and their family to attend regular sessions and implement strategies at home between sessions.(30)

FBT for bulimia nervosa takes a more collaborative approach between the family and young person. The focus for this is on interrupting the pattern of binge eating and purging by modifying parental criticism and reducing shame and secrecy.(30) Likewise, FBT may be used for other eating disorder diagnoses by normalising eating habits, implementing regular family meals, and parents modelling healthy eating.(30)

It's important to note, FBT may not always be available without a trained professional. It also may not always be appropriate, especially when there is significant family conflict, safety issues, the young person is living independently or in out-of-home care, families are unable to take an active role in treatment, or when cultural factors make family-based approaches less suitable. In these cases, individual therapies such as Enhanced Cognitive Behavioural Therapy (CBT-E), Dialectical Behaviour Therapy (DBT), and Acceptance and Commitment Therapy (ACT) may be more appropriate. See the following section for more information on these.

YOUNG PEOPLE OVER 18 YEARS

CBT enhanced for eating disorders (CBT-E) should be the first line of treatment for young people over 18 years old. CBT-E has been found to lead to the greatest symptom reduction trans-diagnostically across eating disorders.(29) It aims to support young people in developing helpful and balanced attitudes towards body image, eating and weight. These interventions also seek to reduce the importance of body shape and weight in defining self-worth and success. CBT-E is usually delivered as 20 weekly sessions for binge eating disorder and bulimia nervosa, while 40 total sessions is used for anorexia nervosa diagnoses.(29)

CBT-E interventions should also:

- provide psychoeducation on the effects of dieting (for example, physical and psychological);
- provide information on balanced nutrition and physical activity; and
- support exploration and understanding of the sociocultural pressure to be thin and the role of the media.

CBT interventions may also address adjunctive mechanisms that maintain disordered eating thoughts and behaviours, such as perfectionism, low self-esteem, interpersonal difficulties, mood dysregulation or intolerance.

Note: *Hospitalisation should only be used when required to manage medical or psychological risk.*

WORKING WITH FAMILIES

Working collaboratively with the young person's systems, including their family, is important for the recovery process. Families play an important role in identifying signs of eating disorders and supporting help-seeking and treatment.(3) As such, families should be seen as part of the solution to overcoming an eating disorder, not the problem.(27,32) Young people can be reluctant to share information with their family, sometimes for fear of their emotional response or because they perceive that this will burden their family. However, most barriers can be problem-solved within sessions.

When appropriate to engage families, mental health professionals should undertake psychoeducation with the family to ensure they understand the young person's eating disorder, its function, and how it presents in the home. As part of this, mental health professionals should communicate the following messages:

- Eating disorders are serious mental health conditions and are not just a 'lifestyle choice'.
- Neither the parent/carer nor young person are to blame for the eating disorder.
- There are effective evidence-based treatments available.
- Early intervention is associated with the best treatment outcomes.
- There are family networks and peer supports available for parents/carers of a young person with an eating disorder.

WORKING WITH EXTERNAL AGENCIES

School: Positive engagement with school gives young people an opportunity to maintain a healthy developmental trajectory, complete key developmental tasks and maintain important peer relationships. Young people with eating disorders are best supported in the school environment when a collaborative approach is taken between the young person, their family, their care teams, and their school. School wellbeing teams can support rehabilitation and relapse prevention efforts through the development of a management plan for when the young person is at school. This may include creating accommodations to support learning and wellbeing in the school environment, supporting communication with families, and implementing strategies for monitoring and managing risk.

General practitioner: For all young people experiencing eating disorders, it's important for them to have access to an empathetic and skilled general practitioner (GP) with knowledge of eating disorders. GPs are an important resource in monitoring the young person's physical health and coordinating a multidisciplinary approach to support. For some eating disorders, GPs can support young people to access a Medicare Eating Disorder Care Plan which provides subsidised access to 40 sessions with a mental health clinician and 20 sessions with a dietitian over a 12-month period.(33)

Dietitians: A registered dietitian can provide young people with nutritional care, supporting rehabilitation alongside mental health counselling.(29) In Australia, dietitians are not required to undergo specialised training in eating disorders, however engaging a dietitian with knowledge and skills to safely care for young people with eating disorders is important. Dietitians can provide tailored, holistic treatments for young people, including developing appropriate nutritional goals, feeding regimes, and weight targets.(34)

TAKE HOME MESSAGE

Eating disorders are complex yet common mental illnesses in young people. It is typical for young people to experience co-occurring mental health or neurodevelopmental conditions alongside an eating disorder. This makes it important for mental health professionals to look for signs of disordered eating, even when the primary reason for presentation may be something different. Young people can access specialised care to support them in their recovery and mental health professionals can engage families and external agencies to support this work.

CASE STUDY

Caitlin is a 16-year-old girl referred to a community mental health service by her GP, who had noted low mood and some vague gastrointestinal complaints during a routine appointment. There was no mention of eating in the referral. Caitlin presented as articulate and socially engaged, and her weight fell within a typical range.

During the first two sessions, Caitlin disclosed that she had been binge eating and purging through self-induced vomiting two to four times per week for approximately eight months. Episodes were typically triggered by stress and conflict at home and were followed by intense shame and self-criticism. She had told no one. Caitlin expressed ambivalence about disclosing further, fearing she would be "made to eat more" and that her parents would be disappointed.

IDENTIFICATION AND ASSESSMENT

Bulimia Nervosa often goes undetected precisely because young people presenting with it may show few outward physical signs and are frequently skilled at concealing their behaviours. The clinician was careful not to screen only for restriction or low weight, instead using open, non-assumptive questions about Caitlin's relationship with food, eating, and her body as a routine part of assessment.

Psychiatric comorbidities were also explored. Caitlin met criteria for moderate depression and reported a history of perfectionism and high self-criticism that predated the eating disorder.

ENGAGING CAITLIN IN TREATMENT

Caitlin's ambivalence was met with curiosity rather than urgency. The clinician validated the function of managing overwhelming emotion while gently building Caitlin's awareness of their impact on her mood, concentration, and physical health. Motivational approaches were used early to explore what Caitlin valued and what she hoped her life could look like. Session structure was collaborative, with Caitlin having input into the pace and focus of sessions to support her sense of agency.

WORKING WITH EXTERNAL AGENCIES

With Caitlin's consent, the clinician contacted her GP to share a clinical summary and recommend medical monitoring, including electrolyte checks given the frequency of purging. The clinician also liaised with Caitlin's school counsellor - not to disclose the full clinical picture, but to ensure Caitlin had a supportive contact during the school day and that academic pressure was being managed sensitively during treatment.

Caitlin's family were brought into the treatment as a supportive resource, consistent with an FBT-informed approach. Sessions helped her parents understand BN and how to reduce inadvertent triggers at home such as critical comments about food and bodies. As treatment progressed, the clinician worked with Caitlin and her parents to develop a shared understanding of her relapse warning signs and a plan for how to respond if episodes increased. The clinician normalised the likelihood of slips to help reduce the shame and secrecy that had allowed Caitlin's behaviours to initially go undetected.

RELATED RESOURCES

- Eating disorders. Fact sheet.

FURTHER INFORMATION

- Eating Disorders Victoria. www.eatingdisorders.org.au/find-support/stories-of-recovery/
- FREED. https://freedfromed.co.uk/
- Inside Out Institute for Eating Disorders. https://insideoutinstitute.org.au/
- National Eating Disorders Collaboration. https://nedc.com.au/
- NICE guidelines. https://www.nice.org.uk/guidance/ng69
- The Butterfly Foundation. www.butterfly.org.au/your-stories/all-stories.
- The Victorian Centre of Excellence in Eating Disorders. https://ceed.org.au/

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