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Recent Advancement in Evidence-based Psychological Therapies for Eating Disorders: A Review

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Abstract: Eating disorders (ED) is a behavioral problem defined by severe and persistent eating pattern disorder and severe mental illness, which will cause serious and even life-threatening risks to the physical and mental health of patients. The best nursing guidelines include early detection and immediate intervention, supported by a science-focused interdisciplinary team approach involving experts in the fields of medicine, psychology and nutrition. This article summarized the current treatment suggestions by understanding ED diagnosis, the Association for Eating Disorders (AED) treatment guidelines, and the evidence-based psychotherapy recommended by AED for children/adolescents, adults, and special populations. Future modifications of the recommendations will take into account fresh scientific knowledge as it emerges because the body of evidence is growing quickly.

Keywords: Eating Disorders (ED), Association for Eating Disorders (AED), evidence-based psychological therapies

1. Introduction

No matter a person's weight, Eating Disorders (ED) are behavioral issues defined by major and continuous eating pattern disruptions and severe mental diseases, both of which pose serious, even life-threatening risks to the sufferer's physical and mental health [1]. One of the highest rates of mortality among patients with EDs of any psychiatric disease is the proportion of those with a diagnosis of a problem. In contrast, women with Anorexia Nervosa (AN) have an early death risk that is 6 to12 times significantly greater than that of the general population [2] once age is taken into consideration. AN and bulimia nervosa (BN) affect women in respective proportions of 0.5 percent and 2-3 percent during the course of their lifetimes. The most common age range for onset is 12 to 25. Despite being present in men 10% of the time, women experience it much more frequently. The two eating disorders that are most prevalent are binge eating disorder (BED) and Other Specified Feeding and Eating Disorder (OSFED), although the prevalence of Avoidant or Restricted Food Intake Disorder (ARFID) is unknown as this category was only recently made [3]. The optimal guidelines for care include early detection and immediate intervention, supported by a scientifically focused, cross-disciplinary group approach that involves specialists in the fields of medicine, psychology, and nutrition [4].

Treatment for eating disorders that are demonstrated by scientific literature and show successfulness or usefulness is referred to as evidence-based treatment. When compared to other accepted treatments, these therapy modalities have undergone extensive testing and deliver the best

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results. Although the body of data is growing quickly, there are still a number of significant holes, and future editions of the study will take new scientific information into account as it emerges. To fill in these gaps in the evidence base, the researchers provide a number of therapeutic recommendations. In cases where there is evidence from research and clinical experience, we anticipate that the advancement will highlight the benefits of specific therapy techniques.

In this work, the author will summarize the current treatment suggestions by understanding ED diagnosis, the Association for Eating Disorders (AED) treatment guidelines, and the evidence-based psychotherapy recommended by AED for children/adolescents, adults, and special populations. Hope to provide some help for future modifications of the recommendations.

2. ED Diagnosis

According to the 5th edition of *the Diagnostic and Statistical Manual of Mental Disorders* [5] and the 10th revision of the *International Statistical Classification of Diseases and Related Health Problems* [6], the following EDs are the most prevalent:

1. Avoidant/Restrictive Food Intake Disorder (ARFID): Severe weight decrease, poor nutrition, reliance on dietary neutraceuticals, or significant problems with social functioning as a result of calorie and/or nutrient limitation, but without concerns about weight or appearance.
2. Anorexia Nervosa (AN): Restricting calorie consumption below what is necessary, results in extremely low body weight as compared to one's age, sex, developmental trajectory, and health state. Additionally, there might be problems with body image, a terrible dread of putting on weight, an insufficiency of awareness of the illness's importance, and/or habits that prevent weight growth.
3. Bulimia Nervosa (BN): This condition is marked by binge eating, which is defined as consuming a lot of food quickly while feeling out of control, followed by purgings/compensatory behavioral patterns, such as self-induced throwing up, laxative or diuretic abuse, insulin misapplication, exercising excessively, or diet pills, once per week or more for more than three months. There may also be a severe fear of gaining weight, issues with body image, and a failure to recognize the seriousness of the situation.
4. Binge-Eating Disorder (BED): Repeated binges for at least three months without using any other coping techniques Binge eating episodes are characterized by fast eating without feeling hungry, stopping only when very full, and/or be accompanied by feelings of embarrassment, humiliation, or grief.
5. Other Specified Feeding and Eating Disorder (OSFED): This term refers to an ED that displays particular disordered eating behaviors as important characteristics, such as limiting diet, purging, and/or food addiction, but does not entirely fit into the aspects for one of the categories stated above. Purging disorder and nocturnal eating syndrome are two examples.
6. Unspecified Feeding or Eating Disorder (UFED): The caregiver is unable to pinpoint the precise ED behaviors being displayed.

3. Academy of Eating Disorders (AED) Treatment Guideline, 2020

An international professional association called the Academy for Eating Disorders (AED) is dedicated to setting the standard for investigating, comprehension, care, and preventing EDs around the world. Specialists in EDs from all over the world attend its yearly International Conference on Eating Disorders (ICED) conference. A companion manual [4] to the AED's medical care manual focuses on research-supported psychotherapy treatment for eating disorders. It is intended to educate doctors across the globe, especially those who practice in regions lacking their rules. It is significant to emphasize that it concentrates on those carefully examined and determined to be successful rather than including all currently available therapies or techniques. It is commonly permissible to use the

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best-supported psychiatric treatments for the nearest diagnosis when there is no suggestion for an exact diagnosis.

4. Evidence-Based Psychological Therapy for Children/Adolescents, Adults, and Special Populations Recommended by AED

The table below (Table 1-3) compiles a number of national recommendations and is organized by developmental stage for children/teens, and adults, as well as its corresponding diagnosis. There are various areas where no evidence-based recommendations for any kind of psychological therapy are being made. This is especially true for the more recently identified and varied illnesses (OSFED and ARFID). In these situations, treating the person as though they had the most similar particular eating problem is the most frequent advice in national guidelines. The seven national guidelines from the US, UK, Germany, France, Netherlands, Denmark, Australia, and New Zealand that served as the basis for the synthesis recommendations for children and adolescents are listed in Table 4-6. Important methodological differences, such as the weight placed on clinical professional judgments, the timing of evidence gathering, contexts, and the quantity of evidence required to support a conclusion, can result in some guidelines' recommendations differing in significant ways. Because there is little research on evidence-supported psychological interventions offered in settings apart from outpatient clinics, this guide does not distinguish between the various contexts in which eating disorders are treated. However, these findings and suggestions can be considered applicable to most clinical practices given that psychotherapy of EDs is effective in routine medical practice if it abides by the guidelines already tested in clinical research settings.

Table 1: Recommendations for children and adolescents(Blank means none).

	FIRST LINE TREATMENTS	SECOND LINE TREATMENTS
AN	Adolescent-Focused Therapy	Family-Based Treatment
BN	As above Cognitive-Behavioral Therapy for Eating Disorders	
BED		Guided Self-Help Cognitive-Behavioral Therapy
Pica Rumination		

Abbreviation as follows:
(1):AFT
(2):CBT-ED
(3):CBTgsh
(4):FBT

Table 2: Advice for adults.

	PRIMARY TREATMENTS	SECONNDARY TREATMENTS
AN	CBT-ED MANTRA SSCN	Focal Psychodynamic Psychotherapy
BN	CBT-ED CBTgsh	IPT Group Psychotherapy

Table 2: (continued).

BED	CBT-ED group or individual CBTgsh	IPT
ARFID Pica Rumination OSFED UFED	None	No

CBT-ED: Cognitive-Behavioral Therapy for Eating Disorders
CBTgsh: Guided Self-Help Cognitive-Behavioral Therapy
IPT: Interpersonal Psychotherapy
MANTRA: Maudsley Model of Anorexia Nervosa Treatment for Adults
SSCM: Specialist Supportive Clinical Management

Table 3: Special populations' advice.

The following factors have insufficient evidence to prove that their exceptional treatment of different age groups should be reasonable:
• Sexual distinction • deformity or being hurt • ethnicity • socioeconomic status or sociocultural background • sex orientation or sexual identity • weight • Mental health (e.g. mood, stress disorder, personality disorder, substance use disorder and other symptoms) • epidemic or chronic disease • religion

Table 4: Evidence-Based psychotherapies for children and adolescents: ANOREXIA NERVOSA.

COUNTRY	THE FIRST THERAPY BASED ON EVIDENCE	THE SECONDTHERAPY BASED ON EVIDENCE	UNPROVEN ALTERNATIVE OPTIONS, WEAK ADVICES, CLINICAL CONSENSUS	VARIABLES FOR PRIMARY OUTCOME	VARIABLES FOR SECONDARY RESULUTS	ORIGIN OF THE EVIDENCE
ANOREXIA NERVOSA						
UK	FBT AFT			Body mass index Eating habits behavious	Life Quality Nervous	NICE 2017

Table 4: (continued).

Germany	FBT			BMI		AWMF German S3-Guideline Diagnosis and Therapy of EDs
France		Family therapies				HAS Clinical Practice Guidelines
Denmark	FBT-AN		Strengthen physical exercise in weight gain stage.	Set the target weight gain and measure it.	Pay attention to symptoms that do not appear. Raise your weight and ensure that it is 50% higher than the standard level	Danish Health Authority 2016
Australia and New Zealand	FBT (manualized)	Family substitution method; Focus therapy for adolescents	Use unconventional means	Weight gain, biological normalization	Dietary change enhanced body image reduced compensatory behaviors	RANZCP guideline 2014
USA	FBT-AN		Avoid family therapy and prevent parents from scolding.			APA Practice Guideline 2012
Netherlands	FBT	CBT-ED; Adolescent Focused Therapy				Practice Guidelines for the treatment of EDs 2017

AFT: Adolescent-Focused Therapy
CBT-ED: Cognitive-Behavioral Therapy for Eating Disorders
FBT: Family-Based Treatment

Table 5: Evidence-Based psychotherapies for children and adolescents: BULIMIA NERVOSA.

COUNTRY	FIRST-LINE THERAPY BASED ON EVIDENCE	SECOND-LINE THERAPY BASED ON EVIDENCE	UNPROVEN ALTERNATIVE OPTIONS, WEAK RECOMMENDATION, CLINICAL-CONSENSUS	VARIAB-LES FOR PRIMARY OUTCOME	VARIABLES FOR SECONDARY OUTCOME	ORIGIN OF THE EVIDENCE
BULIMIA NERVOSA						
UK	FBT CBT-ED			Eating attitudes body image bulimic behaviors	Quality of life anxiety depression	NICE 2017
Germany	Age-adapted CBT	FBT		Abstinence from binge eating and compensa-tory behaviors Remission from BN Reduction of symptom severity	Eating pathology depression	AWMF German S3-Guideline Diagnosis and Therapy of EDs
Denmark	CBT-BN FBT-BN	Individual or group psychotherapy	Do not use motivational enhancement therapy	ED symptoms assessed across therapy		Danish Health Authority 2016

Table 5: (continued).

USA	FBT-BN		Motivational therapy is ineffective in changing eating pathology			APA Practice Guideline 2012
Netherlands	FBT	CBT/CBT-E				Practice Guidelines for the treatment of EDs 2017

CBT: Cognitive-behavioral Therapy
CBT-ED: Cognitive-Behavioral Therapy for Eating Disorders
FBT: Family-Based Treatment

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Table 6: Evidence-Based psychotherapies for children and adolescents: BINGE-EATING DISORDER.

COUNTRY	FIRST-LINE THERAPY BASED ON EVIDENCE	SECOND-LINE THERAPY BASED ON EVIDENCE	UNPROVEN ALTERNATIVE OPTIONS, WEAK RECOMMENDATION, CLINICAL CONSENSUS	VARIABLES FOR PRIMARY OUTCOME	VARIABLES FOR SECONDARY OUTCOME	ORIGIN OF THE EVIDENCE
BINGE-EATING DISORDER						
UK		CBTgsh CBT group				
Germany			Parental intervention psychological treatment	abstinence from binge eating	Eating disorder psychopathology BMI	AWMF German S3-Guideline Diagnosis and Therapy of EDs
Avoidant/ restrictive food intake disorder						
Germany			Mealtime structure Cognitive behavioral interventions with parental involvement	ED symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of EDs
Netherlands			CBT for fear-based problems dietetic advice speech therapy			Practice Guidelines for the treatment of EDs 2017

Table 6: (continued).

CBT: Cognitive-behavioral Therapy
CBTgsh: Guided Self-Help Cognitive-Behavioral Therapy

Serious AN, CBT-E may be a good alternative for inpatient care, according to a 2021 study [7]. These recommendations and research imply that CBT-E may be an effective strategy for treating AN in adult outpatients.

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5. AED's Special Interest Group (SIG) on CBT for ED

Since 2019, the AED has encouraged its members to join a new SIG on the CBT-E website that focuses on CBT for eating disorders. The CBT-ED SIG aims to be a network of clinical and research experts dedicated to the application, development, and assessment of CBT for EDs that is founded on scientific evidence. The study is based on manualized therapy regimens for both adults and teenagers with eating disorders. The major objectives of this SIG are to create a community that (1) supports clinicians in putting these research-based therapies for eating disorders into practice and (2) supports researchers conducting CBT-ED studies. Additionally, it will give experts a chance to collaborate and talk about how to improve CBT-ED, expand its application, and pinpoint areas that still require further study.

6. Conclusion

For the psychological therapy of EDs that is supported by research and evidence, there are several national guidelines. Many studies are required in various crucial areas for the AED guide, which will review and summarize the current recommendations. For instance, the research evidence for psychological treatments for OSFED and ARFID is insufficient to support recommendations with confidence. For older teenagers, there is some data to support the success of CBT-E with family assistance. Future modifications of the recommendations will take into account fresh scientific knowledge as it emerges because the body of evidence is growing quickly.

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