IOM Committee on Preventive Services for Women
Disordered Eating

Recommendation 6: Screening and treatment of Eating Disorders Should be an Essential Preventive Benefit. - DRAFT

I. Statement of the problem

Obesity is included as an essential benefit under the Affordable Care Act. However, eating disorders are not included and should be included. Thinness is culturally promoted in the United States; 59.3% of females between grades 9 through 12 report that they are trying to lose weight and 33.1% described themselves as overweight.[1] Therefore, addressing healthy eating and providing accurate information about weight and BMI should routinely be part of health maintenance visits beginning at a young age.

Eating disorders involves physical health and behavioral health and sometimes substance abuse. While eating disorders are typically associated with the drive to be thin, they can also be the result of physical or sexual abuse. Eating pathology is associated with depressive and anxiety disorders and also increases their risk, as well as risk for future obesity, substance abuse and health problems. The mortality rate associated with anorexia nervosa is 12 times higher than the death rate of all causes of death for females 15 – 24 years old.[2]

Eating disorders, include threshold and subthreshold anorexia nervosa (restricted eating with fixed belief that one is too fat), bulimia nervosa (periods of over-eating followed by and purging via vomiting or laxatives), and binge eating disorder. Eating disorders are marked by chronicity and relapse.

In the United States, the lifetime prevalence of anorexia nervosa, bulimia nervosa, and binge eating disorder are estimated to be 0.9%, 1.5%, and 3.5%, respectively, among women. Median age of onset for the 3 disorders is estimated to be 18-21 years.[3] Rates are similar among Caucasian and minority women. Eating disorders affect adolescents and young adults; 95% of those with eating disorders are aged 12 – 25. Among adolescents, anorexia is the 3rd most common chronic illness.

"Early identification and treatment of disordered eating and weight control behaviors may prevent progression and reduce the risk of chronic health consequences."[4] About 3 percent of U.S. adolescents are affected by an eating disorder, but most do not receive treatment for their specific eating condition, according to an NIMH-funded study published in the Archives of General Psychiatry.[5] Treatment for established eating disorders may be prolonged and require hospitalization.

II. Recommended Prevention Services

Screening in primary care is needed to identify patients with eating disorders. The Eating Attitudes Test (EAT-26), developed by David Garner, is an effective screening instrument used in the 1998 National Eating Disorders Screening Program. It includes 13 dieting scale items, 6 Bulimia and food preoccupation items, and 7 Oral Control subscale items, all scored on a likkert scale. A cut-off score of 20 on the EAT-26 indicates need

for referral for a diagnostic interview to establish a diagnosis.[6]

Secondary (selective) and Tertiary (indicated) prevention.
A meta-analysis of eating disorder prevention programs found that effectiveness of certain intervention persisted as long as 2 years and were superior to minimal-intervention control conditions. Larger effects occurred for selective interventions that were interactive (rather than didactic), and multisession rather single-session) programs; for programs offered solely to females over age 15. [7]

Nutrition counseling by a Registered Dietitian (RD) is an essential component of the team treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders during assessment and treatment across the continuum of care. Diagnostic criteria for eating disorders provide important guidelines for identification and treatment. However, it is thought that a continuum of disordered eating may exist that ranges from persistent dieting to subthreshold conditions and then to defined eating disorders, which include anorexia nervosa, bulimia nervosa, and binge eating disorder. Understanding the complexities of eating disorders, such as influencing factors, comorbid illness, medical and psychological complications, and boundary issues, is critical in the effective treatment of eating disorders.

The nature of eating disorders requires a collaborative approach by an interdisciplinary team of psychological, nutritional, and medical specialists. The RD is an integral member of the treatment team and is uniquely qualified to provide medical nutrition therapy for the normalization of eating patterns and nutritional status. RDs provide nutritional counseling, recognize clinical signs related to eating disorders, and assist with medical monitoring while cognizant of psychotherapy and pharmacotherapy that are cornerstones of eating disorder treatment. Specialized resources are available for RDs to advance their level of expertise in the field of eating disorders.[8]

References

1. Eaton DK, Kann L, Kinchen S, et al. Youth risk behavior surveillance - United States, 2009 *MMWR Surveill Summ*. 2010;59(5):1-142.

2. Sullivan PF. Mortality in anorexia nervosa *Am J Psychiatry*. 1995;152(7):1073-1074.

3. Hudson JI, Hiripi E, Pope HG,Jr, Kessler RC. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication *Biol Psychiatry*. 2007;61(3):348-358. 10.1016/j.biopsych.2006.03.040.

4. Austin SB, Ziyadeh NJ, Forman S, Prokop LA, Keliher A, Jacobs D. Screening high school students for eating disorders: results of a national initiative *Prev Chronic Dis*. 2008;5(4):A114.

5. Swanson SA, Crow SJ, Le Grange D, Swendsen J, Merikangas KR. Prevalence and Correlates of Eating Disorders in Adolescents: Results From the National Comorbidity Survey Replication Adolescent Supplement *Arch Gen Psychiatry*. 2011. 10.1001/archgenpsychiatry.2011.22.

6. Alvarenga MS, Pereira RF, Scagliusi FB, Philippi ST, Estima CC, Croll J. Psychometric evaluation of the Disordered Eating Attitude Scale (DEAS). English version *Appetite*. 2010;55(2):374-376. 10.1016/j.appet.2010.07.003.

7. Stice E, Shaw H. Eating disorder prevention programs: a meta-analytic review *Psychol Bull*. 2004;130(2):206-227. 10.1037/0033-2909.130.2.206.

8. American Dietetic Association. Position of the American Dietetic Association: Nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders *J Am Diet Assoc*. 2006;106(12):2073-2082.