An Introduction to Eating Disorders – Part 2

Presented by Chris Thornton

Clinical Director & Principal Clinical Psychologist of The Redleaf Practice

NEDC Steering Committee Member

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Specific High Risk Groups

Bullying & peer difficulties

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Most common risk factor for eating disorders is **body image concerns** and **dieting** (although they are much more than that).

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Prevalence of Body Image Dissatisfaction

1. High **rates** of body image concerns
   - Adolescent body dissatisfaction in Australia:
     - 50% adolescent boys
     - 75% adolescent girls
   - Of adolescents in a healthy weight range
     - 33% boys believe they're overweight
     - 50% girls believe they're overweight
2. High **importance** of body image concerns
   - Mission Australia Annual Surveys
     - Body image rated in Top 3 concerns every year since introduced in 2006
     - Rated as #1 concern on 3 occasions

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Detection and Screening

Early identification and referral to appropriate services is vital

Detection

Observe	• Physical, psychological and behavioural warning signs
Listen	• Listen to concerns – e.g. family, friends, colleagues
Ask	• Opportunistically screen high risk populations

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Observe Warning Signs

Psychological

- Preoccupation with eating, food, body shape & weight
- Feeling 'out of control' around food
- Distorted body image
- 'Black & white' thinking
- Using food for emotional regulation
- Changes in emotional state

Physical

- Weight loss, gain or fluctuations
- Gastro-intestinal problems
- Overexercising injuries
- Infertility issues
- Feeling cold despite weather
- Fatigue
- Calluses on knuckles, damage to teeth, swelling of jaw & bad breath (signs of vomiting)
- Fainting or dizziness

Observe Warning Signs

Behavioural:

- Dieting or binge eating
- Frequent trips to the bathroom during or shortly after meals
- Vomiting, using laxatives or other compensatory behaviours
- Changes in clothing style
- Compulsive or excessive exercising
- Obsessive rituals around food preparation or eating
- Sensitivity to comments about body, eating or exercise habits
- Secretive behaviour around food

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Warning Signs – More information

Mental Health First Aid:

Eating Disorder Guidelines.

www.mhfa.com.au

NEDC: Evidence based guide about warning signs & early intervention.

www.nedc.org.au

Early Detection

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- Few people will volunteer to anyone that they have an eating problem
  - May present for weight, anxiety or depression
  - May present for conditions which are medical complications of an eating disorder
  - Ambivalence

- Look for clusters of behaviour
  - Physical, psychological and behavioural symptoms we talked about earlier
  - Weight/appearance not a good indicator (80% will not look like they have AN)

- **NEDC: Early intervention within 2 years improves recovery rates and reduces risk of physical consequences**

Early Detection

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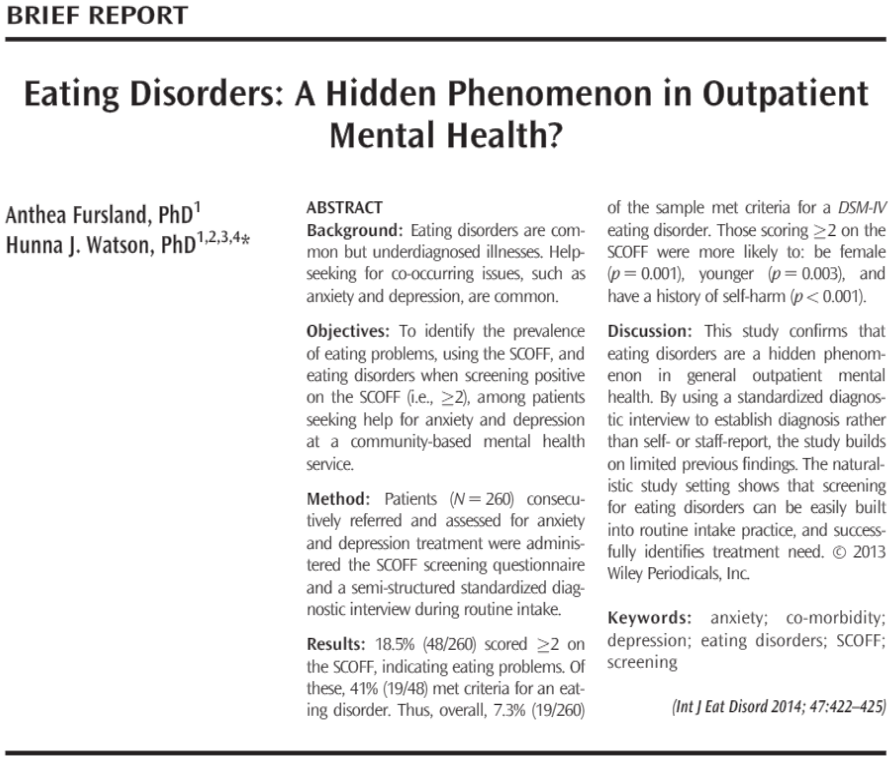
- For any person presenting in a primary health setting, ask questions about eating, like you would sleep, smoking or alcohol use.

- Patients with ED (BN in particular) presented to their GP significantly more for non ED problems than those without ED.

- In BN there is an average of 7 years from an initial somatic presentation to diagnosis of an Eating Disorder. This is 7 years lost.

CCI Study

- Fursland & Watson
  - 260 patients in anxiety/depression clinic.
  - SCOFF (Morgan, Reid, Lacey; 1999)
  - 18.5% ‘probable eating disorder’. 7.3% made criteria for DSM IV ED
  - Female, younger, history of self harm.



BRIEF REPORT

Eating Disorders: A Hidden Phenomenon in Outpatient Mental Health?

Anthea Fursland, PhD[1]
Hunna J. Watson, PhD[1,2,3,4]*

ABSTRACT

Background: Eating disorders are common but underdiagnosed illnesses. Help-seeking for co-occurring issues, such as anxiety and depression, are common.

Objectives: To identify the prevalence of eating problems, using the SCOFF, and eating disorders when screening positive on the SCOFF (i.e., ≥2), among patients seeking help for anxiety and depression at a community-based mental health service.

Method: Patients ($N = 260$) consecutively referred and assessed for anxiety and depression treatment were administered the SCOFF screening questionnaire and a semi-structured standardized diagnostic interview during routine intake.

Results: 18.5% (48/260) scored ≥2 on the SCOFF, indicating eating problems. Of these, 41% (19/48) met criteria for an eating disorder. Thus, overall, 7.3% (19/260) of the sample met criteria for a *DSM-IV* eating disorder. Those scoring ≥2 on the SCOFF were more likely to: be female ($p = 0.001$), younger ($p = 0.003$), and have a history of self-harm ($p < 0.001$).

Discussion: This study confirms that eating disorders are a hidden phenomenon in general outpatient mental health. By using a standardized diagnostic interview to establish diagnosis rather than self- or staff-report, the study builds on limited previous findings. The naturalistic study setting shows that screening for eating disorders can be easily built into routine intake practice, and successfully identifies treatment need. © 2013 Wiley Periodicals, Inc.

Keywords: anxiety; co-morbidity; depression; eating disorders; SCOFF; screening

(Int J Eat Disord 2014; 47:422–425)

Ask: Screening Measure – The SCOFF

S: Do you make yourself **S**ick because you feel uncomfortably full?

C: Do you worry you have lost **C**ontrol over how much you eat?

O: Have you recently lost **O**ver 6.35kg in a three-month period?

F: Do you believe yourself to be **F**at when others say you are too thin?

F: Would you say **F**ood dominates your life?

"Yes" to 2 or more indicates further assessment is required.

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Ask: Screening Measure - BEDS-7

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? (A No to this question ends the screening)
2. Do you feel distressed about your episodes of excessive overeating?
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?

If the patient says yes to question 2 and then indicates sometimes, often or always to questions 3 through 7 a fuller assessment of BED should be carried out or referral to a specialist centre be recommended.

Ask: Bulimia Nervosa

- 3 questions have been shown to indicate a high sensitivity for BN

  ** Are you satisfied with your eating patterns?*

  ** Do you eat in secret?*

  ** Do you ever feel out of control with your eating?*

- A *Yes* to any of these questions warrants further investigation

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Safe Conversations

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I suspect a person has an eating problem. What do I say?

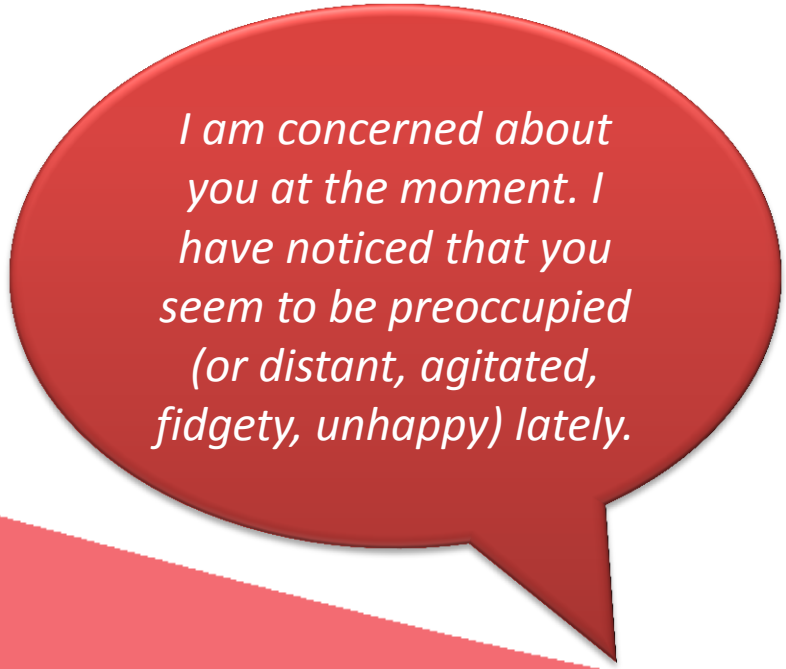
Safe Conversations

Promotion of an open, non-threatening conversation may be helped by:

- Avoiding diagnostic labels
- Not immediately mentioning food or weight symptoms
- Not commenting on appearance (e.g. telling someone they have lost weight)
- Show empathy and support.

Safe Conversations

Prefix your observations with ***'I am concerned...'*** rather than '*You seem...'*. This can reduce the potential judgment the person may feel.



Deepening the Conversation

"What would you eat over a typical day?"

"Many people have concerns about food and weight. Do you have any concerns or worry about these things?"

"Many people have trouble with eating too much. Has this ever been a problem for you?"

"Is it ok for us to talk about this?"

If no – at a minimum assess medical risk.
Re-express concern.
Return to the consequences of the eating disorder at each opportunity.

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Speaking to a young person

- If you suspect that a child is experiencing an eating disorder you should first approach the **parents**, before approaching the child directly about the eating issue.
- The parents are the most important people to engage with to take action
- Encourage the family and the young person to seek further support (rather than convincing them).

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Safe conversations

Be prepared for different reactions such as denial, anger, rationalising of their behaviour, dismissiveness.... and **sometimes** relief.

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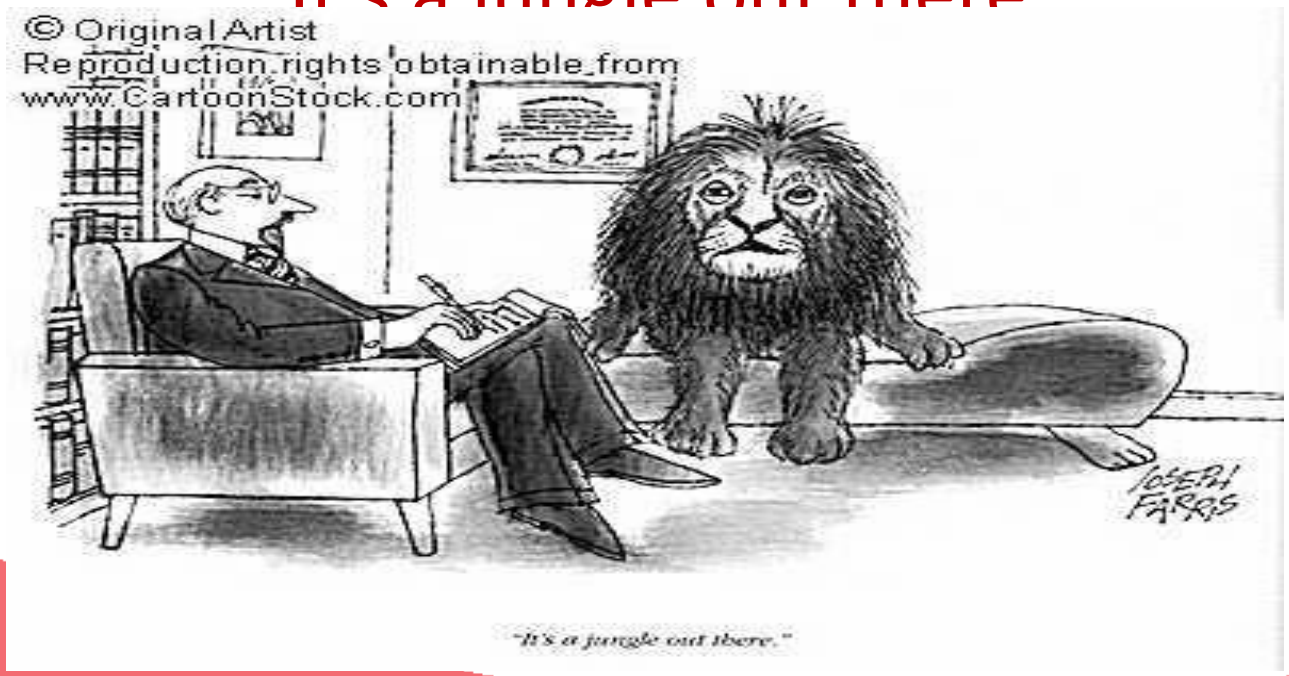
The Next Step: Making Referrals

Referral is necessary whenever there is a suspected eating issue.

"It's a jungle out there"



Referral Pathways

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Specific treatment preferred where possible.

NEDC – www.nedc.com.au

- A great database of ED services and clinicians for each state
- Resources specific to a range of primary care clinicians

- State based organisations
- Local Community Health Centre/Primary Health Network

- If rural/regional, explore Better Access Scheme Telehealth options for specific treatment

Bottom Line

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- A person with a suspected ED needs an urgent assessment by a qualified mental health clinician and a medical assessment.
  - ED treatment always includes BOTH medical and mental health treatment
- Training in detection across primary health care is important to ensure EDs are not missed
- Awareness of referral pathways is important to ensure timely, appropriate treatment

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At work, home & school…

Not Helpful ✗

- Complain about your own body
- Weight as the only indicator of health
- Comments about weight/appearance in general
  - Even compliments
- Allowing appearance-based teasing to occur
- Labelling foods as bad/fatty/no-no's
- Promoting weight/shape/eating as overly important

Helpful ✓

- Complimenting non-appearance attributes & talents
- Encourage scepticism of media messages
  - Challenge the thin ideal
- Act as a positive role model
  - Eating regular meals and snacks
- Be aware of how 'health' messages are being delivered
  - Check anti-obesity messages are not too strong

How do we communicate relevant health messages about lifestyle that do not ‘promote’ disordered eating?

- Weight is a poor indicator of health.
- Interventions should be health focused and not weight loss focused.
- Avoid “fat is bad” messages
- Interventions should focus on modifiable behaviours – physical activity, healthy eating habits, screen time, decrease fizzy soft drinks.
- Promote self esteem, body satisfaction and body acceptance, enjoyable physical activity, regular eating, family modelling, media literacy).

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Interventions

What to expect when you are referring?

EVIDENCE-BASED TREATMENTS

- Family-Based Treatment for young people with AN
- CBT-E for people with BN and BED
- CBT-E for AN
- Guided Self Help - BN

- Specialist Supportive Clinical Management (SSCM) for AN
- Interpersonal Therapy for BN
- MANTRA; Cognitive schema therapies
- DBT
- SSRIs for BN and BED

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Core Principles in ED Treatment

- The bits of therapy that we think we know are helpful and should be in the therapy irrespective of the name of the therapy.
  - An Eating Disorders Therapy
- Informed by evidence base
- Informed by clinical experience
- Informed by patient feedback
- **(Evidence Based Practice)**

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MANDY GOLDSTEIN
PSYCHOLOGY

Core Principles of ED Treatment

- Core Principles
  - Therapy Relationship
  - Motivational Enhancement
  - Nutritional Rehabilitation
  - Weighing
  - Individual Case Formulation
  - Dealing with thoughts/feelings

- Emphasis will differ based on age and diagnosis.

Recovery in Eating Disorders

Given high rate of relapse and recurrence, recovery may be achieved episodically before sustainable recovery is achieved.

Criteria for Recovery (Bardone-Cone, et al., 2010)

- Diagnosis – no longer meeting diagnostic criteria
- Behaviour – no longer engaging in eating disorder behaviours
- Physical health – weight within healthy BMI range
- Psychological – positive attitudes to one's self, food, the body, expression of emotions and social interaction
- Practical – quality of life including capacity for engagement in work or education, and leisure

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Summary

- Eating disorders are common and serious
  - Early detection in primary care is vital
- Early and specific referral = better outcomes

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Questions?

Chris Thornton, The Redleaf Practice

chris.thornton@theredleafpractice.com

www.theredleafpractice.com

02 9487 7799