PSYCHOLOGY WORKS Fact Sheet: Eating Disorders

What Are Eating Disorders?

Eating disorders (EDs) are serious mental health conditions that can influence thoughts, emotions, and behaviours around food, eating, and body image. Beyond affecting mental wellbeing, EDs have profound effects on physical health and quality of life. They can also be life-threatening, with one of the highest mortality rates of any mental health condition (Solmi et al., 2024). For many individuals, ED symptoms can appear persistent and complex, requiring formal treatment and support. EDs currently recognized by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) include:

- **Anorexia nervosa (AN)**, which is characterized by restricting food intake, fear of weight gain, and seeing body shape and weight as central to self-worth. Individuals with AN may present with very low weight but still feel “fat.” In addition to food restriction, some people with AN also use behaviours like vomiting or exercising to control their weight, which can be preceded by binge eating episodes.
- **Bulimia nervosa (BN)**, which involves recurring cycles of binge eating (consuming large amounts of food in a short period of time while experiencing a sense of loss of control), followed by behaviours to compensate or “undo” the eating, such as vomiting, laxative misuse, fasting, or excessive exercise.
- **Binge eating disorder (BED)**, which is characterized by repeated episodes of binge eating without compensatory behaviours. Individuals with BED may diet between binging episodes, but their experience of this differs from the more consistent and severe restriction found in AN.
- **Other specified feeding and eating disorder (OSFED)**, which describes a combination of ED symptoms that cause significant distress and/or impairment, but do not meet criteria for the above diagnoses. For example, someone may experience features of BN but purge less frequently than the criteria require, or they may fit criteria for AN, except their body weight is within the range of what would typically be considered “normal.”

Eating Disorders vs. Disordered Eating

Disordered eating refers to a wide range of attitudes or behaviours around food, eating, and body image that may not meet diagnostic criteria for an ED, while still presenting a health risk. Examples include frequent dieting, skipping meals, binge eating, and using exercise or medications to compensate for food consumed. While not always clinically diagnosable, disordered eating can still cause significant distress, impair social and physiological functioning, and increase the risk of developing an ED.

Eating Disorders vs. Feeding Disorders

Feeding disorders are conditions related to EDs, that similarly affect health and eating behaviours but are not driven by body image concerns or a desire to control shape and/or weight. Feeding disorders currently recognized by the DSM-V include:

- **Avoidant/restrictive food intake disorder (ARFID)**, which involves a strong avoidance of food due to lack of interest, sensory sensitivities (e.g., taste/smell/ texture), or fear of negative consequences (e.g., choking). Significant weight loss and/or nutritional deficiencies are also features of ARFID. This condition can develop at any age and can overlap with traits of neurodiversity and autism.
- **Pica**, which involves regularly eating things that are not food and have no nutritional value (e.g., dirt, paper, chalk, soap). Pica is more common in children, but can also occur in adolescents, adults, and during pregnancy.
- **Rumination disorder**, which involves repeated regurgitation of food after eating, which may then be re-chewed, swallowed again, or spat out.

Why Do Eating Disorders Develop?

EDs do not have a single cause. Instead, they are thought to arise from a combination of factors which can present and interact differently in different people. Accordingly, researchers have started to explore and understand a number of factors that may increase a person's risk and susceptibility to developing an ED. These include:

- Biological factors, such as genetics, neurological and neurodevelopmental processes, and gastrointestinal microbiota or autoimmune reactions.
- Psychological factors, such as difficulties coping with strong emotions, personality traits (obsessive-compulsive traits, impulsivity, perfectionism), and pre-existing psychiatric comorbidities (e.g., anxiety or depression).
- Social and cultural factors, such as internalization of family and/or societal messages that emphasize appearance, experiences of weight stigma, diet culture, socio-economic status, gender, and racialization.
- Life stressors, such as major transitions (e.g., puberty, starting a new job), loss, relationship difficulties, and past or ongoing experiences of trauma.

Overall, EDs appear to develop when personal factors and external pressures intersect in ways that overwhelm a person's ability to cope. Accordingly, ED behaviours may in part serve important, self-preserving functions like boosting self-esteem, providing a sense of control, or numbing distress. This may in part explain why challenging and changing ED behaviours can feel so difficult even when an individual wants to recover. Accordingly, effective treatment must be adapted to the individual's readiness for change and address both the ED symptoms and any underlying factors that sustain the illness.

Psychological Treatment Approaches

Treatment for EDs are offered in outpatient, day program, and inpatient settings, either individually or in groups. Well-established and evidence-based psychological treatments include:

- **Cognitive Behavioural Therapy (CBT)**, which helps people understand the connections between thoughts, feelings, and behaviours. This approach aims to challenge unhelpful beliefs and build skills to reduce ED behaviours.
- **Interpersonal Therapy (IPT)**, which focuses on the role of relationships and social functioning. IPT is typically offered to people who experience binge eating as part of their symptoms and aims to support them in improving communication and address interpersonal challenges that may trigger or maintain ED behaviours.
- **Dialectical Behavioural Therapy (DBT)**, which teaches practical skills in mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. These skills aim to help individuals respond to challenges without turning to ED behaviours to cope.
- **Family-Based Therapy (FBT)**, which directly involves caregivers in treatment. Families are guided to provide support, interrupt ED behaviours, and work together towards recovery. This approach is typically offered to families of children and adolescents with EDs.

Emerging Therapies

While CBT, DBT, IPT, and FBT remain the most well-established interventions, some additional, new treatment models are currently being studied:

- Acceptance and Commitment Therapy (ACT), which focuses on psychological flexibility and values-based living. There is growing support for ACT as a possibly useful therapy for individuals with BN and BED (Onnink et al., 2022).
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), a structured and individualized therapy that targets cognitive, emotional, and relational factors. MANTRA has shown early results as a potential intervention for adults with AN (Schmidt et al., 2015).
- Eye-Movement Desensitization and Reprocessing (EMDR), traditionally used to treat post-traumatic stress, is being explored as a possible adjunct to ED treatment for people whose symptoms are linked to traumatic experiences (Hatoum & Burton, 2024).
- More recently, psychedelic-assisted therapy has also been proposed as a possible intervention for EDs, due its potential to disrupt entrenched cognitive and emotional patterns that often sustain ED symptoms (Calder et al., 2023).

Together, these emerging therapies reflect a shift toward broadening treatment options and tailoring care to meet diverse needs.

Recent Innovations

Over the past decade, new approaches have expanded access to ED care and made treatment more responsive to the needs of underserved communities. These recent innovations include:

- Virtual care expansion: The COVID-19 pandemic accelerated the use of telehealth and hybrid in-person/remote services across Canada. Video sessions, online groups, and phone-based support are now routinely offered to expand access, particularly for people in remote or rural areas (Couturier et al., 2021).
- Early intervention programs: To facilitate early ED symptom detection and improve recovery outcomes, short, structured supports are increasingly implemented in schools, by primary care providers, and community clinics. Additionally, many community-based organizations now offer ED education, resources, and peer support at little or no cost (see, for example, Body Brave, Kelty Mental Health Resource Centre, and National Eating Disorder Information Centre).
- Lived and living experience integration: People with lived and living experience have begun to play a central role in re-shaping the field. Peer mentors, support groups, and recovery stories are increasingly included in treatment programs to foster hope, reduce stigma, and support motivation for change. Lived experience perspectives can contribute to program development, research, and policy, helping ensure that services better reflect the reality of those with EDs.
- Tailored care for diverse groups: ED research in Canada and beyond is expanding to include communities that have historically been underrepresented and underserved in treatment settings. This includes people whose bodies are larger or heavier than considered average, cis-gender men, 2SLGBTQIA+ and BIPOC communities, neurodiverse individuals, and people with co-occurring mental and/or physical health conditions. A more inclusive research base will help create supports that are more relevant and effective for a wider range of people.
- Trauma-informed approaches: There is growing recognition that treatment must be trauma-informed, emphasizing safety, collaboration, choice, and empowerment. Studies have repeatedly shown associations between trauma and EDs (Brewerton, 2019). Systemic issues, such as fatphobia, racism, or food insecurity, can further intersect with trauma contributing to ED development as well as impeding access to care. Acknowledging these links help to ensure that ED treatment addresses not only current symptoms, but the broader contexts that shape, hinder, and facilitate the recovery journey.

Weight Inclusivity and Anti-Stigma Language

Weight stigma refers to the negative attitudes, biases, and unfair treatment of individuals based on body size. It is a well-documented risk factor for ED development. It can also be a barrier to both seeking and obtaining ED care, preventing people (especially those with average or above average weight) from receiving timely treatment. It is therefore important to not make assumptions about a person's health based on their body shape or size, and to not reinforce harmful beliefs that tie self-worth to body size, by focusing conversations on wellbeing rather than appearance. This includes avoiding labels such as "obese" or "overweight". Some people may instead prefer person-first language - e.g., "a person living in a larger body". However, since language is highly subjective it is important to ask about and respect someone's preferences for how they experience and describe themselves. Being thoughtful in how we talk about bodies, food, and health can create safer, more supportive environments for individuals living with, or who are at risk of EDs.

Eating Disorders in Diverse Populations

EDs affect people of all genders, body sizes, and backgrounds. While they often develop in adolescence or early adulthood, they can emerge at any age. However, current ED diagnostic criteria, tools, and guidelines have largely been developed based on research conducted in young, cisgender, white women. This means that there is a risk of overlooking signs and symptoms of EDs in other populations who may experience the disorder differently. For example, 2SLGBTQIA+ populations, especially transgender and gender-diverse populations, are known to be at higher risk of developing an ED. For these individuals, distress may relate to muscularity or trying to change the body's shape to cope with gender-dysphoria. Similarly, EDs are largely under-recognized in people of colour, and little is known about the impact of a person's cultural background, family context, and experiences of racialization on their ED symptomology and treatment needs. Socio-economic status and food insecurity are additional factors that may influence ED development and presentation. Finally, EDs remain poorly understood in people with physical and/or mental disabilities, and older populations. Given the wide range of communities affected by EDs, and the lack of research into ED symptomology and treatment approaches applicable to these groups, it is critical to consider a persons' diverse backgrounds and identities and how these may intersect to give rise to their unique experiences of an ED.

The Role of Carers

Families, partners, and friends often play a central role in supporting ED recovery as carers. Evidence shows that involving carers in the recovery journey can reduce ED symptoms, improve treatment adherence, and strengthen long-term outcomes, particularly for children and adolescents (Hannah et al., 2022). At the same time, supporting someone with an ED can be stressful and isolating. Many carers feel overwhelmed and unsure how to best assist their loved one, particularly if their loved one is an adult. To address these challenges, some treatment programs now include psychoeducation and skills training components for friends and families, which teach how to disrupt ED behaviours while maintaining a supportive and compassionate environment. Community peer groups can offer carers the opportunity to reduce isolation and share support strategies. Additionally, individual therapy or counselling may help family members process their own emotions, build resilience, and prevent burnout. Ultimately, recognizing and supporting the needs of carers is essential, both for their own wellbeing and the recovery of their loved one.

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You can consult with a registered psychologist to find out if psychological interventions might be of help to you. Provincial, territorial, and some municipal associations of psychology may make available a referral list of practicing psychologists that can be searched for appropriate services. For the names and coordinates of provincial and territorial associations of psychology, go to https://cpa.ca/public/whatisapsychologist/PTassociations/.

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