

**EXPANDED BRIEF TO THE  
HOUSE OF COMMONS STANDING COMMITTEE ON  
THE STATUS OF WOMEN**

**PRESENTATION TOPIC:**

Eating Disorders amongst Girls and Women

**PRESENTATION DATE:**

Monday February 24, 2014

**CPA WITNESSES:**

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**Motion adopted by House of Commons Standing Committee on the Status of Women:**

*It was agreed, - That, pursuant to Standing Order 108(2), the Committee conduct a study of eating disorders amongst girls and women, including the nature of these diseases, what treatments are providing the most relief to patients and where they are available, how family physicians can learn more about eating disorders and how to treat them, what roadblocks exist to better serve girls and women with eating disorders, and what resources relevant stakeholders need to improve the lives of these patients.*

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The Canadian Psychological Association is the national association for psychology in Canada. There are approximately 18,000 psychologists in Canada, making us the largest group of regulated, specialized mental health care providers in the country. Psychologists are committed to evidence-based care; care that is both clinically and cost effective. We accomplish this by developing, delivering and evaluating treatments and programs across a wide range of mental and behavioural health disorders, including eating disorders.<sup>1</sup>

**What are Eating Disorders?**

Eating disorders are characterized by physical and cognitive symptoms inclusive of severely disturbed eating behaviours, body image, and self-esteem. Although onset is most often in adolescence or young adulthood, they can present at any point in the life span. Eating disorders are found in both males and females, but are ten times more common in females. In addition to cross-cutting genders, eating disorders cross-cut ethnicities and developmental periods, including those as young as 5 years. (Chung, 2011)

Types of eating disorders include Anorexia nervosa, Bulimia nervosa and Eating disorders not otherwise specified (which includes binge eating disorder). According to the DSM-V (American Psychiatric Association, 2013), these disorders are characterized as follows:

- **Anorexia nervosa** is characterized by a refusal to maintain a normal body weight through dietary restriction. Individuals with anorexia nervosa have an extreme fear of gaining weight or becoming fat, have feelings of 'fatness', and have self-esteem centrally determined by perceptions of body shape and weight. In females, loss of menstruation often occurs as the result of dietary restriction and low weight.
- **Bulimia nervosa** is characterized by eating an excessive amount of food (i.e., binging) followed by use of compensatory strategies to get rid of unwanted calories. These strategies may include self-induced vomiting, abuse of laxatives, diuretics, excessive exercise, and/or fasting. For individuals with bulimia, perceptions of shape and weight are also core determinants of self-esteem.
- **Binge eating disorder** is less well known but is in fact the most commonly occurring eating disorder; it involves binge eating without compensatory behaviours such as purging.

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<sup>1</sup> In 2009, the CPA updated its *Psychology Works* Fact Sheet on Eating Disorders, which can be found at: [http://www.cpa.ca/docs/File/Publications/FactSheets/PsychologyWorksFactSheet\\_EatingDisorders.pdf](http://www.cpa.ca/docs/File/Publications/FactSheets/PsychologyWorksFactSheet_EatingDisorders.pdf). The Fact Sheet was prepared for the CPA by Dr. Josie Geller, Director of Research, Eating Disorder Program; Associate Professor, Department of Psychiatry, UBC; Senior Scholar, Michael Smith Foundation for Health Research.

### **What is the Prevalence of Eating Disorders?**

Data from Statistics Canada's Mental Health Profile of the Canadian Community Health Survey (CCHS, 2012) indicate that over 113,000 Canadians between the ages of 15-24 reported being diagnosed by a health professional as having an eating disorder. Lifetime prevalence for anorexia nervosa is 0.9% of the population; for bulimia nervosa it is 1.5% to 2%, and for binge eating disorder it is 3.5%. Since 1987, hospitalizations for eating disorders have increased among females under the age of 15 and between the ages of 15-24 by 34% and 29%, respectively. (Health Canada, 2002) The prevalence of eating disorders is highest among teenage girls and young adult women – approximately 450,000 girls and women (which includes their families) in Canada will cope with an eating disorder during their lifetime.

Prevalence rates may increase in the coming years as diagnostic taxonomies are finally recognizing that less extreme levels of disordered eating significantly affect health and function.

Factors believed to contribute to eating disorders include biological (e.g. appetite regulation, gender), psychological (e.g. poor body image, maladaptive eating attitudes/weight beliefs, unresolved conflicts, traumatic events), and societal factors (peer group pressures, body-related teasing, specific pressures to control weight). (Public Health Agency of Canada, 2006) (N, K, & C, 2007)

Eating disorders have a devastating effect on individuals and their families. Quality of life, work, education, family, and social functioning are all negatively and significantly affected by an eating disorder. These disorders often co-occur with other debilitating mental health disorders like depression and anxiety, and physical illnesses; in some cases, death is a possible outcome. (Public Health Agency of Canada, 2006)

### **What Treatments are Available for Eating Disorders?**

First and foremost, it is important to note that eating disorders can not only be treated, but a healthy weight can be restored. Effective treatment is not, or at least not exclusively medication-based. Research suggests that psychological interventions are the most effective single treatments for and are considered by most international treatment guidelines to be the first line of treatment for most eating disorders.

Often primary care is the first place that those suffering from an eating disorder go to for help. It is critical that family physicians are educated as to the seriousness of eating disorder symptoms and the need for specialist care.

Treatment may be individual or group-based. Typically, treatments can be provided on an outpatient basis for less severe cases. However specialist care is required in day hospital programs for more severe cases, and inpatient programs for those who are medically compromised.

Ambivalence regarding change is common in this group. It is therefore essential that the treatment approach explores the underpinnings of the illness and is matched to the individual's readiness. As noted in the CPA's Fact Sheet on Eating Disorders (Canadian Psychological Association, 2009), successful

treatment for eating disorders depends on a comprehensive plan, some of which are defined below, that includes:

- Ongoing monitoring of symptoms and stabilizing one's nutritional status;
- Psychological interventions;
- Education and nutrition counselling; and, in some cases
- Medication.

A variety of psychological interventions may be used to treat eating disorders, including cognitive-behavioural therapy, interpersonal psychotherapy and family counselling. (Hay, Bacaltchuk, Byrnes, Claudino, Ekmejian, & Yong, 2009) (Peachey, Hicks, & Adams, 2013)

- In **Cognitive Behavioural Therapy (CBT)**, the most common psychological approach, individuals learn to self-monitor in order to increase awareness of the relationships among their thoughts, feelings, and behaviours. They learn to challenge unhelpful thoughts that trigger or maintain eating disorder symptoms, and learn strategies to eliminate eating disorder behaviours.
- **Interpersonal psychotherapy** focuses on understanding links between eating disorder episodes and relationship issues. For instance, therapy might focus on difficulties in forming or maintaining relationships, unresolved grief, and disputes with friends or relatives.
- **Family therapy** is recommended for children and adolescents with an eating disorder and may also be useful in adult populations. Family approaches focus on assisting the family to work together in overcoming the eating disorder. Multi-family therapy groups can increase and support the sense of community among families struggling with the illnesses.

In addition to the above approaches, motivational approaches and psycho-education are also used to treat eating disorders. As a way to address readiness for change, **motivational approaches** focus on exploring ambivalence, examining the costs and benefits/pros and cons of change, exploring the role of the eating disorder in the individual's life, and identifying higher values. **Psycho-education** is typically offered in the early stages of treatment. It is delivered in a group format and provides factual information about the causes of eating disorders as well as strategies for overcoming an eating disorder.

### **What are the Roadblocks to Treatment?**

One of the great challenges when it comes to caring for the mental health of Canadians is the significant barriers to accessing mental health services. Despite the fact that one in five Canadians will experience a mental health problem in a given year, only one-third will receive the help they need. We have psychological treatments that work, and experts trained to deliver them. Yet the services of psychologists are not funded by provincial health insurance plans, which make them inaccessible to many with modest incomes or no insurance. Unfortunately, the private insurance offered by most plans is frequently too little to allow for meaningful service. Taken together, this means many Canadians can't access the services they need. (Peachey, Hicks, & Adams, 2013)

Publically funded services, when available, are often in short supply and wait lists are long. The cost of mental illness in Canada is estimated at 51 billion dollars annually and the toll on individuals, families, communities and the workplace is great. We need to act now and be innovative in our approach. Canada has fallen behind other countries such as the United Kingdom, Australia, the Netherlands, and

Finland who have launched mental health initiatives which include covering the services of psychologists through public health systems. These initiatives are proving both cost and clinically effective.<sup>2</sup> Last year we were very pleased that Canada's national mental health strategy called for increased access to evidence-based psychotherapies by service providers qualified to deliver them. In response, we commissioned a report – *An Imperative for Change: Access to Psychological Services for Canadians* – to look at how this can be achieved. The report proposes and costs out four models that could be implemented and adapted in Canada.

### **Recommendations**

It is CPA's position that psychological assessments and treatments, for all mental health problems including eating disorders, are a necessary basic health service. As such, the CPA makes the following recommendations:

1. Integrate psychologists on primary care teams. Various estimates are that 30% to 60% of visits to family physicians in primary care are for or related to a mental problem or disorder. With psychologists working or consulting to primary care, a youth or young adult who presents with an eating disorder will have access to the right care in the right place at the right time. Patients with eating disorders are often ambivalent about seeking help, and so their symptoms can be easily missed in a busy family practice. Having a mental health specialist, like a psychologist, in primary care settings can reduce these missed patients. Further, girls and women with mild eating disorder symptoms can be cared for by a specialist in a private office. This would reduce the burden on tertiary care centres, and provide family physicians with specialists to whom they can refer a patient with an eating disorder.
2. Include or maintain psychologists on specialist care teams in secondary and tertiary care facilities for health and mental health conditions. Budget cuts to secondary and tertiary care centres in recent years have reduced the availability of psychological and other services to patients with eating disorders. Given the incidence and prevalence of mental disorders, particularly eating disorders, we need to maintain and augment our mental health resource within publicly funded health care institutions.
3. Provide sustained funding for community based resource and support centres to help those recovering from an eating disorder. These centres currently receive little or no public funding and depend on a range of health care providers and services for their success.
4. Expand private insurance coverage and promote employer support for psychological services. Canadian employers could expect to recover \$6 to \$7 billion of the \$20 billion spent annually with attention to prevention, early identification and treatment of mental health problems.<sup>3</sup> The best mental health return on investment is when services and supports are provided for children and youth. Most mental disorders begin before young adulthood and this is especially true of eating disorders. Children, youth and families need better access to needed psychological care, whether in a health facility, primary care setting, or community based centre.

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<sup>2</sup> Analysis of research in the United Kingdom found that substantial returns on investments could be achieved in the early detection and treatment of common mental health conditions such as depression.

<sup>3</sup> In March 2014, we learned that Canada's Treasury Board doubled the cap on the psychological service benefit from \$1000 to \$2000 available to its hundreds of thousands of employees.

5. As per CPA's commissioned report, adapt the United Kingdom's publicly funded model for Improved Access to Psychological Therapies (IAPT) in the provinces and territories.<sup>4</sup>

It is CPA's mandate and commitment since commission of our 2013 report to speak with funders of care, and the organizations agencies that deliver it, to create parity in how Canada takes care of the mental and physical health of its citizens. Psychologists are integral contributors to effective mental and behavioural health care for Canadians with mental health problems. CPA is committed to working with government and other stakeholders to redress the barriers that exist in getting care that works to Canadians who need it.

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**About the CPA:**

The Canadian Psychological Association is a national professional association of psychologists, organized in 1939 and incorporated under the Canada Corporations Act, Part II, in May 1950. Its mandate is to:

1. improve the health and welfare of Canadians;
2. promote the excellence and innovation in psychological research, education and practice;
3. promote the advancement, development, dissemination and application of psychological knowledge; and
4. provide high-quality services to members.

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<sup>4</sup> Under the IAPT program, psychologists and low intensity therapists deliver care for people with the most common mental health problems: depression and anxiety.