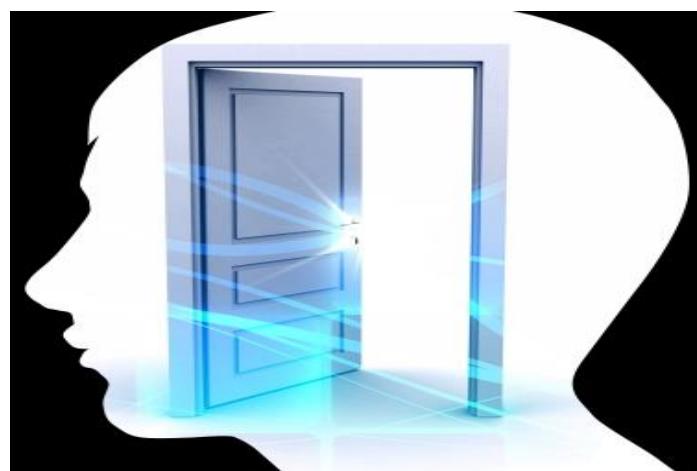


Working and understanding Eating Disorders from a Recovery approach

Dr Jean Morrissey 9th March 2018

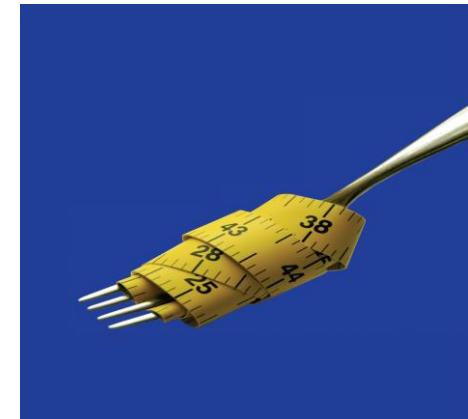


Aims of workshop:

- ▶ To present a holistic approach to the care treatment when working with the child/adolescent from an eating disorder.
- ▶ To discuss the core knowledge and skills to identify, manage and engage therapeutically with people (child/adolescent) and their family affected by eating disorders.
- ▶ To examine responses and attitudes towards people affected by eating disorders and how it impacts on building, maintain and sustaining a supportive working relationship in a therapeutic/helping context

Common Presentations and Key Characteristics

- ▶ Anorexia Nervosa (AN)
- ▶ Bulimia Nervosa (BN)
- ▶ Binge Eating Disorder (BED)
- ▶ Avoidant/Restrictive Food Intake Disorder (ARFID)



Understanding Eating Disorders

- ▶ An eating disorder is a serious and complex mental illness. It typically features severe disturbances in a person's thought processes and their relationship with food, their body and weight.
- ▶ This may lead to significant complications for a person's quality of life, and in their physical and mental health. There are a variety of eating disorders, with different causes and characteristics.
- ▶ A common feature of an eating disorder is low self-esteem and an attempt to deal with psychological distress through a self-destructive relationship with food.

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Irish Statistics

- ▶ Department of Health and Children, up to 200,000 people in Ireland may be affected by eating disorders with 1800 new cases emerging each year, representing 80 deaths annually.
- ▶ In 2016, 12% of all admissions for under 18s to Irish psychiatric units and hospitals had a primary diagnosis of eating disorders.
- ▶ For anorexia nervosa, the peak incidence of onset is 14–18 years and for bulimia nervosa it is 14–22 years.³ Binge eating disorder most commonly presents in the late teens or early 20s.
- ▶ Understanding Eating

More Irish Research

- ▶ Research on adolescents in Ireland (1,841 girls & 1,190 boys): (McNicol, Dooley, McNamara & Lennon, 2012)
 - Disordered eating more prevalent among girls than boys
 - Early female & later male maturation were significant risk factors
 - At risk children demonstrated a greater drive for thinness & body dissatisfaction

Mortality Rate Statistics

- ▶ Highest mortality rates of all psychiatric illnesses
- ▶ In Ireland, 80 deaths attributed per year to ED
- ▶ Yet rates vary between studies & sources
- ▶ Medical complications often reported as cause of death rather than ED
- ▶ Crude mortality rates from American Journal of Psychiatry (2009)
 - 4% for AN
 - 3.9% for BN

Men & Eating Disorders

- ▶ Harvard Research show men represent
 - indicates 25% with AN & BN are Male
 - 40% of those with BED are Male
 - Rate of BED is similar men to women
- ▶ Men with eating disorders share the same characteristics as their female counterparts, including low self-esteem, the need to be accepted, an inability to cope with emotional pressures, and family and relationship issues.
- ▶ Men are stigmatised by having a "woman's disease" and thus fewer men know that they have ED or seek treatment.
- ▶ About 80% of women want to lose weight; about 80% of men want to change their weight, half wanting to lose weight and the other half wanting to add muscle

Male Risk Factors

- ▶ Being overweight for height and age in childhood
- ▶ History of Dieting (Preoccupation with size)
- ▶ Excessive concern for fitness rather than health
- ▶ Participation in sport that requires size restraint
- ▶ Career involvement in size occupations

Concerns for Male Sufferers

- ▶ While presentation may be more ‘male-oriented’ (eg: larger size & exercise), the recovery process is the same as well as their need for treatment & support
- ▶ Males tend to resist treatment because of the stigmas associated with EDs

ED (Children)

- ▶ Growing research substantiates EDs affecting younger populations
- ▶ Higher proportion of boys in EOED (Pinhas, Morris, Crosby, Katzman, 2011)
- ▶ Have higher life threatening medical complications requiring hospitalisations (Madden, Morris, Zurynski, Kohn & Elliot, 2009)
- ▶ Greatest diagnosis has been EDNOS – Symptoms include food avoidance & weight loss without weight/shape concerns (Nicholls, Lynn & Viner, 2011)
- ▶ Co-morbidity

The ED Myths – What are they?

- ▶ Recovery is Rare or impossible
- ▶ You can tell by looking at someone if they have an ED
- ▶ EDs are a phase and will pass
- ▶ EDs only effect higher socio-economic western cultures
- ▶ Caused by media and society
- ▶ Men don't get EDs
- ▶ EDs are a lifestyle choice
- ▶ EDs result from dysfunctional families and controlling parents
- ▶ The person with an ED is attention seeking and manipulative

Common Treatment Misconceptions

- ▶ Getting better is a matter of eating right
- ▶ Getting better is a matter of putting on weight
- ▶ There is no cure – ED is something one learns to live with
- ▶ CBT, DBT, EFT, Psychodynamic, Family Therapy, Inpatient treatment, etc... is the cure



Your Own Personal Biases – Individual reflections

- ▶ What are they?



Your Own Personal Biases

- ▶ How healthy is your relationship with food?
- ▶ How comfortable are you with your own body?
- ▶ What is your belief about the aetiology of EDs?
- ▶ What do you believe about ED recovery?

How are Eating Disorders Currently Understood?

The Theoretical Discourses

Understanding Eating Disorders as a Coping Mechanism

- ▶ An eating disorder is not a diet.
- ▶ It is a serious psychological illness. It develops as a coping mechanism that a person uses to manage how they are feeling.
- ▶ The behaviours and thought processes around food, weight and the body become a way of dealing with distress. For many complex reasons, an eating disorder provides someone with a sense of safety and feeling of control.

- ▶ Disordered eating behaviours can bring a sense of relief, and this may initially 'work' for a person for a period of time, because it allows them to feel okay. However, once trapped within an eating disorder, people often feel a need to maintain it in order to manage other parts of their life which may feel overwhelming. They don't know how they could cope without it. They may feel ashamed and frightened in discussing it. The longer an eating disorder continues the more entrenched it becomes and the greater the impact on a person's health and quality of life.

Understanding Eating Disorders as a Coping Mechanism

- ▶ Eating disorders are, in some cases, fatal.
- ▶ • Denial and resistance to talking about it are common.
- ▶ • Contrary to the misconception, eating disorders are not unique to young people or girls.
- ▶ • No one single cause has been associated with the development of eating disorders.
- ▶ • People directly affected may feel stigmatised due to negative stereotypes or misconceptions.
- ▶ • Mental illnesses often require medical/physical and/or psychological intervention to promote recovery.

- ▶ Frequent changes in weight/weight loss
 - ▶ • Failure to gain expected weight in a child or adolescent who is still growing and developing
 - ▶ • Wanting to lose weight when normal or underweight
 - ▶ • Dry, discoloured skin or fine hair growing on their face and body
 - ▶ • Poor circulation, fluid retention
 - ▶ • Difficulty sleeping, or concentrating
 - ▶ • Calluses
 - ▶ • Enlarged salivary glands
 - ▶ • Digestive problems such as cramps, wind, constipation, diarrhoea, a sore throat or mouth ulcers
 - ▶ • Loss of, or irregular periods
 - ▶ • Unexplained infertility
 - ▶ • Feeling weak, dizzy or tired
 - ▶ • Erosion of tooth enamel, tooth decay
 - ▶ • Muscle weakness
 - ▶ • Cardiac arrhythmias

Multi-factorial Conditions

- Psychological
- Interpersonal
- Social/Cultural
- Genetic & Biological Predisposition

How are Eating Disorders Currently Diagnosed?

Historic & Recent Changes
&
Current Diagnostic Assessment

DSM-5 Eating Disorder Diagnostic

Since May 2013

▶ Current Types:

- AN – Anorexia Nervosa
- BN – Bulimia Nervosa
- BED – Binge ED
- ARFID – Avoidant & Restrictive Food Intake
- OSFED – Other Specified Feeding or ED



» Diagnosing & Assessing

ANOREXIA NERVOSA

AN Characteristic s

- ▶ Onset early to mid-teen increasing in children and mid-life
- ▶ usually triggered by dieting & stress
- ▶ Women 10 x more likely than men to develop
 - Symptomatology similar in men
- ▶ Often co-morbid with depression, OCD, phobias, panic, alcoholism & personality disorders
 - in men, co-morbid with substance dependence, mood disorders or schizophrenia
- ▶ Suicide rates high
 - 5% completing
 - 20% attempting

AN DSM-5 Diagnostic Criteria

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

AN DSM-5 Amendments

- ▶ Criteria no longer require the patient's weight for height to be less than 85% of that expected
- ▶ Cognitive criteria, such as fear of weight gain and shape and weight overvaluation, no longer need to be self-reported and can be inferred by behaviour or by parent report for young people
- ▶ DSM-IV Criterion D requiring amenorrhea or the absence of at least three menstrual cycles has been deleted



Diagnosing & Assessing



BULIMIA NERVOSA

BN Characteristics

- ▶ Involves episodes of overeating followed by purging (vomiting, laxative, abuse, fasting, chewing & spitting out food, &/or exercise)
 - often triggered by stress & emotions - search for control
- ▶ Body shape and weight important for self-evaluation
- ▶ Prevalence is 1-2% of female & 1% of male population
- ▶ 75-85% are normal to overweight
- ▶ Onset usual late adolescence during an episode of dieting regardless of body weight

BN DSM-5 Diagnostic

- ▶ Bulimia nervosa is characterised by frequent episodes of binge eating followed by inappropriate behaviours such as self-induced vomiting to avoid weight gain
- ▶ DSM-5 criteria reduce the frequency of binge eating and compensatory behaviours that people with bulimia nervosa must exhibit, to once a week from twice weekly as specified in DSM-IV

BN Diagnostic Frequency DSM-5

DSM-5 criteria have reduced the frequency of binge eating and compensatory behaviours that people with bulimia nervosa must exhibit from twice a week to once a week. In addition, the purging and non-purging subtypes have been removed.

Frequency of inappropriate compensatory behaviours has been used to specify the level of severity for BN. Severity is indicated by:

- **Mild**; An average of 1-3 episodes per week
- **Moderate**; An average of 4 - 7 episodes per week
- **Severe**; An average of 8-13 episodes per week
- **Extreme**; An average of 14 or more episodes per week

Problems with Diagnosis

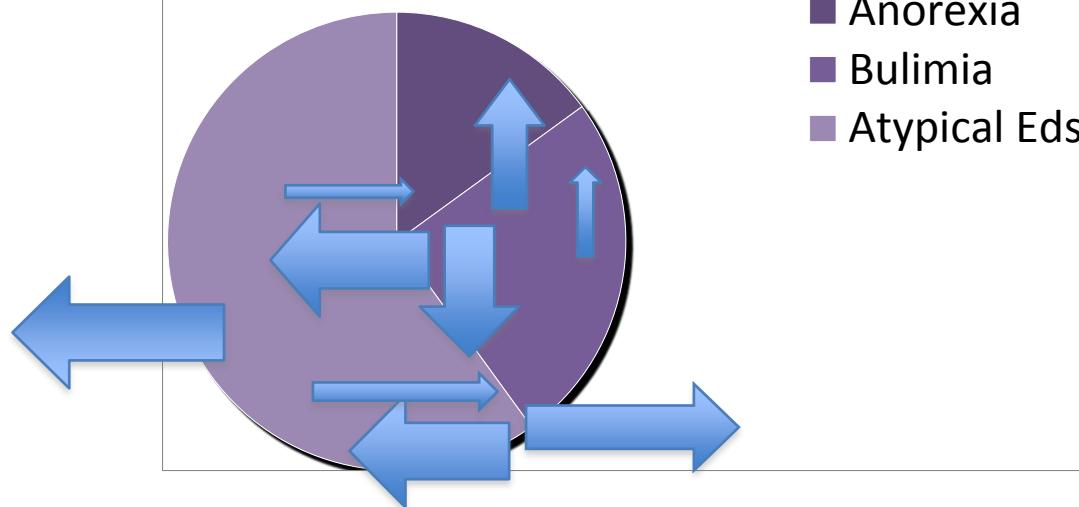
- ▶ As a clinician we can become too concerned with assessing the symptoms to determine which “box” the presenting client fits.



- ▶ Therefore we can focus overly on treatment of the symptoms than treatment of the person

Typical Lifetime progression of EDs

Fairburn & Harrison, 2003



Obesity is NOT ED

- ▶ World-wide obesity campaigns highlight weight management
- ▶ Advocacy without Understanding can promote
 - an epidemic of fear
 - size prejudice
 - societal obsession with size rather than health



Living with EDs



UNDERSTANDING THE WORLD OF EATING DISORDERS

Aoife

AN to BN

- ▶ Childhood AN onset (10 years)
 - Treatment with GP & Nutritionist
 - BN (12 years) to cover eating to make parents happy
 - Moved to College & symptoms went out of control. Suicide attempts
 - Began psychotherapy in order to go back to AN (restricting)
 - Move overseas to do a Masters and sought psychotherapy again to stop binge/purge

Sarah

- ▶ Childhood onset
- ▶ Parents put her on diets encouraging healthy eating
- ▶ Parents took her to a GP to put her on diet pills
- ▶ Suicide attempts led her to Overeaters Anonymous
- ▶ Did for 9 years and got food under control but felt that there was more to life and sought psychotherapy and spiritual healing

Mollie

- ▶ AN College onset
- ▶ Moved to Asia to avoid family
- ▶ Restricted to near death
- ▶ Sent home to work with a therapist
- ▶ She left home again to avoid family
- ▶ Family continued psychotherapy seeking to make connections with her
- ▶ She worked through the food and then sought therapy to work on interpersonal issues

James

Hospital replaced ED food rules with just a different set of rules

- ▶ As child not happy with self
- ▶ In college wanted to have a better body so began cycling – even though he wanted a more cut body, he continued to lose weight
- ▶ in and out of ED programs not able to maintain healthy eating on his own
- ▶ began working with a psychotherapist who was not interested in how he did with food, but encouraged him to journal and look inward

Rachel

- ▶ During leaving cert year, parents brought to a therapist because she only ate carrots, fish fingers, green beans, potato pockets
- ▶ She would gag every time she tried to eat anything new
- ▶ They had tried GPs, testing for allergies, stress reduction techniques
- ▶ Agreed for therapy because it was affecting her socially

Who is in the World of ED

- ▶ Parents
- ▶ Family
- ▶ Friends
- ▶ Siblings
- ▶ Colleagues
- ▶ Employers
- ▶ Teachers
- GPs
- Nurses
- Other Treatment Providers



How Clients Relate to the Others

- ▶ What the ED experience is like
- ▶ Starts as a diet
- ▶ Avoidance of emotions and inability to tolerate uncertainty or discomfort
- ▶ Relationships stay at a surface level
- ▶ Use food and body control to maintain security
- ▶ Use goal oriented achievements to maintain control and the semblance of being “okay”

How OTHERS relate to the client

- ▶ Over time, carers focus on food behaviours as a sign to determine whether the sufferer is “*okay*” or in recovery
- ▶ This focus reinforces the importance of food as control and emotional stability as doing well



Path to Recovery & the Recovery Process

UNDERSTANDING ED RECOVERY

What does ED Recovery Look Like?

- ▶ Mapped into area that reflect ED criteria:
 - Physical
 - Emotional
 - Behavioural
 - Psychological
 - What about the social component?

Therapeutic relationship helps...

- ▶ Learning to be authentic with oneself and others
- ▶ Learning to accept boundaries and limitations
- ▶ Learning to navigate emotional and physical intimacy

10 Phases of Recovery

(Costin & Grabb, 2013)

1. I Don't think I have a problem
2. I might have a problem, but it's not that bad
3. I have a problem, but I don't care
4. I want to change, but I don't know how & I am scared
5. I tried to change, but I couldn't
6. I can stop some of the behaviours, but not all of them
7. I can stop the behaviours, but not my thoughts
8. I am often free from the behaviours, but not all of them
9. I am free from the behaviours & thoughts
10. I am RECOVERED

Process of Recovery (Oberlin, 2013)

- ▶ Pseudo
 - Form of Partial recovery
 - Symptom & behavioural focus
- ▶ Real
 - Integration & Self Developmental stage
 - Relationships with self & others

ED TREATMENTS



Current Treatments

- ▶ To date, there is not ONE recognised therapeutic approach to treatment
- ▶ Many clients report recovery happened outside of therapy or without it at all
- ▶ Most specialised ED treatment providers report working with some form of multi-disciplinary team

Most Common Therapeutic Treatment Approaches

- ▶ Individual
 - Person Centred Approaches
 - CBT-E, DBT,
 - ▶ Family
 - Family Systems
 - Maudsley Approach
 - ▶ Group Therapies
 - Process
 - Topic
- Peer Support



Working Multi-Disciplinarily

- ▶ Often one-to-one therapy is not enough when medical complications co-exist
 - Working with a **GP** and insisting consistent medical examinations by the client can rule out medical complications complicating the process
 - Nutritional support with a specialised **nutritionist/dietician** can help distribute the struggle with food issues

Working Multi-Disciplinarily, con't...

- **Family** member & Significant other inclusion helps improve relationships and refocus the attention to behaviours
- Peer or **group supports** challenge isolation (including on-line groups)
- **Alternative therapies** can help to stimulate awareness and promote alternative means of expression (meditation, art, music, drama, etc.)

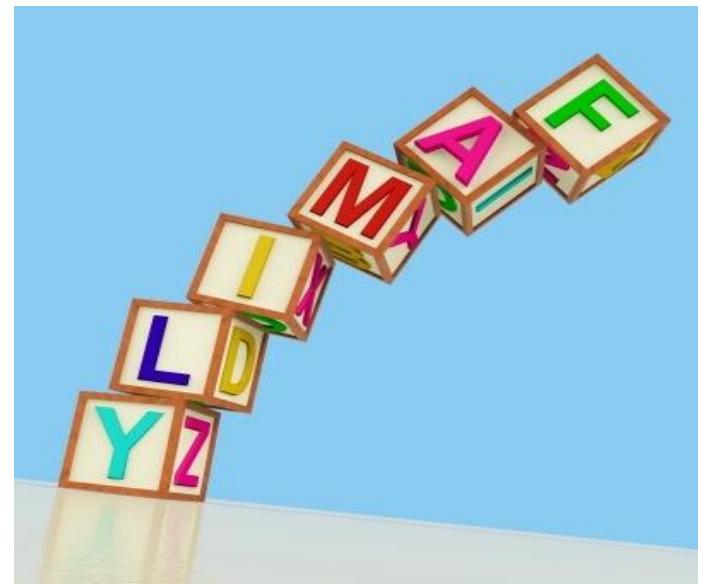
Multi-Disciplinary Challenges

- ▶ Team Splitting
- ▶ Communication breakdowns can result in a client remaining stuck
- ▶ Issues of Confidentiality
- ▶ Financial Burdens
- ▶ When is it time for hospital and who decides?



Working with the Family

- ▶ By the time a person comes for help, the whole family has an ED as they are ALL concerned about the what the client is or is not eating and or doing to themselves





Boundaries & Control in Treatment

- ▶ Boundaries reflect familial or familiar patterns in the client's life
- ▶ Too rigid or not enough is common
- ▶ ED is a struggle between trying to find a balance between controlling themselves (behaviours) & managing their world
- ▶ By being sick, significant others tend to either also inflict either too rigid, inconsistent or insufficient boundaries

Weight



- ▶ Focusing on weight as a measure of successful recovery reinforces the importance of size control

- ▶ When weighing is part of the treatment, be aware of the measures that clients will go to obscure real weight

Clinical Evidence & Weight in Treatment

- ▶ Focusing on weight leads to dieting
- ▶ Diets don't work & can lead to disordered eating
- ▶ Mindful eating can heal broken relationships with food & provide a doorway to vibrant living
- ▶ Mindful eating is about being in the present moment, not postponing one's life until you attain (or in order to attain) some idealised version of beauty or health
- Health is a personal & evolving concept for each individual, one that cannot be measured in numbers
- Beauty comes in all shapes & sizes. Weight is a poor indicator of health
- Using BMI as a surrogate measure of health is misleading
- Weight stigma hurts. Shaming & threatening people doesn't improve health

Body Image

- ▶ Some Ed sufferers are more dissociated with their body than others
- ▶ The more a client dislikes themselves, the more they are focused on body dislike/dysmorphia & body checking or avoidance
- ▶ Body checking is often evident in session & is an ideal way to begin work on body image



Challenges for Worker/ Treatment



- ▶ Working with someone who doesn't want help
Ambivalence & denial
- ▶ Working with self harm and suicide ideation
- ▶ Managing nutrition restoration & medical complications
- ▶ Working with family & other healthcare workers
- ▶ Managing setbacks

Food in Recovery

- ▶ For many, regulating food and engaging in a healthier relationship with food can be the last aspect to change
- ▶ BN & BED and NES struggle with impulsivity of changing the food



Self Care for the ED Professional



- ▶ Training for ED specialisation
- ▶ Clinical supervision – someone familiar with ED issues

Engaging statements....

- ▶ I am concerned for you and it seems that there is an issue here that needs to be addressed.
 - ▶ • Do you have help available to you at the moment?
 - ▶ • Have you spoken to your GP?
 - ▶ • Is there someone you might feel comfortable talking to?
 - ▶ • What do you feel would be helpful for you right now?
 - ▶ • I think you need some help to address this. Can we talk through the options?
 - ▶ • I hear what you're saying...
 - ▶ • What do you see the problem as?
 - ▶ • I appreciate this is difficult to talk about
 - ▶ • It is important to seek professional advice, so that your health is monitored and that you have some additional support.

Useful Websites

- ▶ *Bodywhys* – www.bodywhys.ie/
- ▶
- ▶ beat (beating eating disorders) www.b-eat.co.uk
- ▶