VAADA: an intro to Eating Disorders

Annette Honigman CEED Senior Clinician
Tanya Gilmartin CEED Senior Clinician
Jess Gomularz CEED Senior Dietitian
Gareth Sherring CEED Lived Experience Eating Disorders Advisor

CEED

THE VICTORIAN
CENTRE OF EXCELLENCE
IN EATING DISORDERS

CEED acknowledges the Wurundjeri people of the Kulin Nations as the Traditional Custodians of the land we are meeting on today and pay our respects to Elders past and present.

Walk Together
By Dixon Patten
Gunnai and Yorta Yorta
Bayila Creative

CEED

Acknowledgement of Lived Experience

This artwork represents how I feel when I'm following my authentic self with a full heart. During recovery, I found that I was able to have these moments of feeling "ME" - the real self, doing things that align to "My" values. When I feel these moments of authenticity, even if its not often, I feel so proud - like my heart is full and "mine".

The character in the image is holding her heart close, as a transformation of colour from b&w occurs. This is how I feel in those small moments. I can see clearly, & in colour. I can see ME (and its so exciting!)

Artwork by:
Sarah Nechama Israel.

CEED

About us:

- **Annette Honigman** – Accredited Mental Health Social Worker
- **Tanya Gilmartin** – Senior Clinical Psychologist
- **Jess Gomularz** – Dietitian
- **Gareth Sherring** – Lived Experience Advisor – Consumer Perspective

CEED

About CEED

Strengthening the system of care to provide excellence in eating disorders treatment for Victorians

CEED

Learning Outcomes

Key Features for Early Identification understanding clinical features, prevalence and impact, risk factors and warning signs of eating disorders.

Response to an Eating Disorder explores engaging with a person experiencing an eating disorder, screening and screening tools, completing a comprehensive eating disorder assessment and formulating an initial understanding of the eating disorder

Shared Care covers referring to appropriate services in the stepped system of care for eating disorders, understanding and working in the multidisciplinary care team, and engaging families and supports.

Treatment provides an understanding of mental health treatment, medical care, nutrition support and stepping up care and/or referral pathways

Lived Experience helps us to understand the perspective of the consumer struggling with an eating disorder

CEED

What comes to mind when you think about eating disorders?

CEED

“You can’t tell if someone has an eating disorder by looking at them”

CEED

National Eating Disorders Collaboration

Evidence | Experience | Expertise

Eating disorders: myths debunked

https://nedc.com.au/assets/Infographics/NEDC-Infographic-Myths.pdf

CEED

Myth
Eating disorders are not serious; they are a life-style choice or about vanity.

Truth
Eating disorders are serious and potentially life-threatening mental illnesses. A person with an eating disorder experiences severe disturbances in their behaviour around eating, exercising and related self-harm because of distortions in their thoughts and emotions.

Myth
Eating disorders are a cry for attention or a person 'going through a phase'.

Truth
Due to the nature of an eating disorder a person may go to great lengths to hide behaviour, or may not recognise that there is anything wrong. Eating disorders are not a phase and will not be resolved without treatment and support.

Myth
Families, particularly parents, are to blame for eating disorders.

Truth
There is no evidence that a particular parenting style causes eating disorders. Although a person's genetics may predispose them to developing an eating disorder this is certainly not the fault of their family.

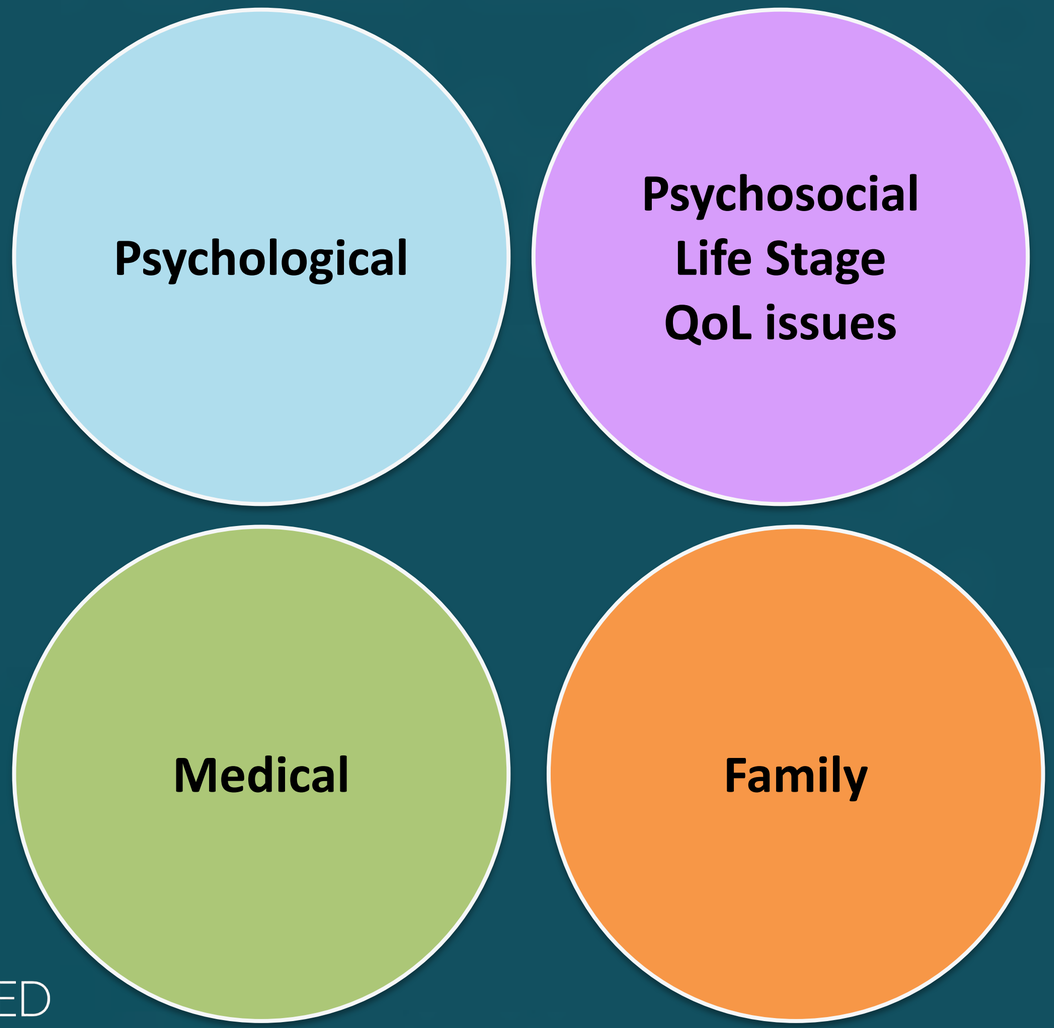
Myth
Dieting is a normal part of life.

Truth
Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Dieting is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and, contrary to expectation, with an increase in weight.

Myth
Eating disorders only affect white, middle-class females, particularly adolescent girls.

Truth
Eating disorders can affect anyone. They occur across all cultural and socio-economic backgrounds, and can affect people of all ages, from children to the elderly, and all genders.

Eating Disorders are Serious Mental Illnesses



CEED

Impacts of Eating Disorders

Psychological

Poor sense of identity; inadequacy & ineffectiveness; guilt; anxiety; rumination; compulsive behaviour; poor problem solving; poor emotional coping; poor emotional regulation; unsatisfactory relationships

Depression, anxiety, PD, DSH, suicidality, AOD use

Psychosocial
Life Stage
QoL issues

Incomplete / disrupted education

Work / school issues / skills

Social isolation, restricted life experience

Self neglect, personal austerity

Burden of ED symptoms on personal time

Housing, financial & legal issues

CEED

Impacts of Eating Disorders

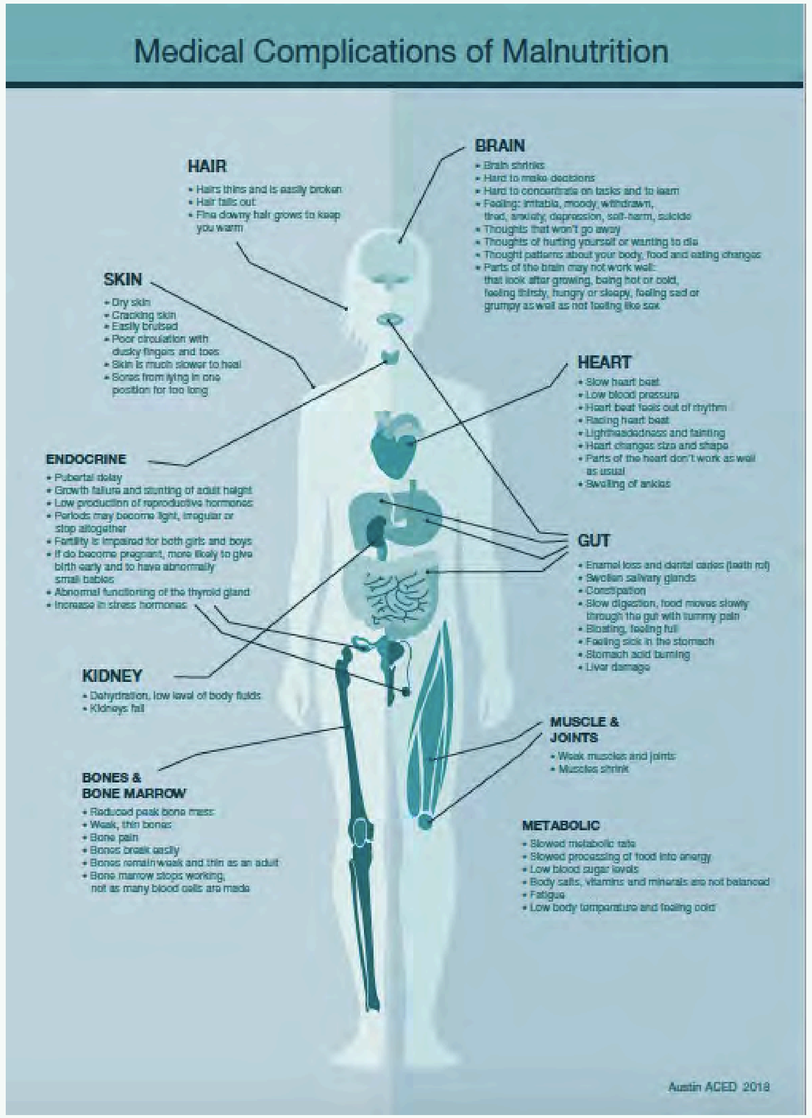
Medical

Resulting from acute - chronic starvation / malnutrition & purging behaviours:
Long-term and potentially irreversible:

- Nutritional stunting & growth delay
- Infertility, birth related problems
- Osteoporosis & increased fracture risk
- Damage to all organ systems
- Subtle brain changes & cognitive impairment
- Dental – enamel erosion, tooth loss
- Cardiac damage & risk of arrest
- Gastrointestinal problems

Type II Diabetes

Highest mortality rate of all psychiatric illnesses.



CEED

Impacts of Eating Disorders

Family

High Burden of care

ED symptoms can become a central focus of family life

May struggle to engage in previously enjoyed activities

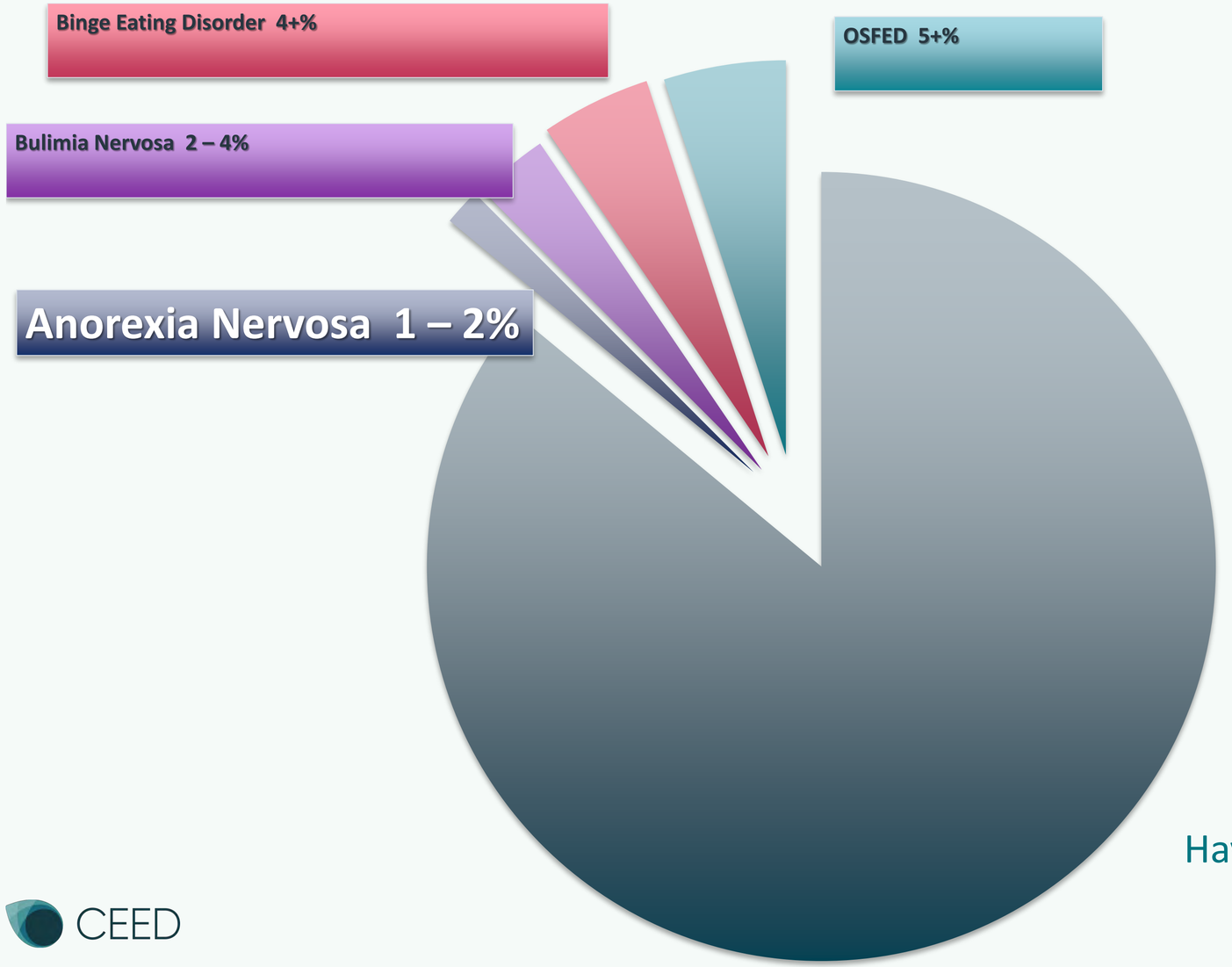
Life put on hold

Stuck, helplessness

Stressful meal times

CEED

Eating Disorders Are Common
Eating Disorders Population Prevalence – Australia



- **16% Adults**
- **8 – 15% Adolescents & Children as young as 5 years**

ANZAED Eating Disorder Treatment Principles & General Clinical Practice & Training Standards (2020)

Hay, Girosi & Mond (2015)

CEED

Eating Disorders DO NOT Discriminate

Gender/ Sexuality:

- ~80-85% individuals with AN or BN are female *(Hay, Mond, Buttner & Darby, 2008)*
- ~15-20% of individuals with AN or BN are male *(Hay, Mond, Buttner & Darby, 2008)*
- Gender distribution for BED is roughly equal for males and females *(Hay, Mond, Buttner & Darby, 2008)*
- Transgender people are more likely to be diagnosed with an ED or to engage in disordered eating than cisgender people *(Watson, Veale & Saewyc, 2017)*
- An Australian study found that 23% of transgender young people have a current or previous diagnosis of an ED *(Strauss et al, 2017)*
- People who identify as LGBTIQA+ are at a greater risk for disordered eating behaviours *(Calzo et al., 2017)*

CEED

Eating Disorders DO NOT Discriminate

Age:

- EDs can affect people of all ages and have been diagnosed in those <5yrs and >80yrs *(NEDC, 2017)*

Income, Education and Ethnicity:

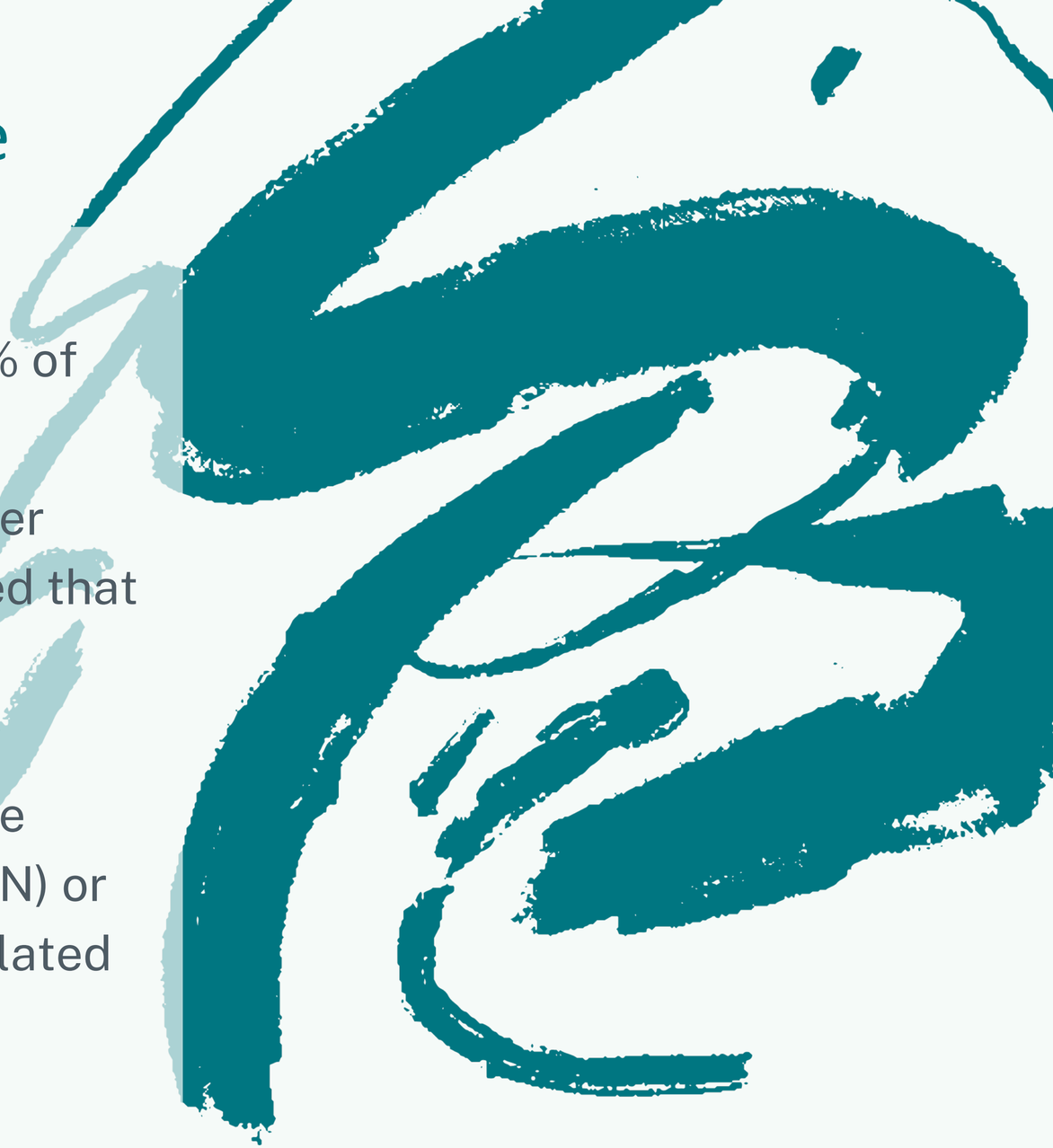
- Most people with EDs have similar household incomes and education levels as the general population *(Hay, Girosi & Mond, 2015)*
- EDs occur in all ethnicities, nationalities and cultural backgrounds *(Schamberg et al., 2017).*
- Though research is limited, it has been estimated that EDs incidence is much higher in Aboriginal and Torres Straight Islander populations with estimates up to 27% *(Burt, Mannon, Touyz & Hay, 2020)*

CEED

Eating Disorders DO NOT Discriminate

Neurodiversity:

- Autistic people are thought to represent up to 37% of those with anorexia nervosa (AN)
- On the other hand, those with ADHD are at a greater risk of developing an eating disorder. It is estimated that those with ADHD are 3 to 6 times more at risk of struggling with an eating disorder.
- While most of the emphasis has been placed on the connection between ADHD and bulimia nervosa (BN) or binge eating disorder (BED), ADHD has been correlated with all eating disorder subtypes



CEED

Eating Disorders DO NOT Discriminate

~55-97% of people diagnosed with an eating disorder have a co-occurring psychiatric disorder *(NEDC, 2017)*

- ~45-86% have co-occurring depressive disorder *(O'Brien & Vincent, 2003)*
- ~64% have co-occurring anxiety disorder *(Kaye et al., 2004)*
- ~58% have co-occurring personality disorder *(NEDC, 2017)*

Feeding difficulties and eating disorders are overrepresented in neurodivergent people:

- 20-37% of individuals with AN are also Autistic *(Westwood & Tchanturia, 2017; Adamson et al., 2022)*
- 21% of Autistic individuals have co-occurring ARFID *(Koomar et al., 2021)*
- Eating disorder risk was 3x higher for ADHD children (31.4%) than non-ADHD children (12.1%) *(Jahrami et al., 2021)*

Trauma

- Trauma is a significant risk factor for developing an ED (particularly BN & BED) *(Brewerton et al., 2018)*
- ~30% of people who have experienced a sexual assault present with an eating disorder *(Behar et al., 2016)*

- **Additionally:**
  - High co-occurring rates for AOD use, OCD, PTSD and non-suicidal self-injury

CEED

High Risk

Groups:

- Females – esp. during biological/social transitions (i.e. puberty, relationships, pregnancy, menopause, change in social role
- Children/Adolescents – EDs can develop at any age – however: highest risk 13-17yrs
- Competitive occupations, sports, performing arts/ activities that emphasise thin body shape/weight
- LGBTQIA+ communities

Presentations – those who:

- Seeking to lose weight
- Experiencing weight loss (whether intentional/unintentional)
- Diet – limiting intake
- Restrictive dieting (due to intolerances/allergies)
- Co-occurring conditions which cause wt loss/gain or focus on body image (i.e. T1DM, T2DM, PCOS, Coeliac Disease)
- Co-occurring MH
- Neurodevelopmental conditions
- Low self-esteem
- AOD misuse
- Hx of trauma
- Current or historical experience of food insecurity
- Perfectionist or compulsive traits
- Family Hx of EDs

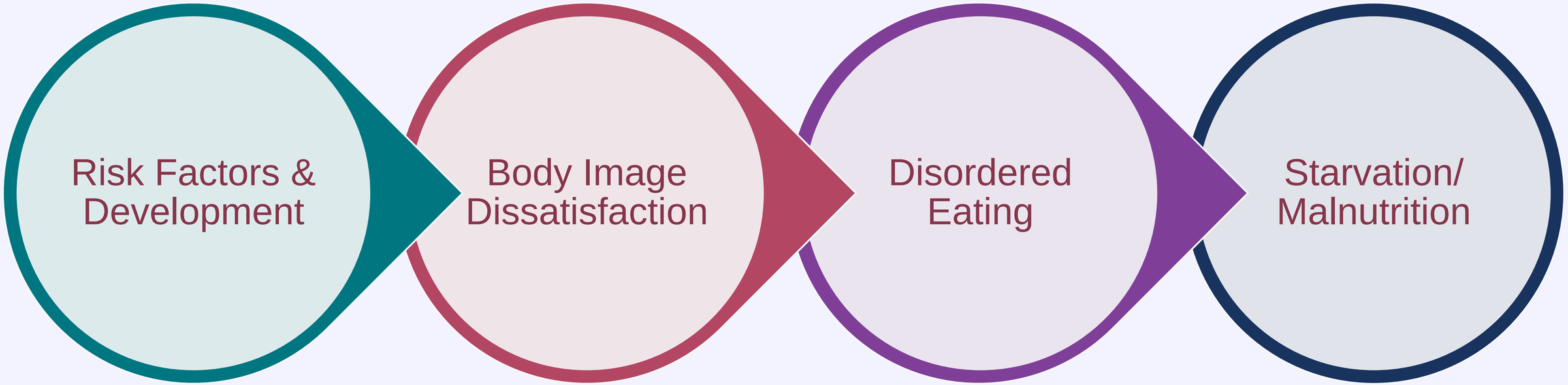
CEED

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 which *interfere* with their life & relationships. Common to hide, disguise or deny ED behaviour, they may not recognise there's anything wrong.

Eating Disorders do not usually resolve without treatment.

CEED

Key Concepts



CEED

Risk Factors
&
Development

What contributes to eating disorders?

Strong Neurobiological Component

- Gender, temperament, appetite & eating behaviour, puberty, genetics
- AN has an estimated hereditability of 58% (Wade et al., 2000)

Environmental and Personal Factors

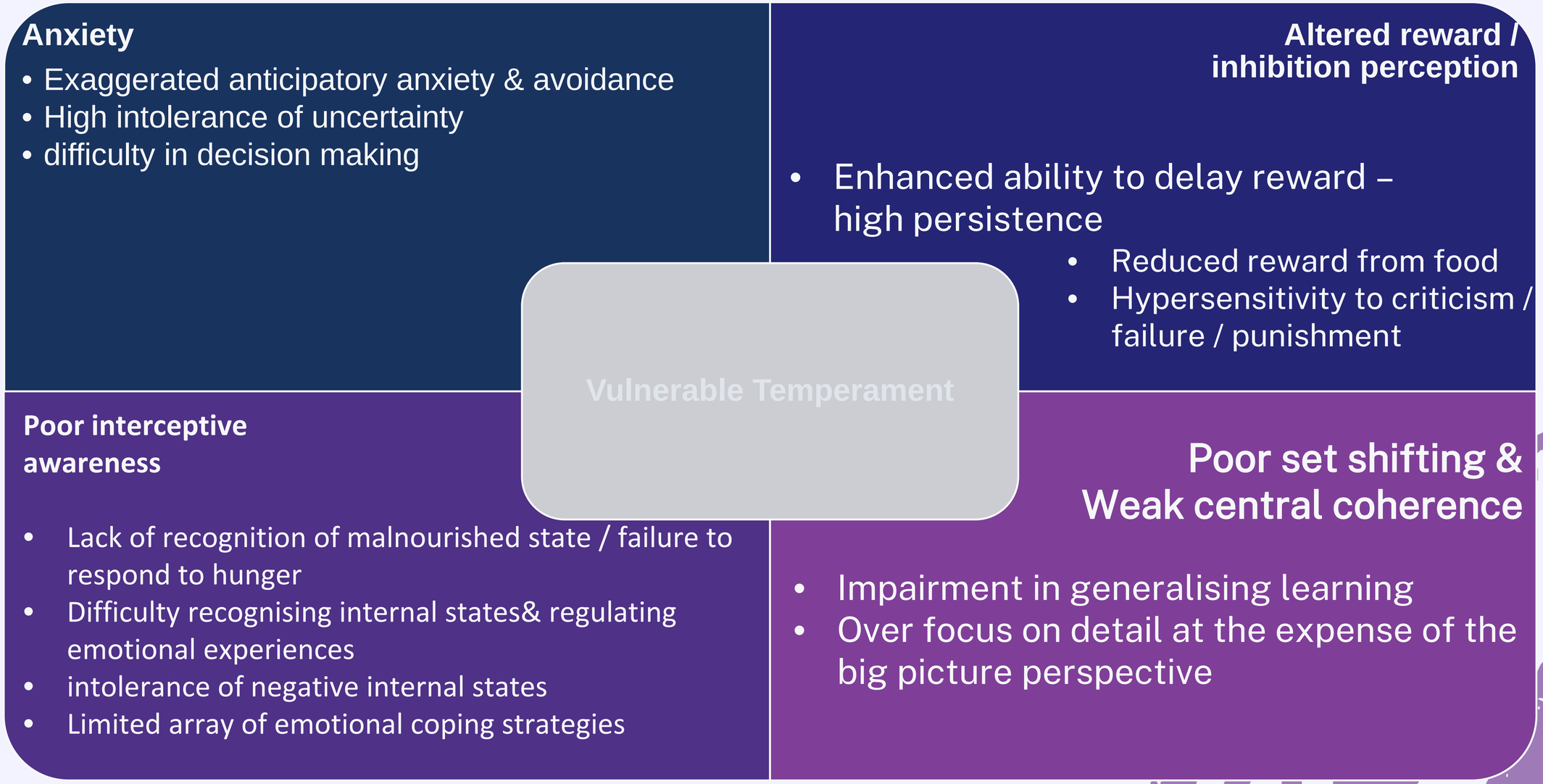
- Weight bias & body dissatisfaction
- Availability of highly palatable foods
- Trauma/loss
- Pressure & comments from others, weight teasing

Caloric Restriction → Dieting

- Most people have a change in eating behaviour prior to developing AN (APA, 2013)
- Dieting is the trigger point

CEED

Strong Neurobiological Component



CEED

Kaye et al. European Eating Disorders Review 2014

Environmental and Personal Factors (High Risk Groups)

Being **female**	• Females comprise around 64% of people with an eating disorder (Butterfly Foundation, 2012) • An estimated 20% of females have an undiagnosed eating disorder (NEDC, 2012) • particularly during key transition periods
Being an **adolescent**	• - males & females – especially those presenting with MH concerns
Having **diabetes or PCOS**	• Adolescents with diabetes may be two times as likely to develop an eating disorder (Pereira and Alvarenga, 2007).
Engaging in **performance or appearance based sport**	• Athletes, Dancers, Gymnasts, Models

People with a **family history** of eating disorders

People seeking **help for weight loss**

CEED

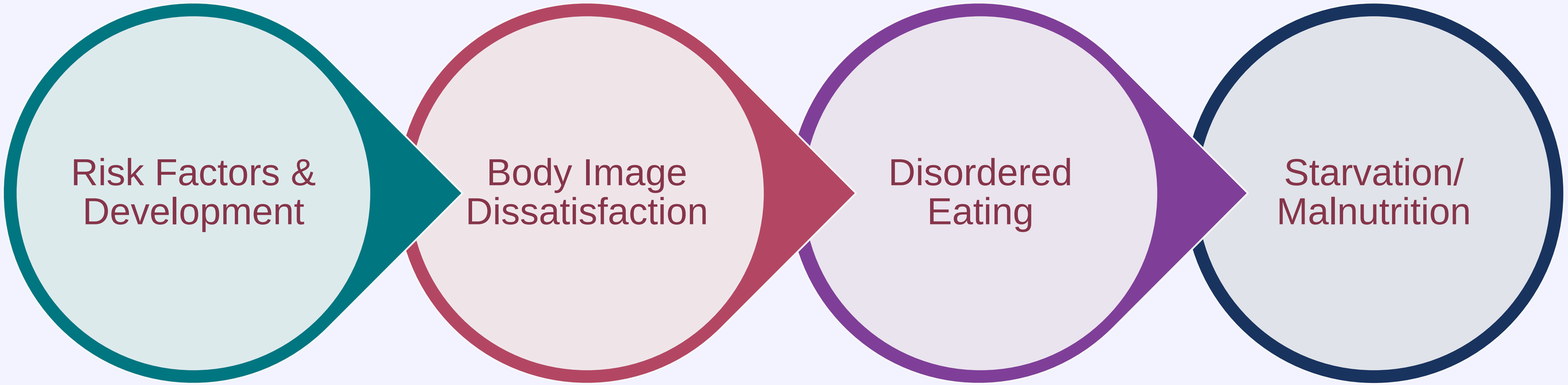
Dieting and Weight Control

Weight-control practices among young people reliably predict greater weight gain, regardless of baseline weight, than that of adolescents who do not engage in such practices

(Neumark-Sztainer, 2006)

CEED

Key Concepts



CEED

Body Image Dissatisfaction

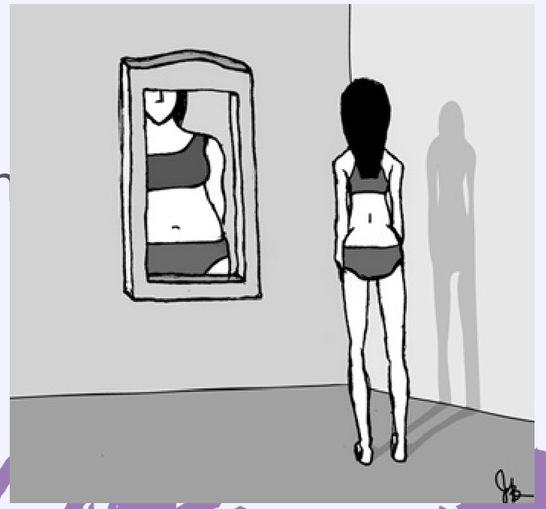
A person's negative thoughts & Feelings about his/her body

Components of Body Dissatisfaction:

- Internalisation of Socio-cultural body shape ideals & meanin
  - slenderness & muscularity vs fatness
  - look good = feel good = be good

- Body - weight / shape - evaluation
  - externalised/ objectified view of self

- Body image investment
  - importance of BI to sense of self



CEED

Body Image Dissatisfaction

The way a person thinks & feels about their body, including the way they look

Body acceptance and/or confidence

Contributes to high levels of self-esteem, self-acceptance, & healthy behaviours

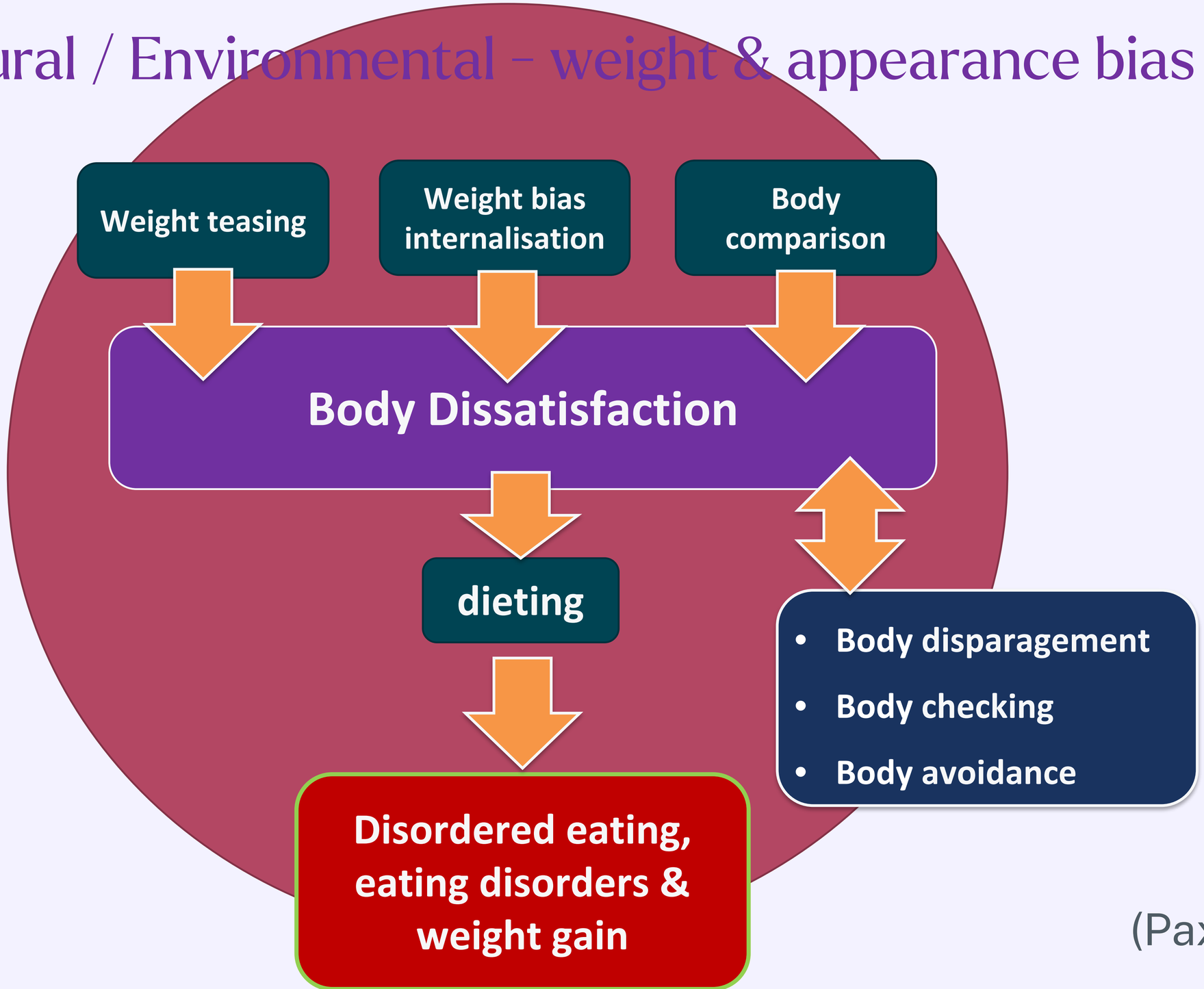
Body dissatisfaction

Is a risk factor for disordered eating, depressive symptoms & low self-esteem.

- Many people strongly believe that their self-worth is linked to their body shape & size.
- BI is a key maintaining factor in eating disorders, & BI concerns leave people in recovery from EDs vulnerable to relapse

CEED

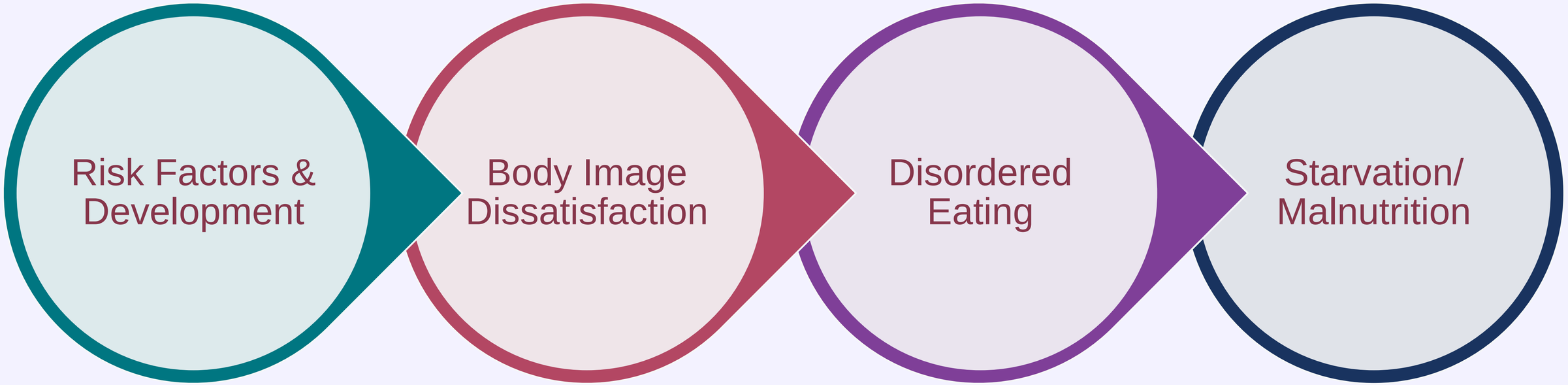
Cultural / Environmental - weight & appearance bias



CEED

(Paxton 2011)

Key Concepts



CEED

Disordered Eating

When a person changes their pattern of eating, usually because they feel unhappy with some aspect of their body weight/shape/appearance

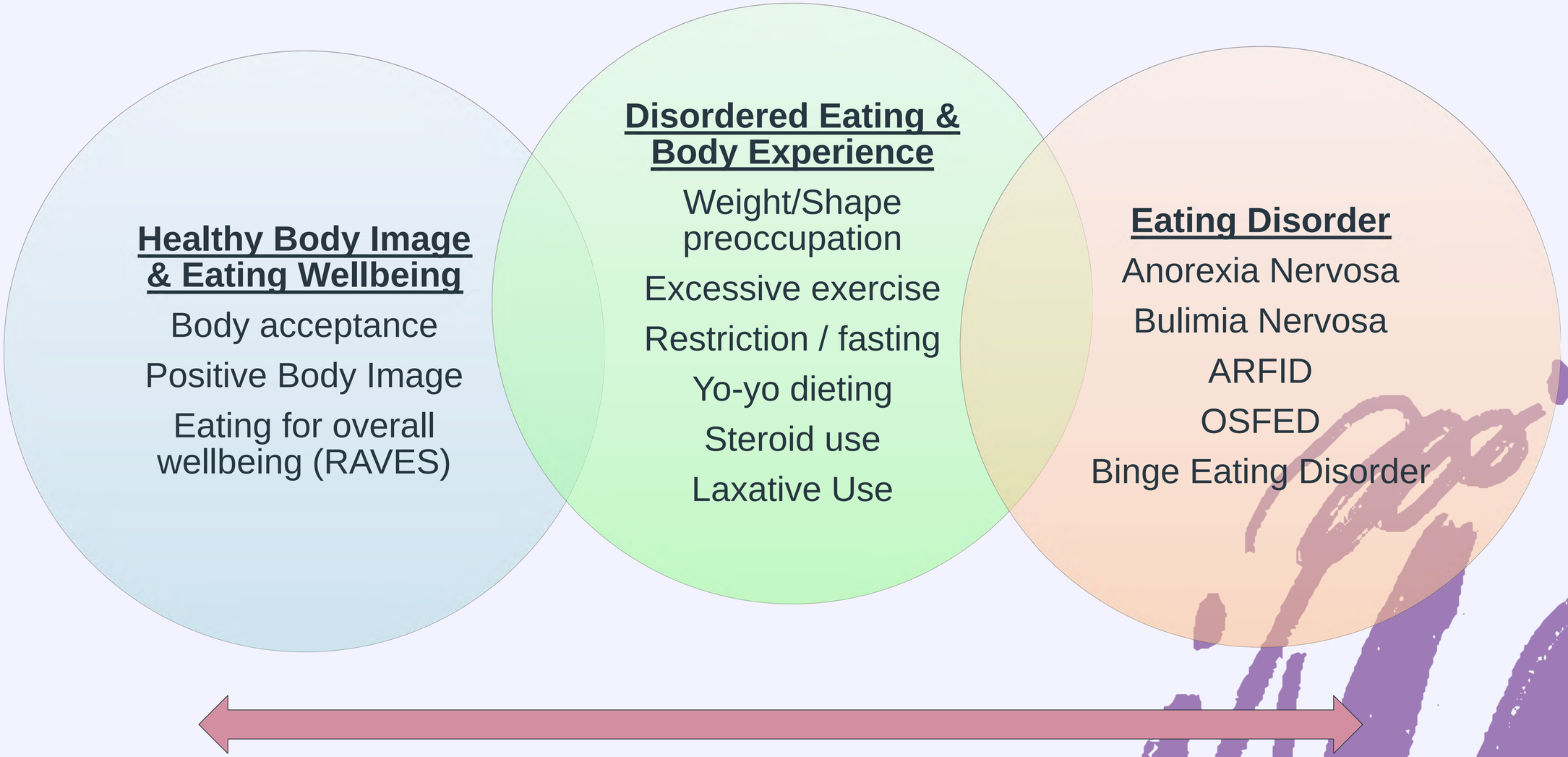
- Not dieting is protective against eating & body image problems
- Eating well is about more than just the type of food we eat. Eating well also means eating for enjoyment, meeting physical needs, & connecting socially over meals.

e.g.

- Irregular or inflexible eating pattern? (e.g. fasting)
- Restricting amount or variety?
- Overeating or loss of control when eating?
- Extreme weight loss behaviours?
- Laxative, diuretic misuse
- Steroid and creatine use

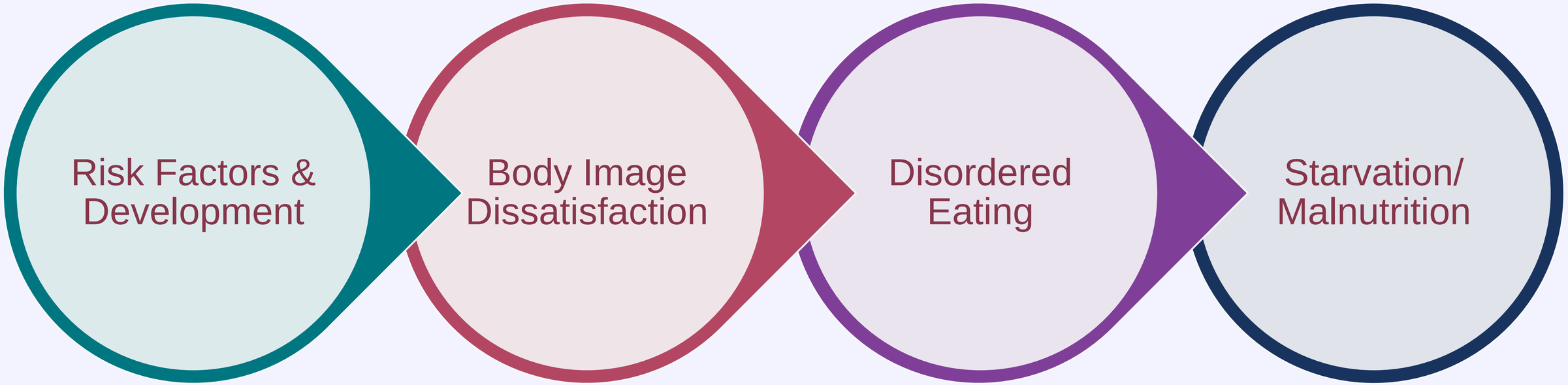
CEED

Spectrum of Eating Disorders



CEED

Key Concepts



CEED

Malnutrition / Starvation Syndrome

Starvation/
Malnutrition

6 months of semi-starvation:

- **~1600kcal / 6600kj intake + ~ 5km vigorous walking / day**

Loss of 25% body weight

Minnesota Semi-Starvation Experiment
'Biology of Human Starvation'
Ancel Keys et al (1950)

Major impact on overall functioning

- **Physical**
- **Cognitive / Psychological**
- **Social**
- **Eating Behaviour**

CEED

Impact of Starvation

Physical

Wasting, weakness, ↓strength, ↓endurance, poor sleep, low sex hormones

Psychological

↑Anxiety, ↑obsessionality, ↓libido,↓ concentration, ↓comprehension, ↑sense of ineffectiveness

Behaviour changes

Preoccupation with food, altered eating habits

Social changes

↓humour, ↓able to work as a group; distracted by food

CEED

Persistent Dietary Restriction: Malnutrition, the brain & behaviour

↓ **Social cognition** (understanding how people think)

↓ **Emotional regulation** (buffering fluctuations in mood)

↓ **Emotional expression** (accurately signalling empathy)

↓ **Decision-making**

↓ **Flexibility & Planning**

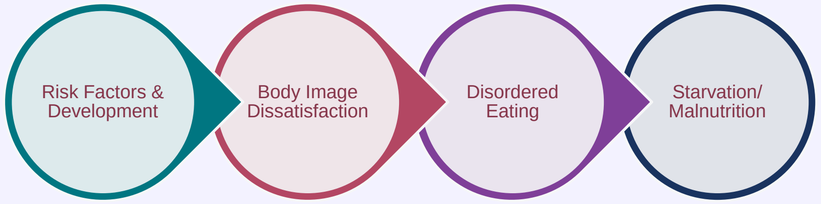
↑ **Compulsive & repetitive behaviours**

↑ **Emotional reactivity**

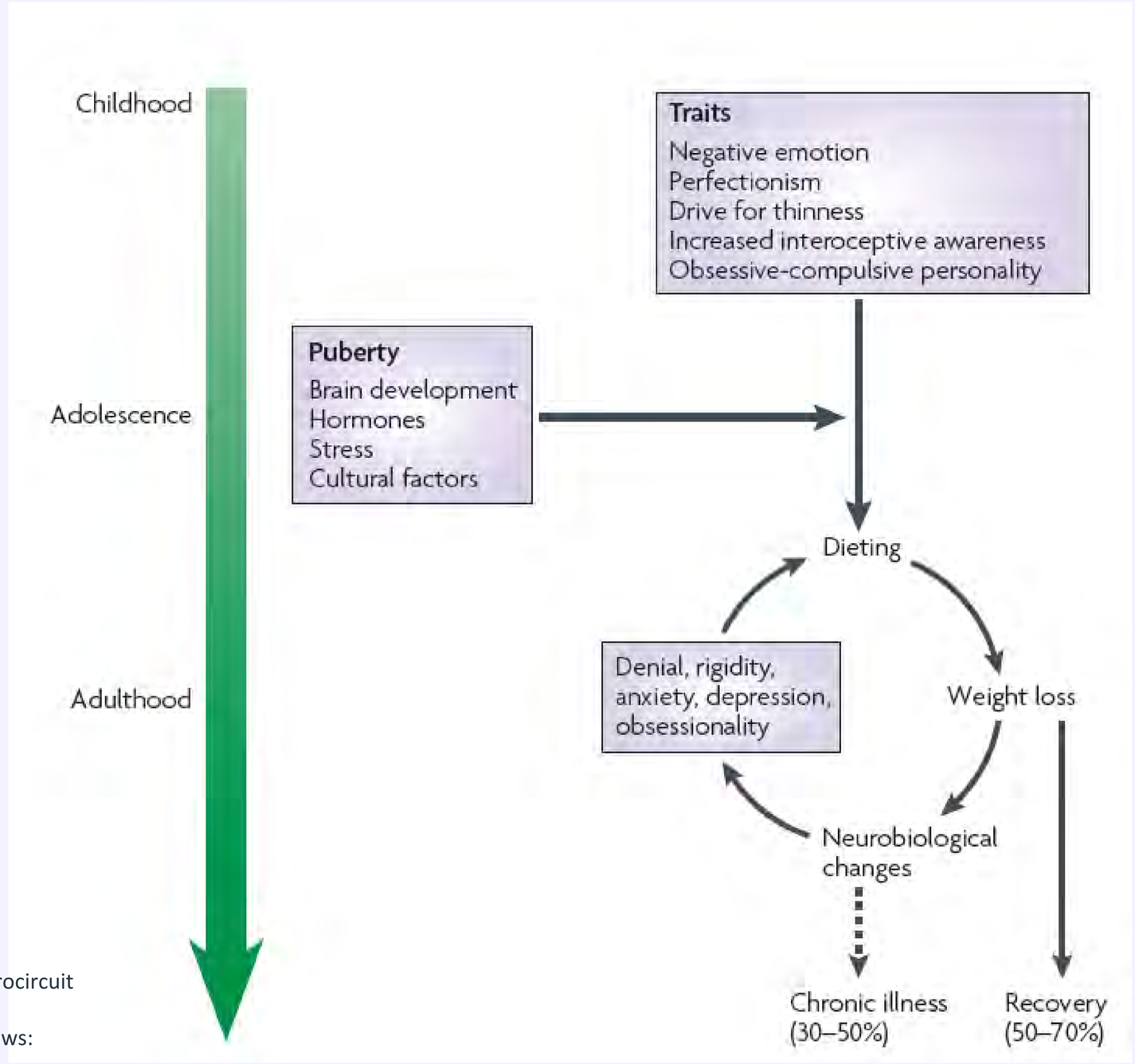
↑ **Avoidance &/or impulsive actions**

Dieting / weight loss → **Malnutrition** → **Brain changes**

CEED



Putting the Pieces together



New insights into symptoms & neurocircuit function of anorexia nervosa.
Kaye, Fudge & Paulus. Nature Reviews: Neuroscience. Vol 10. 2009

CEED

Anorexia Nervosa

- **Restriction of oral intake**
  → significantly low body weight
  → less than minimally expected wt
- **Intense fear of weight gain/fatness**
  → behaviour that interferes with wt gain, despite low wt
- **Disturbance in body image**
  → self evaluation unduly influenced by body weight / shape
  → persistent lack of recognition of seriousness of low wt

Bulimia Nervosa

– Recurrent Binge-eating

– Inappropriate compensatory weight control behaviours

– Frequency ≥ 1 / week for 3 months

– Self-evaluation unduly influenced by body weight / shape

– Absence of Anorexia Nervosa

Binge Eating Disorder

– Recurrent Binge-eating

– Abnormal eating behaviour with marked distress / guilt

– Frequency ≥ 1 / week for 3 months

– Absence of:
→ compensatory behaviours
→ Anorexia Nervosa
→ Bulimia Nervosa

OSFED

– Mixed behaviours / presentation, but serious illness:

→**Atypical AN (AAN)** – 'normal weight' AN

→Sub-threshold BN

→Sub-threshold BED

→Purging Disorder

→Night Eating Syndrome

AAN *(OSFED)*

– Restriction (+/- binge eating / compensatory behaviours)

–Significant weight loss

– 'Normal' weight but malnourished / presents with medical complication

– Body disparagement, feelings of fatness, fear of fatness, lack of concern about weight loss & medical problems

ARFID

Eating or feeding disturbance, with persistent failure to meet nutritional needs associated with:

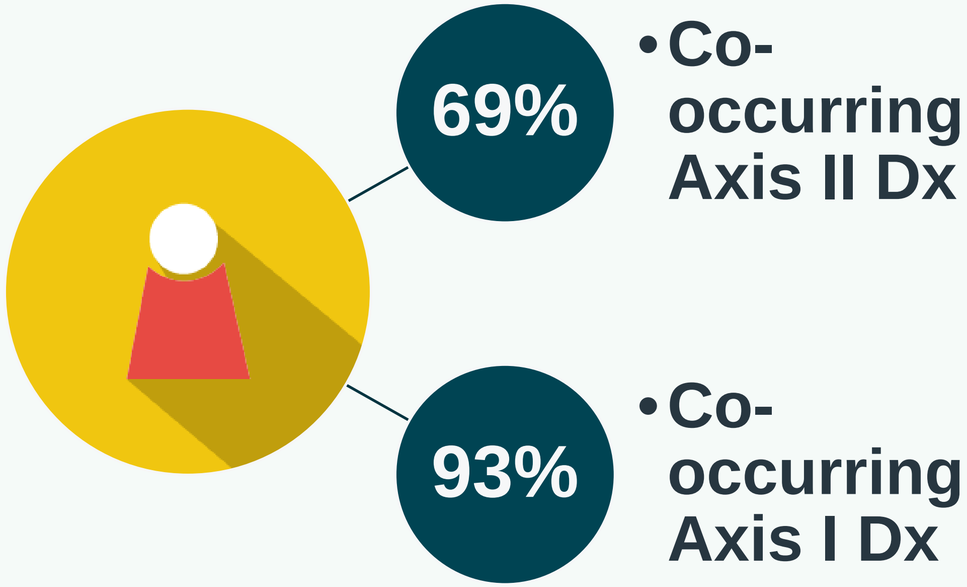
significant weight loss / growth failure
→ significant nutritional deficiency
→ dependence on enteral feeding or oral nutritional supplements
→ marked interference with psychosocial functioning

No better explanation: eg other eating disorders or medical Dx; famine; neglect; culturally sanctioned practice

Co-Occurring Conditions

Eating Disorders have a **high rate of co-occurring conditions.**

Up to….



- **Co-occurring Axis II Dx**
- **Co-occurring Axis I Dx**

(Blinder et al., 2006)

CEED

Co-Occurring conditions: AN

40%	• Depression
32%	• Dysthymia
30%	• OCD
15%	• Agoraphobia
45%	• Sexual dysfunction
31%	• Generalised Anxiety Disorder
27%	• Social Phobia
20%	• Panic
30%	• OAD
17%	• SAD

(Blinder et al., 2006)

CEED

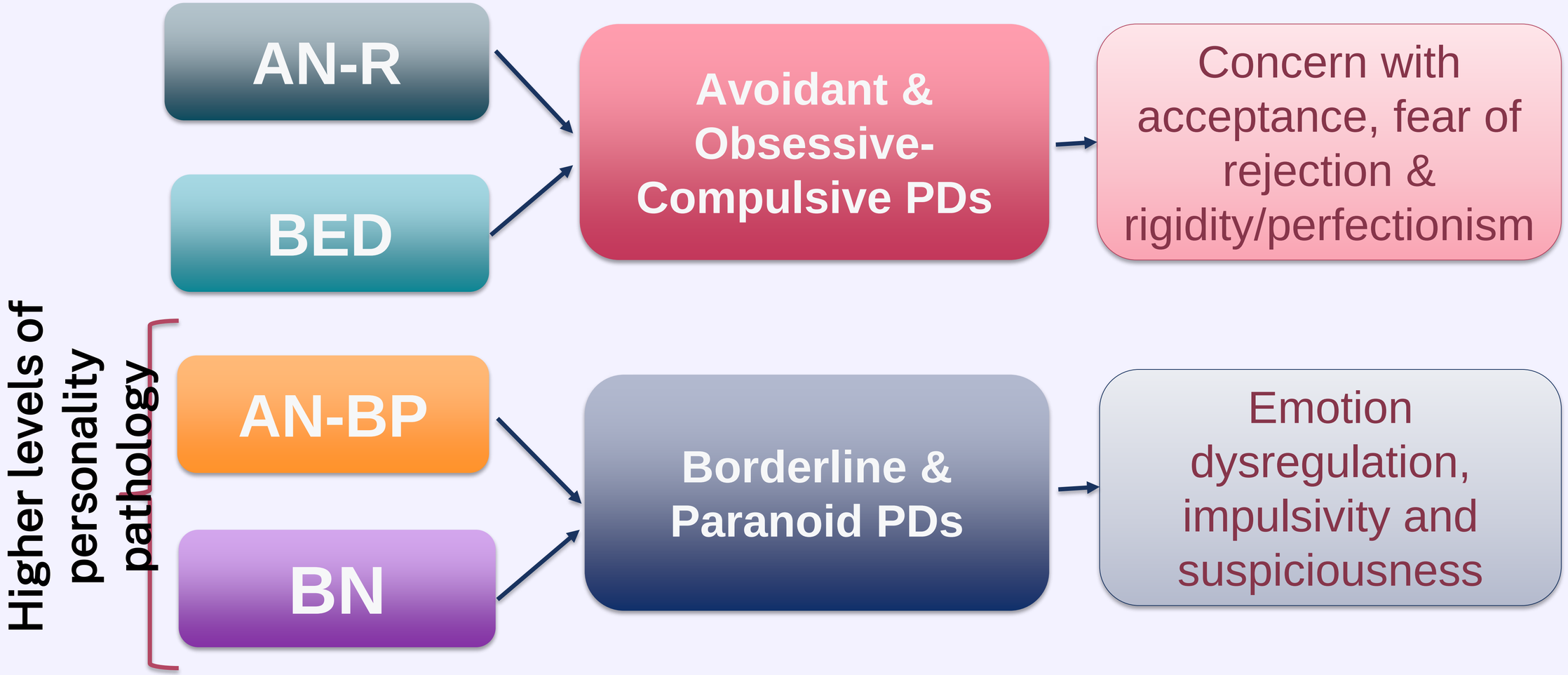
Co-Occurring conditions: BN

68%	•Major Depression
36%	•Dysthymia
25%	•Social Phobia
32%	•Alcohol
39%	•Drug Dependence
30%	•PTSD

CEED

(Blinder et al., 2006)

Co-Occurrence with Personality Disorders



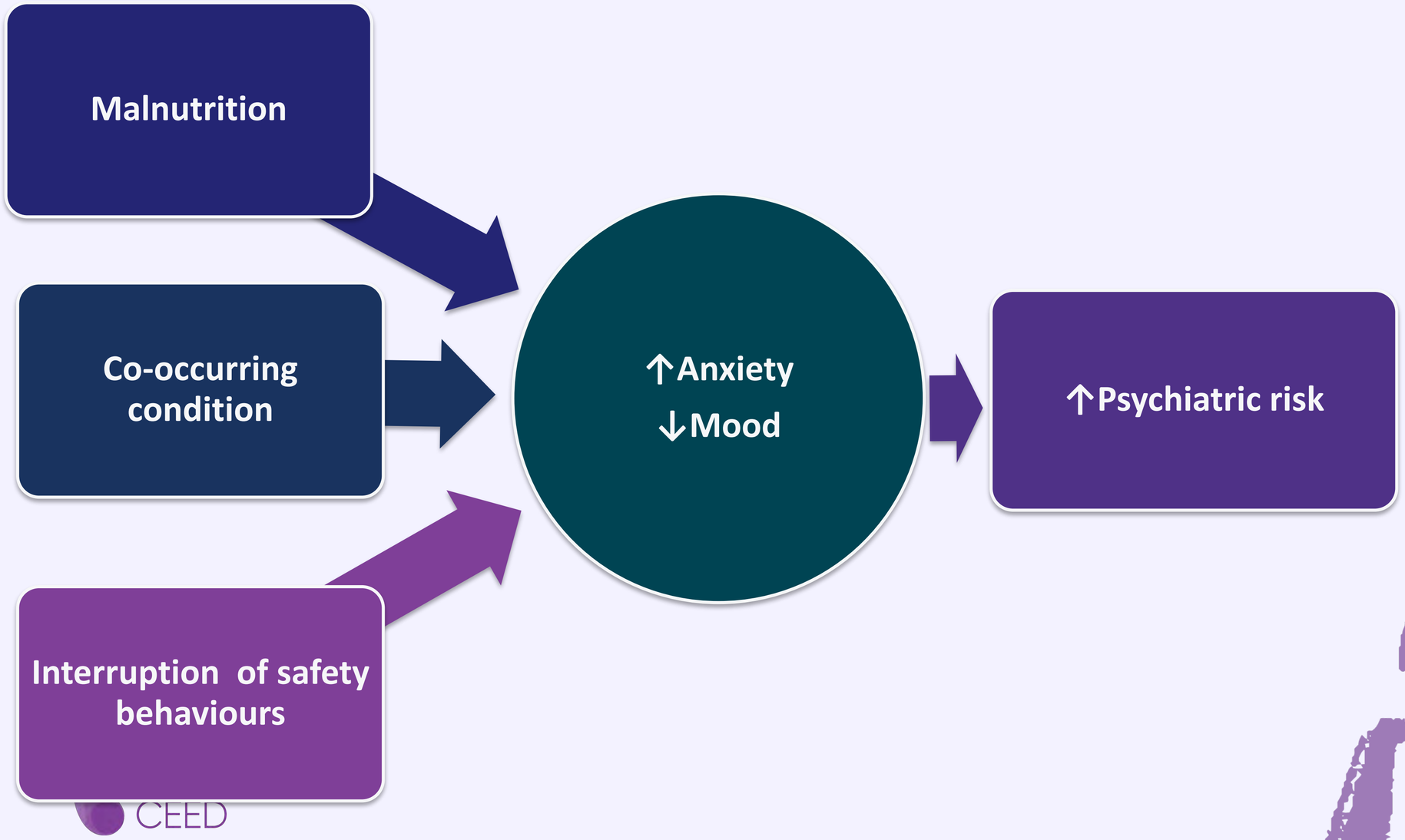
CEED

(Anderluh et al., 2009; Spindler & Milos, 2007; Farsted et al., 2016)

Lived Experience Example: Ben

Ben is 24. His parents recently separated and he now lives with his Dad. Ben recently went on a diet to lose weight. He'd been bullied at school for being overweight and his parents and GP had expressed concerns about his weight. He lost 10kg in 2 months (BMI now 24) by eating only dinner and drinking coffee to suppress his appetite. Ben received praise from his family, and his soccer coach who all think he is doing a great job of looking after his health, and this really buoyed his enthusiasm. Ben is having trouble concentrating at school, becomes dizzy at times and has also been irritable at home. His Dad offered to take him out for breakfast last weekend and Ben became furious, saying he would not eat out & criticising his Dad for trying to 'make (him) fat again'. Ben has been exercising between 1-2 hours every day and feels compelled to do 200 sit ups and push ups before bed. He says this is to better his performance at soccer. He recently started taking steroids to 'bulk up'.

Psychiatric Risk in EDs



CEED

Medical Risk in EDs

Dietary restriction & weight loss → **Malnutrition** → **Medical instability**

Purging (vomiting or laxative misuse) behaviour → **Electrolyte disturbance & Dehydration** → **Medical instability**

CEED

Fear

The eating disorder develops for a reason – often to protect the person from something they fear, or to cope with experiences or feelings that seem otherwise unmanageable. Sometimes this is very much driven by biological or brain-based processes that alter the fear pathways in the brain, particularly as these relate to food, eating, and body experience. Sometimes the fear is that you will take away an important coping mechanism, or ask someone to give away something that has become important to them. Be mindful that as you assist someone with an eating disorder to move away from this, you are often requesting them to walk with you into fear, anxiety and uncertainty.

CEED

Screening for Eating Disorders

CEED

Screening

“ The most effective screening device probably remains the health professional thinking about the possibility of an eating disorder.”

(NICE, 2004)

CEED

Identification of EDs

Few people will volunteer to anyone that they have an eating problem

For any person presenting with depression or anxiety, ask questions about eating

CEED

Signs and Symptoms

The signs of an eating disorder are not always obvious.

But there are some signs you can look for if you have concerns.

Warning signs can be:

- Physical
- Behavioural
- Psychological

CEED

Signs and Symptoms

GREEN

· Choose food for hunger & preference

· Social eating

· Lack of guilt/shame around eating

· Body Acceptance

· Healthy weight for age & body type

· General feeling of wellbeing & vitality

· Socially engaged

Prevention

ORANGE

· Dieting, fasting

· Social withdrawal; fatigue; low concentration

· Increased exercise, use of steroids

· Change in food preferences; lying about food; feel guilt & shame

· Over-focus on food, weight, shape

· Anxious about food, avoiding social eating

· Unusual/excessive body checking/ dissatisfaction

· Mood changes; anxiety

- Weight loss/gain/fluctuation

Warning signs
Early intervention

RED

· Binge eating

· Vomiting or laxative use

· Not eating enough to meet nutritional needs

· Rapid weight loss or gain

· Fainting, feeling cold

· Change/loss of menses

· Swelling around jaw

· Dehydration

- Compulsive exercise

Warning signs – Get direction and Medical check

Early Identification is Key

- Key to recovery from eating disorders is early identification and treatment

- There are evidence based treatments for eating disorders

Prognosis improves with access to early treatment

CEED

Screening Tools

Eating Disorder Screen for Primary Care (ESP)

Are you satisfied with your eating pattern?
Do you ever eat in secret?
Does your weight affect the way you feel about yourself?
Have any members of your family suffered with an eating disorder?
Do you currently suffer with or have you ever suffered in the past with an eating disorder?

Individual screening Q's

Does your weight affect the way you feel about yourself?
Are you satisfied with your eating patterns?
(Cotton, Ball & Robinson, 2003)

CEED

https://nedc.com.au/eating-disorders/early-intervention/health-professionals/
https://insideoutinstitute.org.au/screener/

Aims of Assessment

- Engagement & development of therapeutic alliance
- Clarify diagnosis
- Assess immediate risk – how physically unwell is the client?
- Preparation for psychological treatment
  - What might make it difficult for the client and family/supports to engage in treatment?
  - What strengths/ resources do they have?

CEED

Assess: Eating Disorder

PHYSICAL RISK

- Eating Disorders are mental health disorders with severe Physical health consequences
- Malnutrition can have a serious impact on an individual's physical and mental health
- Just because someone presents as a healthy weight or overweight does not mean that they are not experiencing health consequences
- Important that each client has a treatment team engaged to manage risk and support the clinician conducting therapy

CEED

MH Clinicians Guide to Assessing Physical Safety

- Current height & weight
- Weight & growth history (note rapid weight loss)
- Menstrual history
- Persistent restriction of fluid or food
- Persistent vomiting
- Physical Symptoms – fainting, dizziness, chest pain, palpitations

ALL clients with suspected EDs need to have a medical assessment & ongoing medical monitoring with a skilled medical practitioner throughout treatment

CEED

CEED

THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Physical Risk in Suspected Eating Disorders
Mental Health Clinician Response Guide

Response Required	Indication / Symptom / Behaviour
Presence of **any one** of these symptoms / behaviours: arrange **urgent (on the same day) medical review** with medical practitioner or at emergency dept for decision re need for medical admission	• Reporting fainting / collapse / dizziness • Chest pain, heart palpitations, shortness of breath • Acute total cessation of food or fluid intake over 3 – 5 days
Presence of **any one** of these symptoms / behaviours: Discuss / recommend arranging medical review **within the next 48 hours**	• Reporting cold, blue extremities • Rapid (≥ 0.5kg / wk) / weight loss ≥2 consecutive weeks • BMI < 15 (adult); > 10% loss of body weight (child adolescent) • Persistent restriction of fluid intake (< 500ml / daily) • Persistent increased fluid intake (> 3000ml / daily) • Persistent self-induced vomiting ≥ 1 episode daily • Persistent & escalating laxative / other medication use to control weight
Presence of **any one** of these symptoms / behaviours: Discuss/recommend **increase in frequency of medical monitoring to** / or maintain **weekly – fortnightly medical review**	• Ongoing weight loss • worsening dietary restriction (<1200kcal / 5000kJ daily) • Restriction of fluid intake (< 1000ml / daily) • Increase to purging / binge eating frequency • Self-induced vomiting ≥ 2 episode weekly • Laxative / other medication use to control weight
Discuss/recommend medical monitoring as advised by medical practitioner	• Ongoing mild to moderate eating disorder behaviours

Local Contacts for Action

Complete details of those relevant to your client / service

Local General Practitioners (if client's GP unavailable):

Physician / ED Medical Specialist available for secondary consultation:

Mental Health Triage:

Emergency Department:

ECATT:

Emergency Dept Psychiatric C/L contact:

CEED co
8387 2669 / 8387 2789

How to facilitate a discussion about EDs

- Develop rapport & create a safe, non-judgmental environment to disclose
- Be curious about the individual's experience, checking in & demonstrating your understanding
- Speak from your knowledge about EDs & the impact
- Hold onto hope for the individual, seeing life without the ED
- Draw out & acknowledge their ambivalence, roll with resistance
- Maintain boundaries related to your duty of care and self-disclosure

CEED

What we can do

- Avoid conversation about food, diet, or weight
- Avoid comparisons (with other staff or patients)
- Offer distraction – puzzles, games, question cards, news/tv discussions
- Non-judgemental approach
- Empathise
- Encourage and support – “You’re doing a really good job”, “I know this must be difficult, but keep going”, “Is there anything I can do to help you eat/finish your meal?

CEED

Assessment Resources

- CEED
  - http://ceed.org.au/resources-and-links
- CEDD clinical assessment forms
  - http://cedd.org.au/health-professionals/test-health-professionals-clinical-resources-tools/test-health-professionals-assessment/test-health-professionals-clinical-assessment-tools/
- SCID
  - http://www.scid4.org/revisions/pdf/Module_H_Eating_Disorders.pdf
- EDEQ (Fairburn & Beglin, 2008)
  - https://www.rcpsych.ac.uk/pdf/EDE-Q.pdf
- RACGP: Early Identification in General practice
  - https://www.racgp.org.au/download/documents/AFP/2011/March/201103yeo.pdf

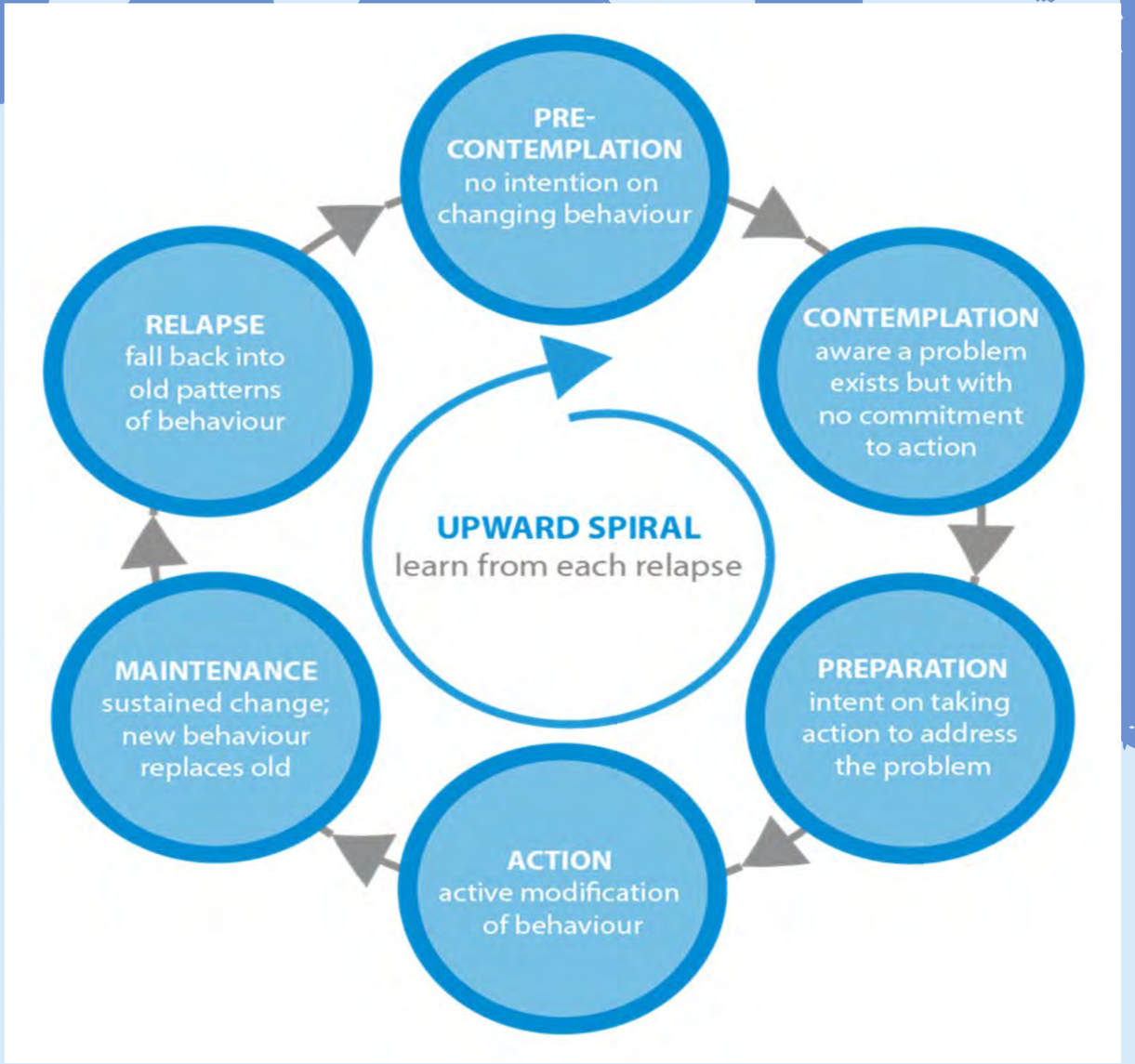
CEED

Short Break

CEED

Transtheoretical Model of Change: The Cycle

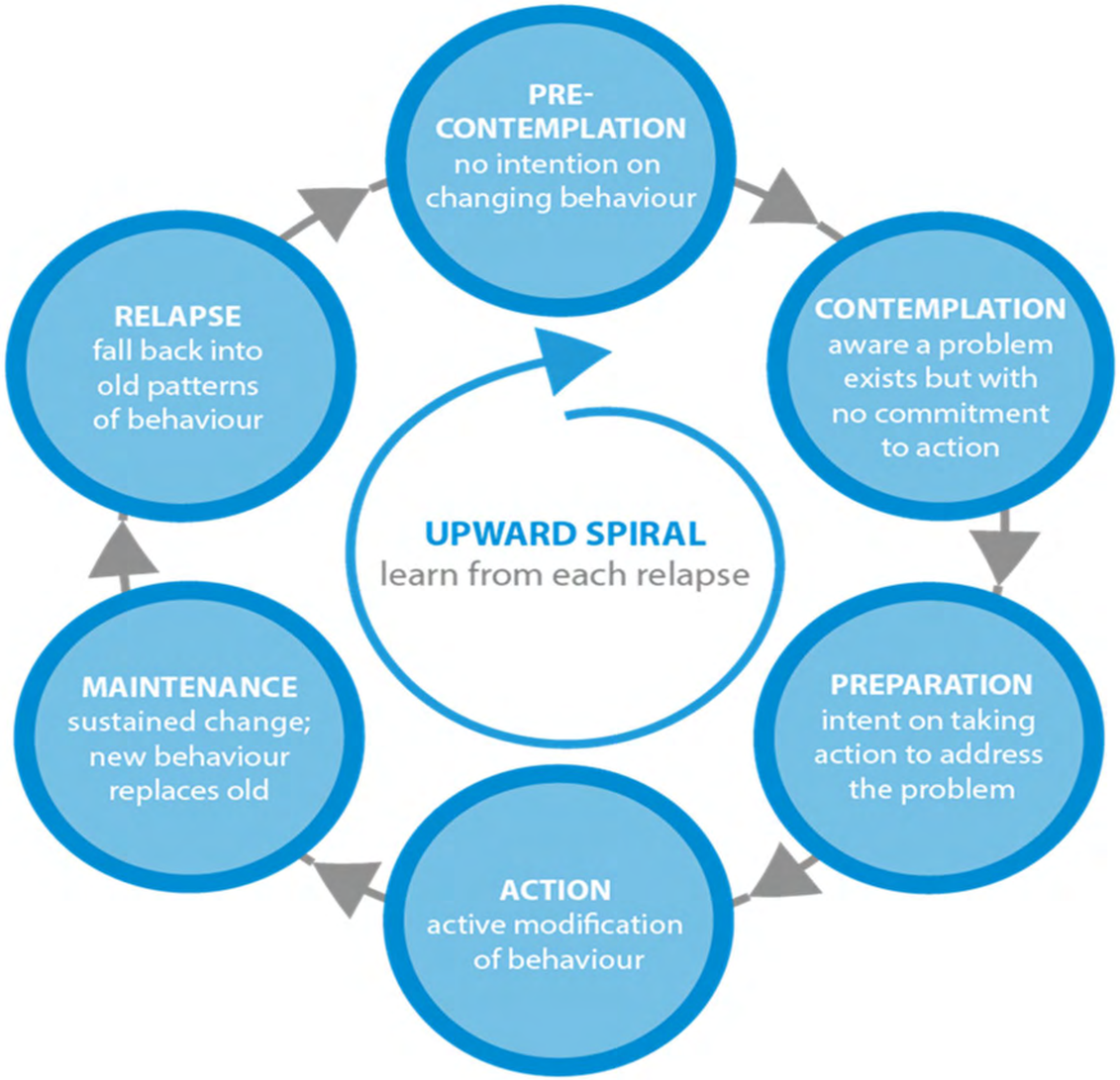
- Pre-Contemplation: ED is a solution, not a problem. Offers rewards without perceived costs
- Relapse: Slips back into old patterns of behaviour. Lapse/relapse
- Maintenance: Consolidating and building on progress. Redeveloping connections outside ED. Resisting relapse
- Contemplation: Ambivalent, sees both costs and problems of ED as well as rewards and positive aspects. Sees obstacles that change brings. Either not important enough to change or may lack confidence to change. Shifts between change/don't change. State of confusion
- Preparation: Costs seen to outweigh benefits. Making plans to change in the near future. Recognises difficulties of change but determined to at least try change
- Action: Begins making steps to get help or change. Old triggers and positive aspects of ED remain. Will be many setbacks



Transtheoretical Model of Change: The Cycle

- Pre-Contemplation: AOD is a solution, not a problem. Offers rewards without perceived costs
- Relapse: Slips back into old patterns of behaviour. Lapse/relapse
- Maintenance: Consolidating and building on progress. Redeveloping connections outside of AOD. Resisting relapse
- Contemplation: Ambivalent, sees both costs and problems of AOD as well as rewards and positive aspects. Sees obstacles that change brings. Either not important enough to change or may lack confidence to change. Shifts between change/don't change. State of confusion
- Preparation: Costs seen to outweigh benefits. Making plans to change in the near future. Recognises difficulties of change but determined to at least try change
- Action: Begins making steps to get help or change. Old triggers and positive aspects of AOD remain. Will be many setbacks

Transtheoretical Model of Behaviour Change (Prochaska & DiClemente, 1983)



CEED

Nutrition

CEED

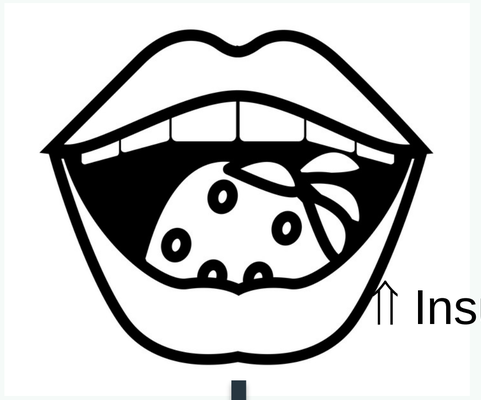
Rapid weight loss and risk...

- Weight loss on the background of disordered eating is concerning (includes yoyo dieting and weight fluctuations)
- More than >0.5 kg / week over 2 weeks
  - Weight loss beyond this increases risk of medical instability
- Or 10-15% in 3-6 months (Malnutrition)
- This should trigger MHC to request medical review
  - Including postural observations and random blood sugar monitoring
- Rapid weight loss from *any* starting weight is dangerous
- More medical complications seen in those who have rapid weight loss from a higher weight

- Starvation is *tranquilising*
- Important to consider cognitive capacity regardless of body weight
- Consider the function of the *low power mode* on your phone –what happens when you set this?

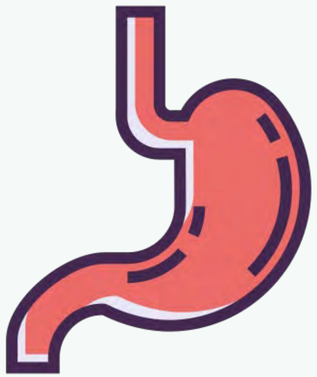
CEED
THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

What happens when we normally eat carbohydrates?

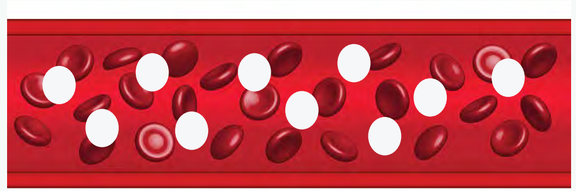


⇑ Insulin

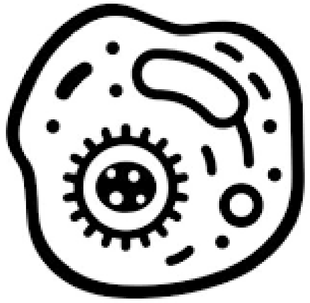
Carbohydrate

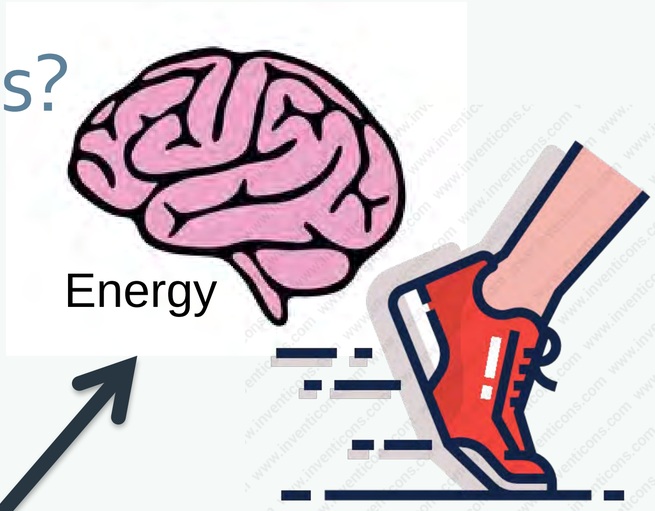


Glucose



⇑ Insulin





Energy

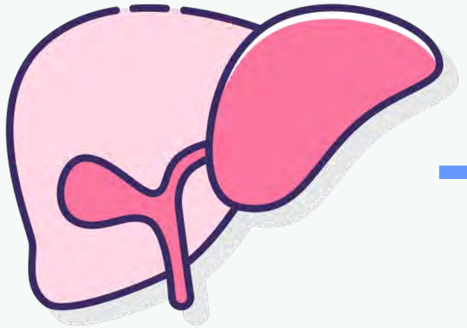
Glycogen Storage
(Liver and Muscle)

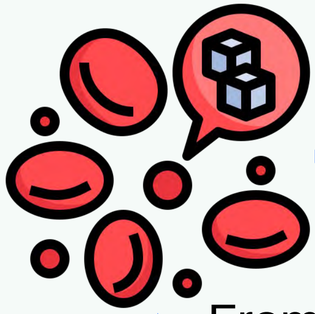
CEED

THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

What happens in starvation?

1. Glycogen

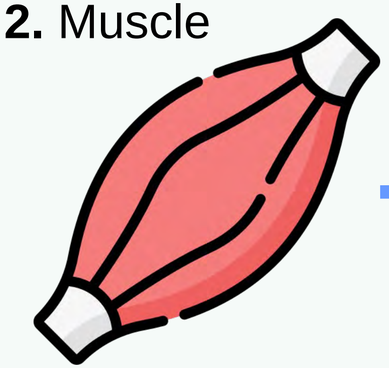




Blood Glucose

From muscle to protein to glucose

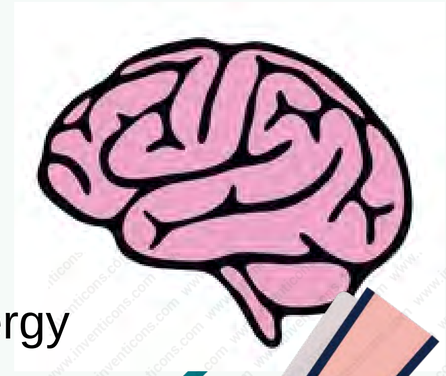
2. Muscle



3. Fat cells

Ketones

Energy



Example of inadequate intake

Breakfast	Morning Tea
	 
Lunch	**Afternoon Tea**
 	 
Dinner	**Supper**
 	

CEED

THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Refeeding syndrome

Risk Factors

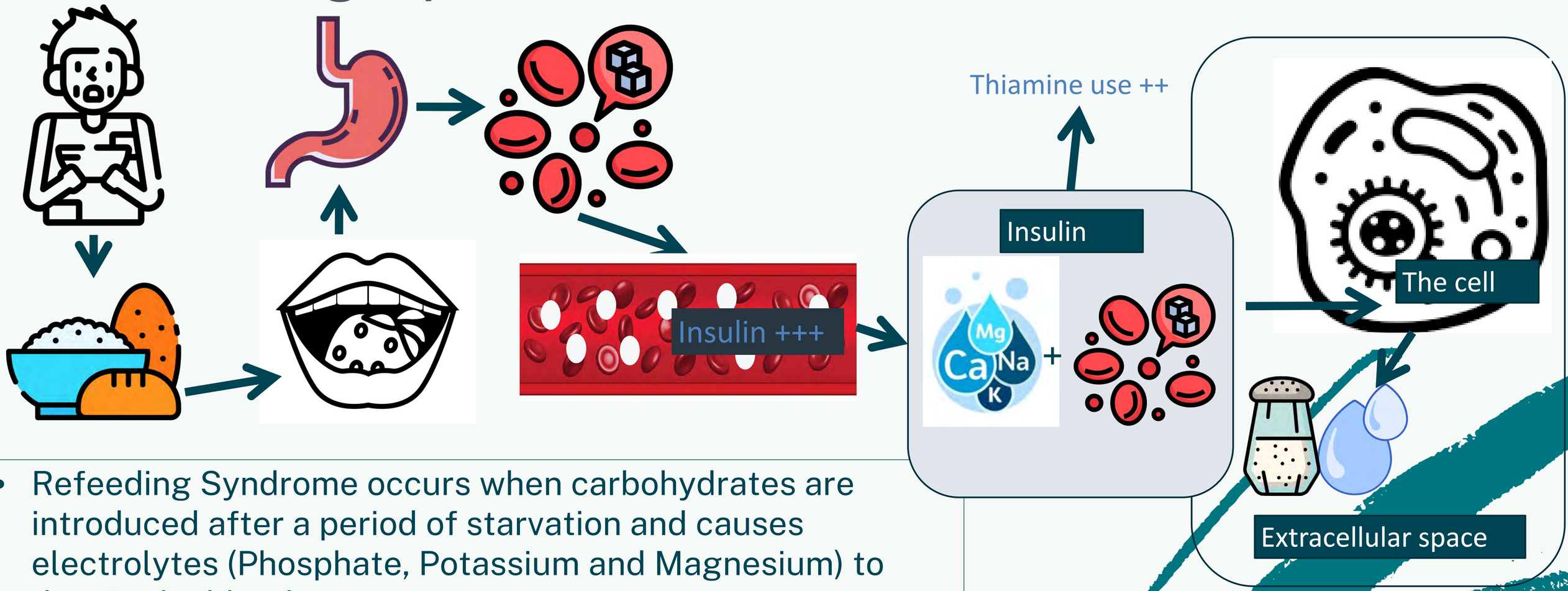
Risk factors for general population:

- Those with little (<500kcal) or no nutritional intake prior (especially in the last 5 days)
- Weight loss 10-15% past 3-6months
- BMI <16
- Low serum electrolytes – K, PO4, Mg
- History of insulin, diuretic or alcohol abuse
- Rapid Refeeding, particularly of carbohydrates, can lead to cardiac arrest due to rapid drop in serum electrolytes

Usually occurs in first 72hours of refeeding (Friedli et al, Syst review RFS Nutrition 2017)

CEED

Refeeding Syndrome



- Refeeding Syndrome occurs when carbohydrates are introduced after a period of starvation and causes electrolytes (Phosphate, Potassium and Magnesium) to drop in the blood.
- The quicker carbohydrates are introduced, the quicker electrolytes drop… if they drop quickly a person is at risk of a cardiac arrest.

CEED

CEED THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Management of RFS

General recommendations for Inpatient: *Best case scenario

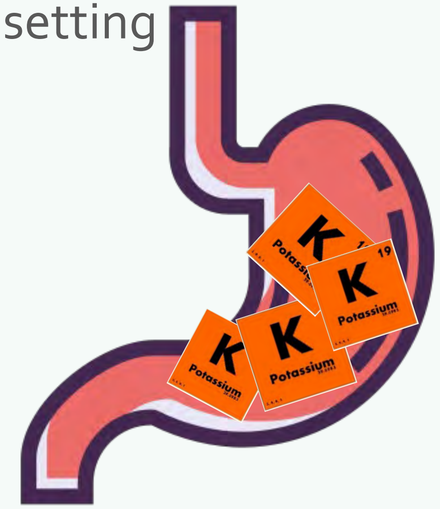
1) 200-300mg thiamine to start before and for at least 10 days post refeeding - **one month for community**
2) Balanced multivitamin/trace element supplement (e.g. Centrum) to start before and for at least 10 days post refeeding **- Ongoing until meeting requirements or healthier weight**
3) Supplement any electrolytes that are already low
4) Daily blood tests for electrolytes and BSL**- Viability or consider thrice/twice weekly in community**
5) If any electrolytes fall low, then to supplement i.e. phosphate (Phosphate Sandoz), Potassium (Sando K), Magnesium (Magnesium oxide or glycerophosphate) **– can consider prophylactic phosphate prior to feeding**
6) Refeed carbohydrate slowly - often seen when an IP

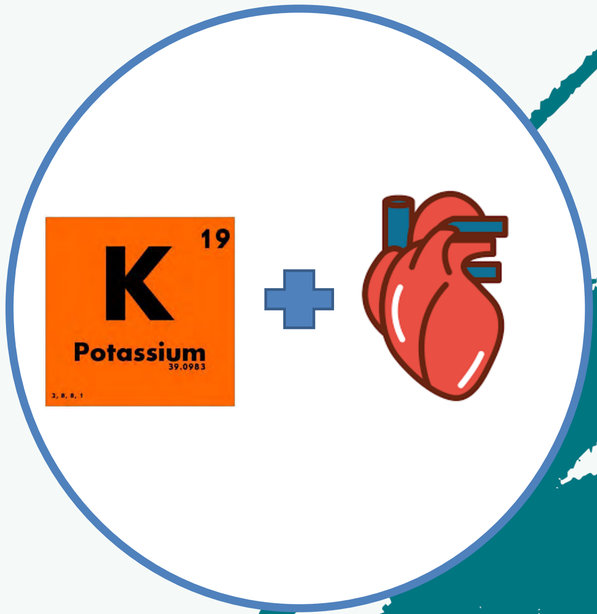
Clinical Judgement important

CEED

Let’s talk about purging…

- The stomach contains potassium
- Draws on potassium from the blood stream
- The body has strict upper and lower limit
- Risk of cardiac arrest
- Concerning amount of purging is >1 per day
- Might require supplementation of potassium
- Consider frequency, intensity, volume, setting





CEED

CEED THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Questions for MH clinicians to screen for purging risk...

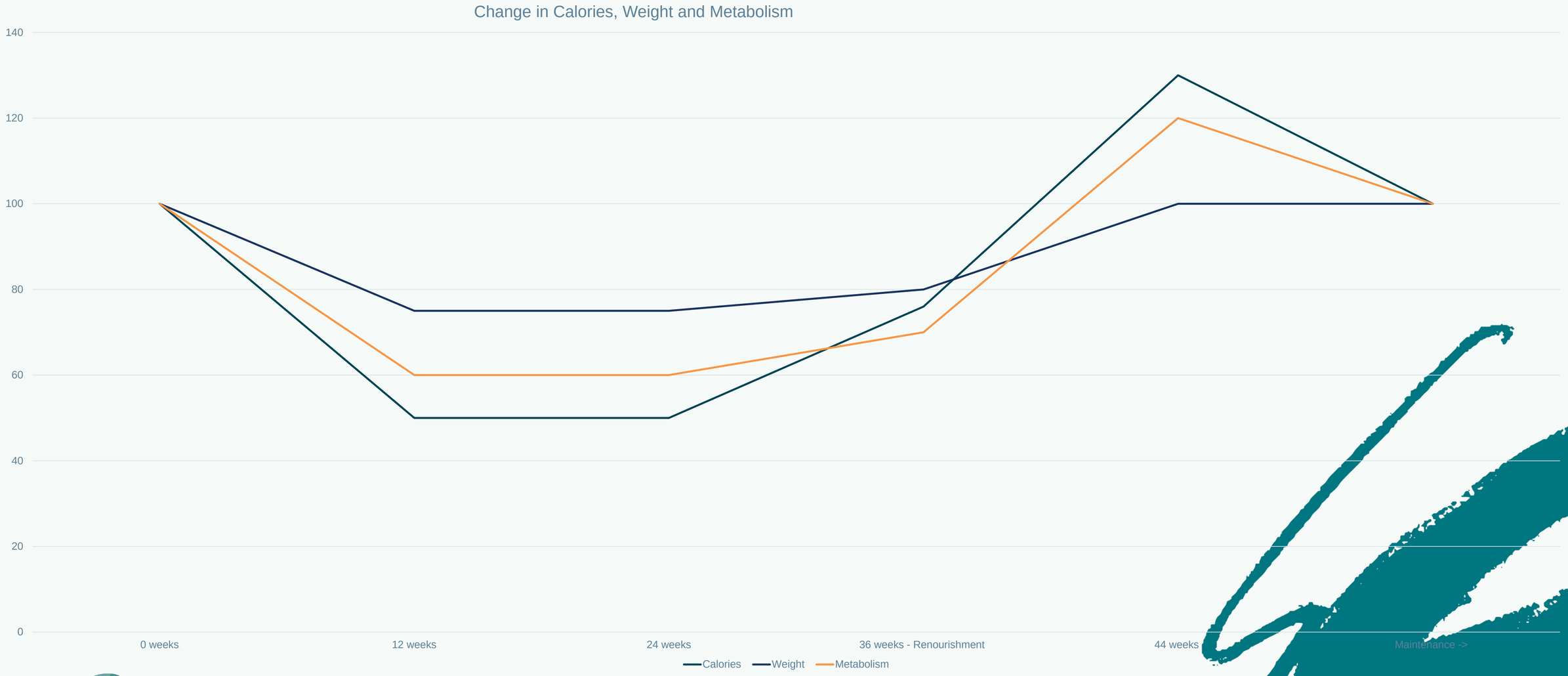
- Do you purge?
- How often do you purge? (frequency)
- How much do you purge? (volume)
- How do you purge?
- Has this increased recently?
- Is the context/setting always the same?
- Are there triggers that prompt the purging? (e.g. feelings of fullness, high levels of distress, etc.)

Note: Ensure your questions are *non judgemental* and provide some *clarification/psychoeducation* re: why you are asking these questions (i.e. risk concerns – physical, psychological) – there is considerable shame in purging behaviour

CEED

THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Minnesota Starvation Experiment



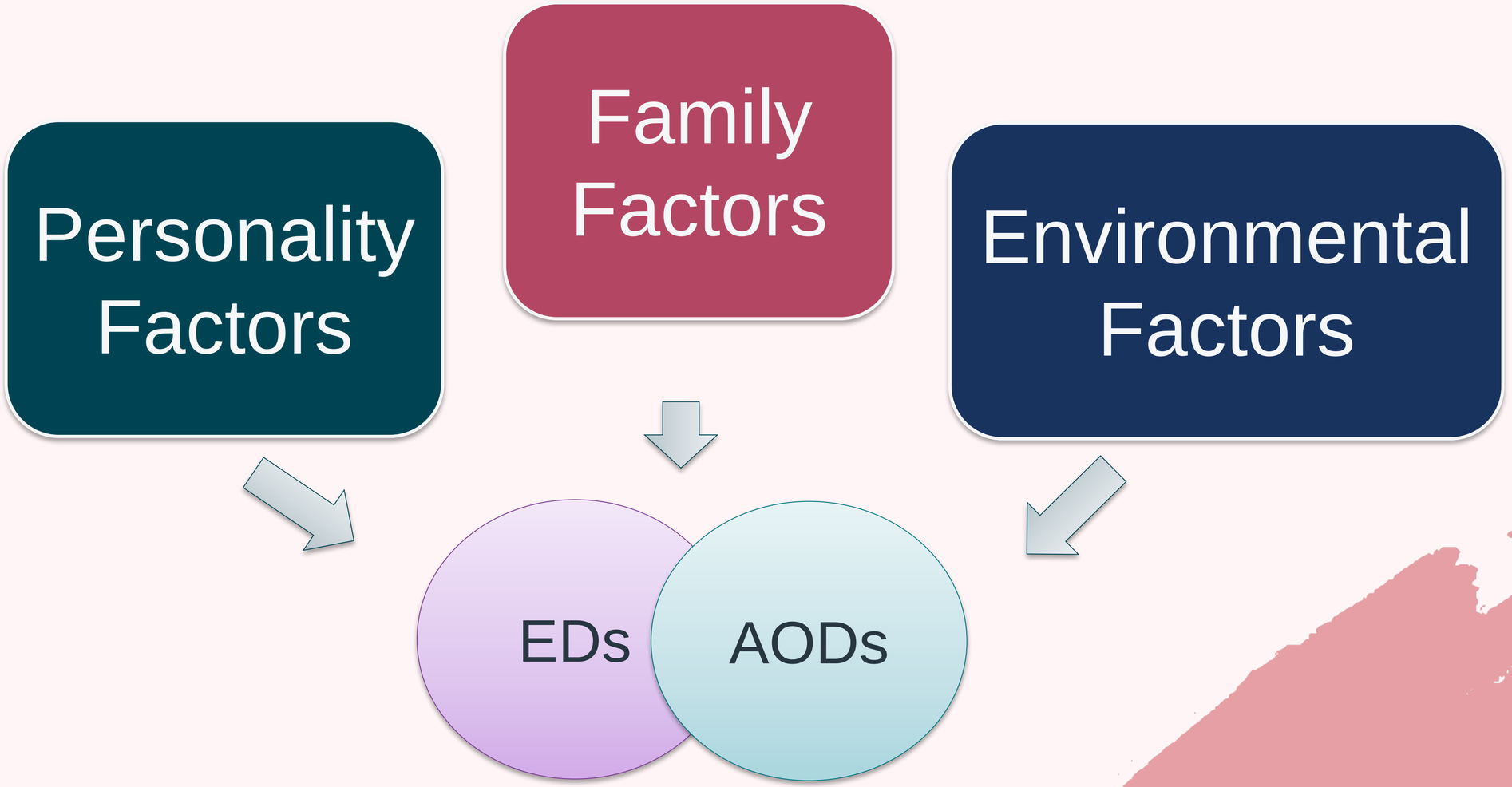
CEED

Eating Disorders & AOD use

- Over 1 in 4 individuals with eating disorders will meet diagnostic criteria for an AOD use disorder
- Nicotine, Caffeine and Alcohol are the most common
- AOD use behaviours are more frequently associated with binging and purging behaviour
- Disordered Eating Behaviours are likely to precede AOD use behaviour

CEED

Why do EDs and AOD use co-occur?



Similar etiological factors

CEED

Personality Factors

- Impulsivity**
- Compulsivity
- Anxiety/risk sensitivity
- Emotion Dysregulation
- Perfectionism
- Cluster B personality traits

Neurobiology and coping** style have also been found to have a significant influence

CEED

Family Factors

- Family history of mental illness
- Family/cultural norms of problem behaviour
- Dysfunctional family dynamics

Environmental Factors

- Childhood trauma
- Childhood adversity
- Social difficulties

Dieting has been found to be a risk factor for both EDs and AOD use

CEED

How do you manage EDs & AOD use concerns together?

Assess

Formulate

Engage

CEED

ED and AOD Use Risk

It’s a complicated relationship

Focus on assessing the problem behavior and engaging the medical team to understand the relationship

CEED

Formulate:

Understand the two behaviours as an expression of underlying pathology

What may be some “P’s”

- Predisposing factors
- Precipitating factors
- Perpetuating factors
- Protective factors

CEED

Formulate:

How do the behaviours co-occur?

- Do the behaviours serve a similar function
  - ie. Regulate emotions; “stop” thinking
- Does one behaviour cause another
  - ie. Binge drinking leads to an eating binge; eating binge leads to amphetamine use
- Does the pattern of one behaviour change when another is ceased?

CEED

How to Engage:

- Motivational interviewing
  - Identify the behaviours clients want to change, don’t want to change
- Set non-negotiables
  - Manage safety and boundaries
- Consider following protocol for “treatment butterflies”
  - Set up a plan for non-engagement at the beginning of treatment

Principles of care: Engagement & Motivation

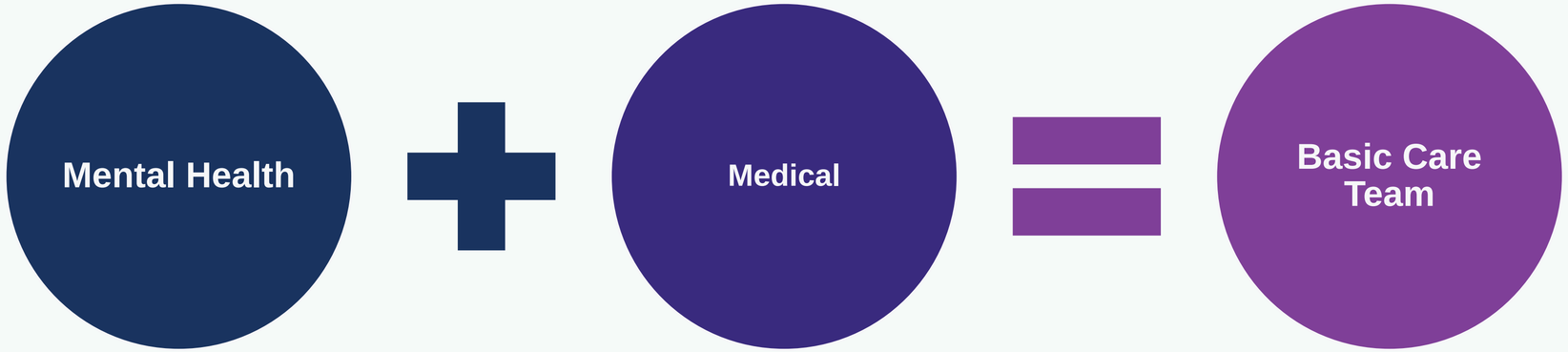
- Anticipate resistance
  - Reframe this as fear
  - Do not try and change the person's mind, or to argue
  - Roll with resistance
- Expect ambivalence, or pre-contemplation
  - Hear from the YP's perspective, active listening & reflecting back

CEED

Treatment for Eating Disorders

CEED

Care Team



CEED

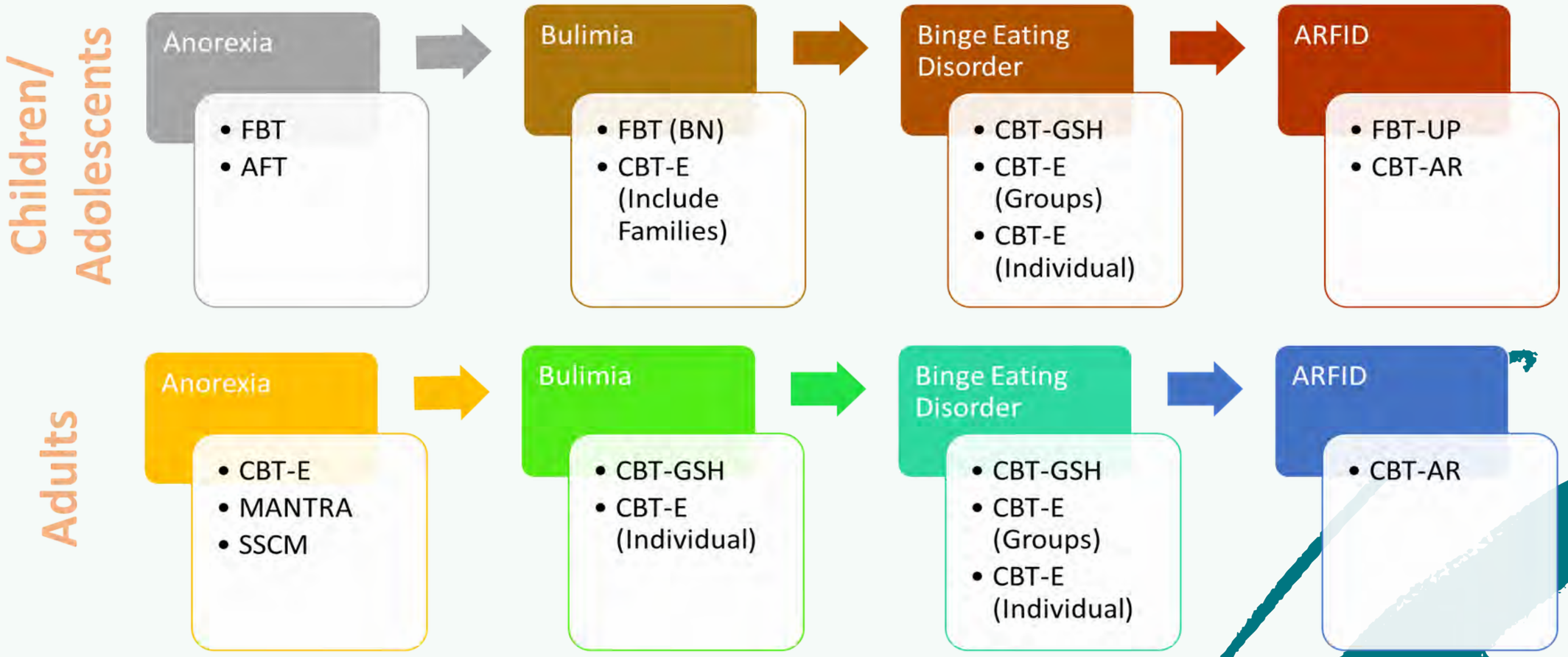
Care Team

Person	Mental Health Professional	Medical Professional	Dietitian	Family/Supports
• Attend appointments • Attempt behavioural change • Engage with care team	• Lead care team • Deliver mental health intervention/s • Ax/manage psychiatric risk • Facilitate mental health admission/s	• Ax/manage medical risk • Facilitate medical admission/s • Inform care team members of medical screening & investigation outcomes	• Consultation on meal plan/s • Guidance on adequate caloric and nutritional intake	• Determine role in collaboration with person • Support meals/daily living tasks • Offer emotional support and distraction • Encourage treatment

Communicate - review - collaborate

CEED

Therapeutic Modalities



CEED

At the Beginning of ALL ED treatments:

Re-establishing Normal Eating

- Reducing the impact of starvation/malnourishment
- A person cannot recover from an eating disorder if they engage with disordered eating

Engaged Care Team

- Need for both Mental health and medical team, and communication between team members
- Engage family/carers when able to/appropriate to do so

Re-establishing Normal Eating

- Encouraging 3 meals and 2-3 snacks
  - No more than 4hours between eating
  - Not about what people eat, it is about **when** people eat
- Graded, building on goals each week
- Tends to eliminate most binges
- Generally involves Psycho-education
- Focused on “Sound Nutritional Principles”
- Includes reducing Excessive exercise, purging, laxative use

CEED

Eating in Recovery

Weight gain is hard work:

- Generally people require **far more** than they expect or enjoy in order to restore weight to healthy levels
- Focus on health recovery will be required for a **sustained time period**

Common Side Effects to increasing oral intake

- Gastro-intestinal discomfort is one of the most common side effects of recovery eating
- More ‘noise’/ED thoughts and distress

CEED

Eating in Recovery

R	**REGULARITY** • Establish a habit of eating at regular intervals • Foundation step in re-integrating food & eating into life
A	**ADEQUACY** • Sufficient food to meet your nutritional requirements, whatever they may be
V	**VARIETY** • Further step in developing a positive relationship with food • Forms the foundation for eating socially & challenges rigid food beliefs
E	**EATING SOCIALLY** • Integrating eating back into the social setting & re-forming connections
S	**SPONTANEITY** • Flexibility & ease of decision-maing around eating

CEED

A step-by step approach to re-establishing normal eating. By Shane Jeffrey, APD (2013)

Unhelpful language & comments

Be mindful of conversations around:

- Dieting, food or weight
- Body shapes or size
- Exercise, going to the gym
- Comparisons (with other staff or patients)
- How someone looks – “You look well”

CEED

What we can do

- Offer distraction – puzzles, games, question cards, news/tv discussions
- Non-judgemental approach
- Empathise
- Encourage and support – “You’re doing a really good job”, “I know this must be difficult, but keep going”, “Is there anything I can do to help you eat/finish your meal?

CEED

Recommended Online Resources

ceed.org.au

nede.org.au

ccinhealth.wa.gov.au

eatingdisorders.org.au

thebutterflyfoundation.org.au

edfa.org.au

CEED

Feed Your Instinct (FYI)

- Steps families through a checklist of behaviours/signs based on warning signs families observe
- Personalised GP and parent report
- GP report has current best practice assessment and referral recommendations
- Parent report has key actions families can take now

www.feedyourinstinct.com.au

"I think this website is terrific - very helpful to both families and professionals. I find myself using and recommending it all the time!"

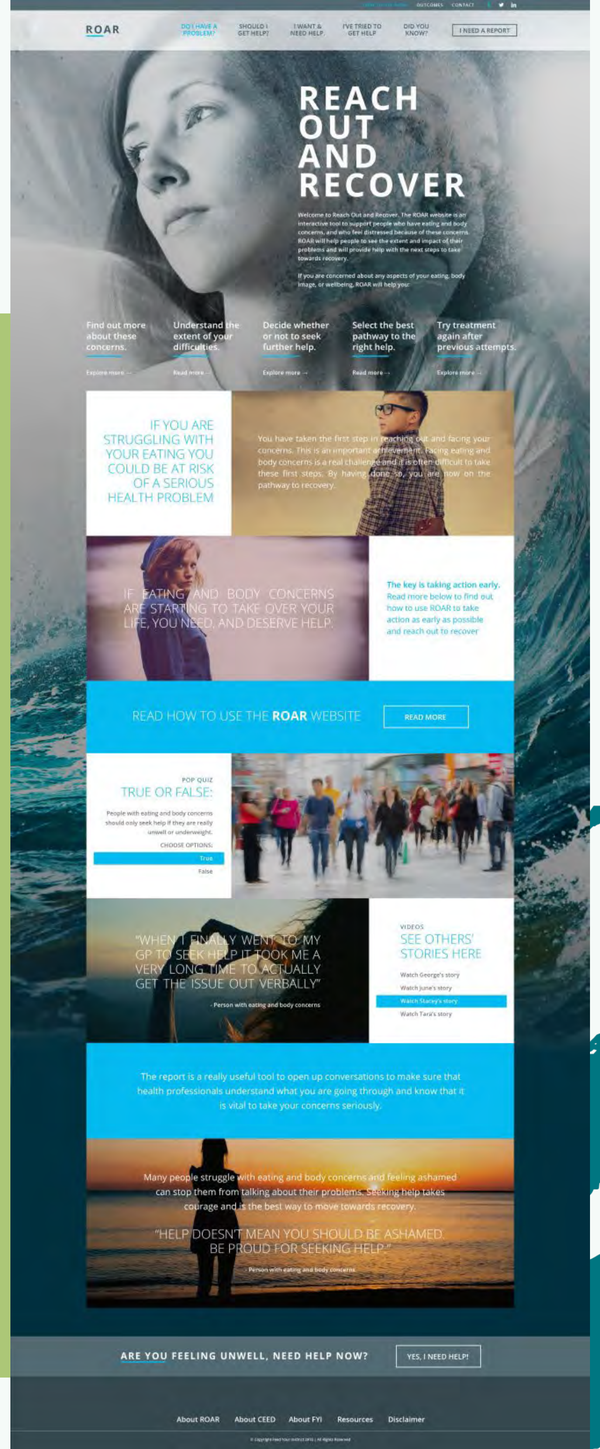
(Paediatrican - Melbourne)

CEED

Reach Out And Recover (ROAR)

www.reachoutandrecover.com.au

- Web-based tool to ***fast-track help seeking*** in ***adults*** who have concerns about their relationship with food, nutrition, weight or exercise
- Uses a ME approach to empower & encourage adults who have early signs of / concern about DE & BI or with longer standing eating disorders to take action to seek help & support.
- **Features:**
- **Online tool:** Utilises components of EB tools to formulate:
  - A tailored personal report promoting self-efficacy & help seeking
  - a tailored HP report to support initial discussion with GP / HP
- **Psycho-education:** information about eating disorders including risks, benefits of seeking help early, warning sign, treatment options including self-help options, & first & high risk contact options
- **Personal stories:** stories of the recovery journey of a range



Take home messages

- Understanding the myths about mental health and eating disorders leads to a more aware and accepting community, and improves prevention, early identification, and help-seeking
- Early identification and intervention is key to recovery from eating disorders
- There are a number of warning signs that may alert you to the presence of an eating disorder
- There are tools available to assist in screening and assessment of eating disorders
- There are strategies to assist with supporting someone during a meal and with an eating disorder
- People who have an eating disorder may not wish to disclose this. Keep this in mind as you facilitate a curious and non-judgmental discussion to assist them to get help

CEED

Questions??

CEED