eating disordersqld.

CLINICAL GUIDELINES

FOR THERAPEUTIC INTERVENTIONS IN EATING DISORDERS

By Dr Jenny Gilmore

EATING DISORDERS QUEENSLAND CLINICAL GUIDELINES

Eating Disorders Queensland 2021 Clinical Guidelines for Therapeutic Interventions in Eating Disorders: Author Jenny Gilmore

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Disclaimer: These guidelines are intended as a general guide to practice with clients who experience eating disorders. They are based on the best available evidence from research and literature and the insights of EDQ practitioners.

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FOREWORD

I was honoured when Belinda Chelius, CEO of Eating Disorders Queensland (EDQ) asked me to provide this foreword. I have had the benefit and privilege of working with and alongside EDQ for almost twenty years. During that time, I have observed many changes in name, venue, programmes, leadership and staffing. But there are some things that, thankfully, have remained the same. These include a dedication to social justice and community engagement, a systemic and feminist perspective, a trauma informed approach, and a nonjudgmental, safe, person-centred approach to helping those struggling with eating issues.

I have learnt much from EDQ over the years. I have watched a peer workforce grow and flourish. I have seen the benefits of a welcoming, safe, nonthreatening community environment for those suffering from eating disorders. And I have seen a wonderful variety of community-based actions to address the toxic social and cultural factors that cause and perpetuate eating disorders and stigma around weight and shape.

Many times, I have stood alongside people with lived experience, supported by EDQ, as they helped me deliver training to doctors and other clinicians. As these clinicians hear about the lived experience of those with eating disorders, I often see, within minutes, years of misunderstanding and stigma dissolve before my eyes. Thanks to EDQ, I have seen carers helping carers, survivors helping those in recovery, and authentic, highly-skilled and sensitive clinicians from EDQ opening the minds and hearts of other clinicians. I look forward to a long, continuing relationship with EDQ, and I highly recommend these thoughtful, comprehensive, contemporary, and beautifully person-centred guidelines to you.

A/Prof Warren Ward MBBS FRANZCP FAED
Director, Queensland Eating Disorders Service (QuEDS)

ACKNOWLEDGEMENTS

The staff at Eating Disorders Queensland (EDQ) devoted a great deal of their time and energy to generating the content for these guidelines. They participated in multiple workshops, recommended research and literature, read copious drafts and were always available to answer my many questions. Working with such an inspiring group of dedicated practitioners has been the highlight of this project for me.

Thank you all for your commitment to ensuring these guidelines are a true reflection of the high-quality work you do at EDQ.

Thank you to the CEO of EDQ, Belinda Chelius, who had the vision to initiate these guidelines. Belinda has gently guided the process and has provided me with constant support throughout the project. Thank you to the EDQ Board who supported this idea and made the project possible. A special thanks to the senior workers Christophe, Melissa, Emma and Rohie for their extra assistance with editing the drafts of this document.

Thank you to several other people who were involved in the production of this document: Kristen Young for undertaking the initial literature review; Sandra Hogan for her work in editing the final document; Lisa Kelly for her beautiful art work and illustrations; dtb! Advertising for the design and formatting of the final document.

I would also like to thank the Blue Knot Foundation for their internationally acclaimed Practice Guidelines for Clinical Treatment of Complex Trauma. These guidelines have provided much needed information on trauma informed practice, and we have drawn guidance and inspiration from them in the creation of these guidelines.And finally, I would like to acknowledge the many clients and carers / key supports and loved ones who have accessed the service since its inception in 1996. These guidelines are the culmination of our learning over these years, and it is our hope that they will make it more possible for other workers and organisations to embrace this approach to working with people with eating disorders.

We would like to respectfully acknowledge the Traditional Owners of the land on which Eating Disorders Queensland operate, and their Elders past, present and emerging.

We honour the women elders in diverse communities of which we are a part and we celebrate the extraordinary diversity of women's bodies, genders, sexualities, capacities and relationships that we all represent. We pay our respects to all the people with a lived experience, carers / key supports and loved ones who have shared their recovery wisdom with us.

INTRODUCTION

Eating disorders are serious and complex mental health issues that have strong medical and psychological components. In fact, eating disorders have the highest mortality rate of any mental health issue. While we previously considered the impacts of eating disorders primarily on young, white women, we now know that eating disorders can affect people regardless of gender, age, race, ethnicity, body shape and weight, sexual orientation, and socio-economic status. Despite the seriousness of eating disorders, we now know that recovery is possible. We also know a great deal more about a variety of causation factors and a wide range of effective interventions.

Eating Disorders Queensland (EDQ) has been at the forefront of therapeutic intervention for the treatment of eating disorders for over 25 years. We have pioneered therapeutic approaches to individual therapy, therapeutic group work, support programs for carers / key supports and loved ones, peer support and mentoring programs, psycho-educational group work, advocacy and social change. In all of these areas we have highlighted the value of incorporating the lived experience of people who have had eating disorders and have recovered.

One of the defining features of the work of EDQ has been our focus on feminist and trauma informed approaches to understanding and working with eating disorders. This work began at the Women's Therapy Centre in London in the 1980s when many young women were presenting with serious and complex eating disorders. The highly gendered nature of eating disorders drew the attention of feminist therapists and through this work, the connections between experiences of childhood trauma, especially experiences of sexual violence, became clear. Interestingly, there is a now a firm evidence base for this early work as the neurobiology of trauma has shown us the devastating effects of trauma on the brain and body. Feminist approaches combined with trauma informed approaches continue to inform the work of EDQ, along with a very substantial knowledge and skill base informed by a range of other therapeutic perspectives.

Current clinical guidelines for the treatment of eating disorders in Australia are aimed at treatments for medical and psychiatric care in line with the DSM-5 and International Classification of Diseases (ICD-11). The EDQ clinical guidelines presented here have been specifically developed to inform clinical therapeutic practice with clients who have eating disorders, rather than to manage their medical and psychiatric care. The work of EDQ exists on the continuum of care and these guidelines sit alongside a range of medical and psychiatric interventions.

There is increasing recognition that a range of treatments for eating disorders are important in overall recovery and that treatments that only focus on medical care are often ineffective for client recovery. We now recognise that many clients with eating disorder presentations have histories of complex / developmental trauma and therefore guidelines that address trauma informed practice responses are long overdue.

These clinical guidelines have been generated from the ongoing experiences of practitioners at EDQ in addition to the growing research and literature base about eating disorders, feminist therapy and trauma informed practice. They are designed to share the range of approaches developed by EDQ over many years and it is our hope that colleagues, new and known to us, will take this opportunity to explore a diverse range of practice approaches to recovery for clients with eating disorders and those who care for them.

This includes other health professionals, social workers, psychologist, private practitioners, dieticians, youth workers, sexual assault counsellors, general practitioners, psychiatrists, teachers, school health nurses, guidance officers and any other professional working in this complex area.

Finally, it is important to address the issue of use of language. EDQ has traditionally rejected the term 'eating disorders' instead preferring to talk about 'eating issues'. In these clinical guidelines we have chosen to use the term 'eating disorders' because this is the language of our sector. We also wish to ensure there is no confusion about what is being discussed and to ensure that the severity of these issues is not minimised by using a different, less known, term.

However, it is important to note that we do not regard eating disorders as 'disorders' but rather as social issues that result from a range of complex factors in our society but that manifest within individuals as a response to these factors.

EATING DISORDERS QUEENSLAND

Providing treatment and support for people experiencing an eating disorder as well as their carers. Through individual and group therapy, peer mentoring and community building, we aim to alleviate the impact of eating disorders for everyone concerned.

Eating Disorders Queensland since 1996.

Eating Disorders Queensland is a state-wide, community-based not-for-profit organisation. EDQ is funded by Queensland Health. We provide the largest community support and treatment services for individuals and families in Queensland who are living with and recovering from eating disorders, their carers and loved ones. By the sharing of recovery treatment and support, we aim to involve people with a lived experience, carers and family members, and loved ones.

Support options include therapeutic and psychosocial support for individuals as well as coaching and community connection for carers / key supports. EDQ also provides early intervention opportunities with community education events focusing on creating healthy relationships with food and our bodies. We are passionate about eradicating weight stigma and diet culture. Lived experience drives our service delivery. We promote the voices of lived experience through consultation, employment opportunities, and EDQ Board representation of both carer / key supports, and peer lived experience.

Our Vision: A world free from eating disorders

Our Mission: To facilitate hope and recovery for all people affected by eating disorders

Our Values:

Nurture
Creating an inclusive, connected community that inspires hope and passion.

Empower
Fostering a safe environment where people have the power to lead recovery.

Integrity
Working with deep respect, embracing honesty, trust and empathy.

Innovate
Creating together to provide high-quality responsive programs, services and initiatives.

Collaborate
Valuing diversity through sharing learning among people with eating disorders, carers and sector partners.

HISTORY OF EDQ

EDQ was founded in 1996 by a group of feminist practitioners. They sought to develop alternative approaches to the bio-medical model of working with women with eating issues. Originally auspiced by Zig Zag Young Women's Resource Centre, the service was then called Isis: The Eating Issues Centre, named after the Egyptian goddess of rebirth, growth and nourishment by young women who used the service.

In 1996 Isis received funding from Queensland Health to provide therapeutic groups and support services to women with serious eating disorders. In 2015 the service changed its name to The Eating Issues Centre.

In 1993 the Queensland Association for Mental Health established a support group for carers of people suffering from an eating disorder. In 1996 this group became incorporated as the Eating Disorders Association and received funding from Queensland Health to provide referral, information and support for people living with an eating disorder in Queensland and their carers.

In October 2018 The Eating Issues Centre and the Eating Disorders Association merged to form Eating Disorders Queensland. This created the largest community service in Queensland offering support and treatment for individuals living with and recovering from an eating disorder, their carers and loved ones.

SERVICE DELIVERY MODEL:

The below diagram illustrates the EDQ service delivery model and referral pathways.

Referral Pathways In

QuEDS
Hospital Inpatient

Primary Health Care
GP, PHN Hubs

Self/Carer/Family

HHS & Rural
Remote
fast track

Counselling

Psychosocial Peer Support

FUNDING

QHealth

Medicare

NDIS

PHN

Care Navigator

Individual ED Clinical Treatment

Carer/Family/ Loved Ones
Targeted Short term coaching/ support

6 monthly PMP
5 week
Meal Support Program

30 Clinical Counselling
Intentional Peer Support sessions

10 Weekly Therapeutic ED treatment group
ED Community Reconnect groups
Peer Support

Support Groups
Online info sessions

Fostering Recovery
Skills Workshop

Single Session Coaching
Carer Peer Mentoring

(NDIS)
Therapeutic Supports
Level 3 Specialist Support Coordination
Psychosocial Recovery Coaches

(Medicare)
EDP 40 sessions
MH Plan 20 sessions
EPC for Dietetics

(PHN)
Psychoeducation Groups

Target Group
- aged 16 years and over

RESOURCES:

EDQ has developed a range of resources that are freely available on the web page. These include:

- Carers Help Kit
- Understanding Eating Disorders
- Eating Disorder Recovery Stories
- Sharing and Connecting with the Voice of Lived Experience
- General Practitioners Kit
- Vodcasts
- Coping with the Holiday Season
- Weight Stigma Poster
- Navigating Lunar New Year
- Coping with Physical Isolation

SETTING THE SCENE

Eating Disorders Queensland (EDQ) occupies a unique place within the broader eating disorder service system. The eating disorder treatment environment is predominantly based on a medical approach to working with clients with eating disorders. While EDQ sits outside a purely medical model, we have developed an integrated model of care that fits seamlessly in a Stepped Care model of treatment.

Since 1996 EDQ has developed a unique, evidence informed model of care. EDQ is funded by Queensland Health through the Connecting Care to Recovery Plan[1], to deliver Community Mental Health Treatment Services for eating disorders including:

- **Group support and rehabilitation**
- **Individual peer work**
- **Group-based peer work**
- **Individual carer support**
- **Group carer support**
- **Structured psychological therapies**

Within the service system, EDQ is strategically placed to deliver a Stepped-Down treatment and support service for clients exiting tertiary treatment facilities such as hospitals and community bed-based services or community treatment services such as the Queensland Eating Disorders Service. Given that eating disorders are the 12th leading cause of mental health hospitalisation costs in Australia[2], EDQ makes a significant contribution to the overall eating disorders service system.

EDQ's practice is informed by and consistent with, the National Stepped Care approach. This approach[3] provides flexibility to ensure that individuals have the option to step treatment up or down throughout the continuum of care. Treatment and support are matched to the individual's current needs, from least to most intensive. Therefore, individuals can enter or exit treatment at any point on the continuum in response to the development of their eating disorder. EDQ sits within levels 1-4 on the continuum of care[4].

One of the central goals of the Stepped Care approach is to reduce hospital admissions by providing clinical treatment and non-clinical recovery support for people with serious and complex mental illnesses.

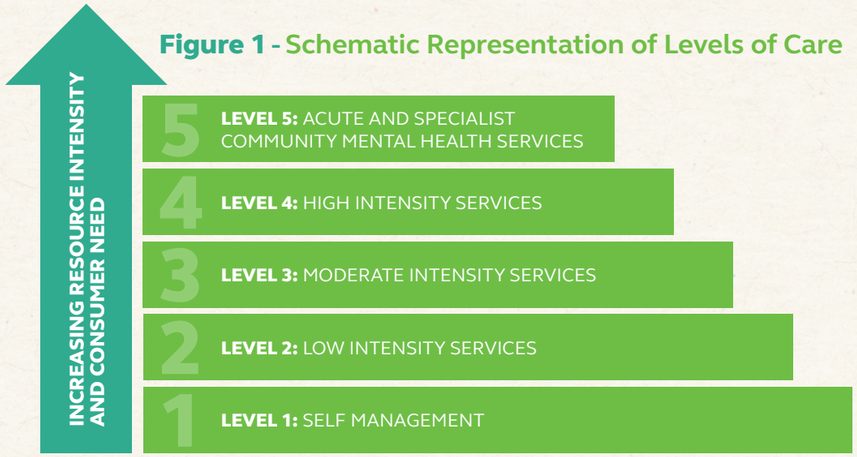
In relation to eating disorders, community-based models are generally eating disorder specific programs, such as EDQ, that provide an intermediate level of care and support between primary health and hospital interventions.

In line with state and national guidelines, EDQ's clinical guidelines will inform how other practitioners and services might work alongside clients and their key supports to achieve self-directed recovery from an eating disorder[5].

The components of this approach include:

- **Recovery Planning:** ensuring that people leaving treatment have clear plans and support strategies to assist them to transition to self-directed recovery.
- **Counselling and Brief Clinical Interventions:** to sustain the outcomes of treatment during periods of difficulty.
- **Peer Support and Peer Mentoring:** access to communities of recovery to sustain the outcomes of treatment.
- **Life Skills Education:** group-based and self-directed learning opportunities to develop capabilities related to sustaining a healthy relationship with food and exercise, and coping strategies.
- **Re-entry:** to treatment pathways for earlier intervention during setbacks to recovery.
- **Case Coordination:** for people who require ongoing access to multiple services.

Figure 1 - Schematic Representation of Levels of Care



[1] *Connecting Care to Recovery 2016-2021: a plan for Queensland's State-funded mental health, alcohol, and other drug service* (2016).
[2] Butterfly Foundation. (2017) *The National Agenda for Eating Disorders 2017 to 2022: Establishing a baseline of evidence-based care for any Australian with or at risk of an eating disorder*, Sydney: Butterfly Foundation.
[3] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March.
[4] Butterfly Foundation. (2017) *The National Agenda for Eating Disorders 2017 to 2022: Establishing a baseline of evidence-based care for any Australian with or at risk of an eating disorder*, Sydney: Butterfly Foundation.
[5] Butterfly Foundation. (2017) *The National Agenda for Eating Disorders 2017 to 2022: Establishing a baseline of evidence-based care for any Australian with or at risk of an eating disorder*, Sydney: Butterfly Foundation.

EDQ PRACTICE FRAMEWORK

The EDQ practice framework articulates the central values, knowledge and skills that inform service delivery. Importantly, all service delivery at EDQ aspires to a high level of consistency between values and actions. This is achieved through a strong commitment to reflective practice.

REFLECTION

We are committed to reflective practice that encourages all workers to reflect on their work with clients as well as their own wellbeing. We provide individual supervision, external supervision, team supervision as well as a range of informal means of connection and reflection as a team.

OUR VALUES

1. Community

Warm and Welcoming, Belonging, Safety, Generosity

IN PRACTICE

- We create a safe and warm environment for clients to feel welcome, which includes ensuring clients have a sense of ownership over the space.
- We are clear about confidentiality and privacy.
- We ensure clients from differing backgrounds are comfortable by using language intentionally and respectfully.
- We invite feedback and collaboration.
- We value generosity of time and flexibility around client's needs.
- We provide intentional and diverse opportunities for people to have a sense of community.
- We are willing to be client led at all stages of the process.

OUR VALUES

2. Connection

Authenticity, Relationship, Compassion, Acceptance

IN PRACTICE

- We are welcoming to all clients and ensure our physical space is warm and inviting.
- As workers we are constantly reflecting on our values and how we put them into practice in all parts of our work.
- We see authenticity, fun and enjoyment as key parts of our work together.
- We facilitate client involvement in community events that we run, not just in our therapeutic services.
- We support authentic connections between group participants and workers.
- We offer lots of choice in our different programs.
- We value the lived experience of workers.
- We value compassion.

OUR VALUES

3. Social Justice & Inclusivity

Diversity, Equity and Accessibility, Valuing Lived Experience, Anti-oppressive

IN PRACTICE

- We are always working towards empowerment and participation for all clients.
- We promote agency and choice and attempt to minimize power imbalances wherever possible.
- We value the lived experience of workers and clients and the diverse ways in which eating disorders present.
- We value diversity and inclusivity in relation to gender, culture, sexuality, ability, class.
- We do not require a diagnosis for referral and all clients are self-referred.
- We ensure equity for workers in relation to workloads and work-life balance.
- We see the client as the expert over their own lives.

OUR VALUES

4. Sustainability

Wellness, Enjoyment and Fun, Communication, Adaptable, Flexible, Responsive

IN PRACTICE

- We ensure staff are well supported and provided with a variety of professional supervision and professional development opportunities.
- We ensure sustainability in our staff group by training all workers in all programs and rotating workers in these different roles.
- We make time for each other on a regular basis.
- We accept that we cannot meet demand with current levels of funding and are always lobbying for additional resources.
- We have good communication and clear boundaries.
- We bring out passions to work (yoga, art, plants, cooking, music).

KNOWLEDGE

We are committed to our ongoing professional development and learning to ensure our knowledge base is current. We value a diverse range of knoweldges including formal theories (such as feminist theory, trauma informed theories, person centred theory, narrative theory, strengths based theory, system theory, acceptance and commitment therapy, dialectical behaviour therapy, anti-oppressive theories), practice wisdom and lived experience.

THE GUIDELINES

1. UNDERSTANDING EATING DISORDERS

There are many components to a thorough understanding of eating disorders in our society and all knowledge that contributes to an understanding of this complex issue is valuable.

At EDQ we have a bio-psycho-social understanding of eating disorders where we see eating disorders as a complex interaction of mental health, developmental and familial experiences, trauma related experiences, genetic predispositions, social and cultural forces, and the interrelationship between these various factors. Eating disorders are complex issues that have significant impacts on a person's emotional and physical health as well as impacting on those who care for and support the person.

1. Eating disorders are maladaptive coping strategies that have been created and maintained by our society.

Our society plays a role in the incidence of eating disorders. We need to see eating disorders within the larger context of our social preoccupation with dieting and weight loss and socially approved body images and sizes[6].

Eating disorders should be approached from a perspective that is informed by the broader social and cultural forces that encourage the objectification of bodies and that values specific body shapes and sizes rather than unique and diverse bodies.

2. Feminist approaches to understanding and working with people with eating disorders have provided an alternative understanding that is complementary to other approaches.

In the 1990s feminist therapists suggested that eating disorders were an expression of a greater problem for young women and these underlying issues give rise to difficulties with eating. It was suggested that eating disorders were obsessions with food and these obsessions were designed to conceal a greater conflict in the person's life[7].
Therefore, the eating behaviours could be seen as the solution the person had found to a greater problem in their life. There is now an undeniable evidence base within neurobiology for the practice principles that feminism has developed over many years of work with women with serious eating disorders[8].

More recently, the feminist-relational model, which promotes the importance of relationships and connection, has been applied to the field of eating disorders[9]. Importantly, this perspective combines two overlapping spheres involving the relationship and political contexts within the social world[10]. This approach includes attention to connection, social support, voice, empowerment and feminist identity. A rich body of literature informs feminist approaches to understanding and working with eating disorders.

3. Eating disorders are adaptive coping strategies.

Eating disorder behaviours are designed to keep the person safe[11]. It is important to acknowledge that this is a protective part, despite the significant health implications of this issue. Eating disorders are the solution that person has found to assist them in coping with other life problems and will not shift until the person address the underlying issues giving rise to their behaviours[12].

4. Issues of power and control are central to all forms of eating disorders.

A strong correlation exists between eating disorders and experiences of loss of power and control that a person has had in their life. For many people with an eating disorder, their eating behaviour allows them

[6] Fahs, B. & Swank, Er. (2017) 'Exploring stigma of "extreme' weight gain: The terror of fat possible selves in women's responses to hypothetically gaining one hundred pounds', *Women's Studies International Forum,* 61, 1-8; Fikkan, J. L., & Rothblum, E. D. (2011) 'Is fat a feminist issue? Exploring the gendered nature of weight bias', *Sex Roles,* 66, 575-592; Matacin, M.L. & Simone, M. (2019) 'Advocating for Fat Activism in a Therapeutic Context', *Women and Therapy,* 442:1-2, 200-215; Smith, C.A. (2012) 'The Confounding of Fat, Control, and Physical Attractiveness for Women', *Feminist Forum,* 66, 628-631.
[7] Lawrence, M. (1984) *The Anorexic Experience,* The Women's Press: London.
[8] Chami, R. & Treasure, J. (2019) 'The Neurobiology of Trauma and Eating Disorders', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders,* Springer Publishing: New York, 59-74.
[9] Maine, M., & Bunnell, D. (2008) 'How do the principles of the feminist, relational model apply to treatment of men with eating disorders and related issues?', *Eating Disorders,* 16, 187–192; Wacker, E.C. (2018) 'Application of the Feminist-Relational Model for the Treatment of Subclinical Eating Disorders', *Journal of Feminist Family Therapy,* 30:2, 71-89; Wacker, E.C., Dolbin MacNab M.L. (2020) 'Feminist-Informed Protective Factors for Subthreshold Eating Disorders'. *Qualitative Health Research,* 30:10, 1546-1560.
[10] Wacker, E.C. (2018) 'Application of the Feminist-Relational Model for the Treatment of Subclinical Eating Disorders', *Journal of Feminist Family Therapy,* 30:2, p. 75.
[11] Finlay, H.A. (2019) 'Recognising the Territory: The interaction of trauma, attachment injury, and dissociation in treating eating disorders', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders,* Springer Publishing: New York, 35-44.
[12] Lawrence, M. (1984) *The Anorexic Experience,* The Women's Press: London.
[13] Peterson, R.D., et al. (2008) 'Empowerment and Powerlessness: A closer look at the relationship between feminism, body image and eating disturbance', *Sex Roles,* 58, 639-648; Wacker, E.C. (2018) 'Application of the Feminist-Relational Model for the Treatment of Subclinical Eating Disorders', *Journal of Feminist Family Therapy,* 30:2, 71-89.

to feel in control of some aspect of their life. No matter how much others insist, they are in control of their eating.

Research has suggested that feelings of powerlessness are related to body image and eating disorders, suggesting it is important that interventions focus on empowering clients to take control of their lives[13].

5. There is an established link between experiences of childhood trauma and the incidence of some eating disorders. Eating disorders cannot be fully understood without understanding the impacts of childhood trauma.

Substantial evidence exists to suggest a link between the experience of childhood trauma and the later development of eating disorders (Finlay, 2019; Trottier & MacDonald, 2017; Vanderlinden & Palmisano, 2019). Histories of childhood sexual abuse, childhood physical abuse and childhood emotional abuse have been studied intensively and are considered to be nonspecific risk factors for the development of eating disorders[14].

As well as the trauma that may underlie an eating disorder, many clients report that the system designed to assist them with their eating disorder is both disempowering and traumatising. EDQ recommends a recovery-oriented approach where the client is seen as the expert over their own lives and has ultimate control of the healing process.

6. Eating disorders are different for every person and causation is multifaceted.

It is crucial that we take the time to understand each individual person's experience of their eating disorder. We must see eating disorders within the broader context of a person's life and what is and has been happening for them that has led to the development of their eating disorder. While similarities may exist, there is no single presentation or treatment for eating disorders[15].

7. There is much we still do not know about eating disorders, but we learn more each time we listen to people share their stories and experiences with us.

This is a complex area of practice and there is much we still do not know. The knowledge base that informs practice at EDQ is based on respect for the individual's right to share their own experiences in their own way and at their own pace. We work alongside the client and listen to their experiences and their goals rather than working with a prescribed view of the most appropriate pathway to recovery.

8. We work from a range of evidence based theoretical perspectives that inform our work including:

- **Feminist Practice:** This involves working in ways that are transparent and genuine to reduce power differentials in the therapeutic relationship; recognising the person we are working with as a whole person with skills, strengths and solutions to their own issues; providing information so that people can make informed decisions about the support they are looking for; recognising the personal is political – that we live in a patriarchal society where structures and institutions privilege men over women and there is significant inequality at multiple levels.

- **Person Centred/Rogerian:** Similar to feminist practice, we work from a base of empathy, genuine support and acceptance of the person we are working with; the person is seen holistically and is at the centre of the therapeutic relationship; we are working together to understand what each individual person wants and needs to live their own life.

- **Cognitive Behavioural Therapy:** This helps to explore connection between our thoughts, behaviours and emotions and the role they may place in the experience of eating disorders.

- **Acceptance and Commitment Therapy:** This is to enhance cognitive flexibility; acceptance and commitment to recovery-oriented change.

- **Dialectical Behaviour Therapy:** This is to develop specific skills for managing distress, uncomfortable feelings and interpersonal communication.

- **Narrative Therapy:** This is to explore an individual's dominant story and provide space for re-authoring.

- **Embodied Practice/Mindful Movement:** This is used to nurture connection between the mind and the body.

- **Expressive and Art-Based Therapy:** This is used to explore alternative ways of expressing and communicating.

[14] Vanderlinden, J. & Palmisano, G.L. (2019) 'Trauma and Eating Disorders: The state of the art', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders*, Springer Publishing: New York, pp.15.
[15] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March.

2. INDIVIDUAL THERAPEUTIC SERVICES

Eating Disorders Queensland (EDQ) provides quality therapeutic services to individuals through several different funding streams – Queensland Health funded services, Medicare counselling services and NDIS funded packages.

Therapy is available to individuals across Queensland aged 16 years and over and can be provided either face-to-face or via telehealth. Clients do not require a medical diagnosis of an eating disorder to access the services at EDQ. Therapeutic support allows people to explore their underlying issues with skilled practitioners in a safe, therapeutic and confidential environment.

9. Safety is always a priority: the therapeutic relationship.

Workers must consistently facilitate a safe therapeutic environment. Given that many clients who have experienced an eating disorder have a history of childhood trauma, safety is of paramount importance. One of the most effective ways of establishing safety in the sessions is through developing a strong therapeutic alliance. There should be clear communication and transparency in the therapeutic relationship where the counsellor is authentic, empathic, compassionate, flexible and kind. This is one way that we ensure that we can facilitate safe exploration for the client.

In Judith Herman's stages of recovery, the first stage is safety, especially the relational safety found in the therapeutic relationship.

The first task of recovery is to establish the survivor's safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured. No other therapeutic work should even be attempted until a reasonable degree of safety has been achieved.[16]

10. Safety is always a priority: risk assessment and safety planning.

A key part of ensuring safety for the client is to undertake thorough risk assessment and safety planning with the client. This is an ongoing process that continues for the duration of the therapy in recognition that the level of risk may change throughout the course of therapy[17]. It is also important to ensure that confidentiality issues and issues of consent are covered in the initial session, and throughout therapy as needed.

11. Safety is always a priority: physical health implications.

Eating disorders have serious physical health implications, so it is essential that all clients have an open and active relationship with their general practitioner (GP)[18]. Therapists are not medically trained and do not have the authority to monitor physical symptoms. Workers should refer to the client's GP if they have concerns about the physical health of a client. This should only be undertaken in consultation with the client, unless there are mitigating factors that may reduce the safety of the client. in the initial session, and throughout therapy as needed.

12. The lived experience of the client is always valued.

This is a core principle of feminist practice – that the therapeutic relationship is based on the notion that the client is the expert over their lives regardless of their experiences and backgrounds[19].

Sessions should be tailored to fit with the knowledge and experience of the client. This means that a flexible approach is essential. If the worker approaches each session in a directive way that does not allow client agency and empowerment, the session will most likely meet the needs of the worker, but not the client.

This is a crucial issue given that over 75% of people who identify as having an eating disorder do not seek help[20]. It appears there are many reasons for this including the shame and stigma that come from having an eating disorder[21]. By valuing and affirming the client's lived experience we can encourage and support them towards recovery.

We value the lived experiences of those who have had eating disorders by incorporating these diverse voices in all levels of the organisation.

[16] Herman, J.L. (1994) *Trauma and Recovery: From domestic abuse to political terror*, Pandora, pp. 159-160.
[17] Surgenor, L. J. & Maguire, S. (2013) 'Assessment of Anorexia Nervosa: An overview of universal issues and contextual challenges'. *Journal of Eating Disorders*, 1:29.
[18] Hay, P. et al. (2014) 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders,' *Australian and New Zealand Journal of Psychiatry*, 48:11, 1-62.
[19] Brown, L.S. (2018) *Feminist Therapy*, 2nd edition, APA: Washington.
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13. Therapy is person centred and client led.

Person centred approaches put the needs of the person at the core of all decision making about treatment and support.[22]

One of the core practice principles of working with people with eating disorders is to ensure that the services provided are person and family centred[23]. Individual treatment plans are developed within a person-centred, family and culturally sensitive and recovery-oriented framework[24].

We need to see the whole person and work with the entirety of the client, not just their eating disorder. We believe that eating disorders are the solution to a greater problem in the client's life, so we need to actively work to know the client as a person and to understand the life experiences that have brought them to this point.

We meet clients where they are now, at this point in their lives. We build on their protective factors and strengths and work towards building a healthy sense of self. It is always the client who sets the direction and the goals for the sessions in a respectful collaboration with the practitioner.

A diagnosis should not be required for access to services. This is in line with the national standards developed by the NEDC 2012 to remove 'diagnostic criteria as a point of access to services.'[25]

14. Therapy is trauma informed.

A trauma informed approach to work with clients with eating disorders recognises that experiences of trauma, especially in childhood, may underlie an eating disorder. Trauma in childhood may involve a range of experiences including abuse and neglect, traumatic and insecure attachment to primary care givers, serious illness or death of family members, motor vehicle accidents, peer bullying and abuse, invasive medical procedures and many other events[26].

All workers in this sector should be informed about the nature of trauma and its responses and organisations should adhere to trauma informed practice guidelines. The Blue Knot Foundation has developed Practice Guidelines for Clinical Treatment of Complex Trauma[27]. These internationally recognised guidelines provide extensive information and resources for workers in this and related fields.

15. Therapy is trauma informed: Explore the role the eating disorder plays in the client's life.

We know that eating disorders serve a purpose for the client and it may help the recovery process for the client to be clear about why their eating disorder developed. For many clients this will relate to experiences of trauma in their childhood and the eating behaviour will have provided a coping strategy to help them deal with a greater trauma they were experiencing.

We all hope to develop healthy coping skills to assist us to cope with difficulties in life, but children have very few options for this if they are not guided by an emotionally attuned caregiver. Children will do whatever is required to survive and adapt. The benefits of working from a trauma informed approach has a strong evidence base in the research[28].

16. Therapy is trauma informed: Externalise the eating disorder part.

At times it can appear that there are 'two selves' and a split exists between the self and the eating issue. This is often experienced as a 'battle' - a critical, illogical and irrational entity that battled against and controlled their rational, true self[29].

Related to a trauma informed approach, clients with eating disorders often find it helpful to externalise the 'eating disorder part' of them. Clients learn from the 'eating disorder self' and this helps to develop and strengthen the 'healthy self' so that this part might contribute more to the recovery journey.

The use of externalising questions comes from narrative therapy[30] and is also informed by parts work which is a well-established strategy for working with trauma survivors and others who have mental health concerns. This work relates to inner child work[31], Internal Family Systems Therapy[32], Schema Therapy[33] and models of Structural Dissociation[34]. It can be helpful to differentiate between the different parts of us and to see and understand our inner critic and our inner nurturer.

This can be very useful way of working as we ensure that we're working with the eating disorder part rather than demonising this part of the client. Some therapists use a process of dialoguing to achieve this[35].

17. Therapy is recovery oriented.

Recovery from an eating disorder is possible and should be the goal of all service provision[36]. A recovery approach is aimed at restoring the human rights and full community inclusion of people with mental health issues[37]. Recovery-oriented approaches are typically seen as an alternative to the medical model approach which is frequently considered pathologising and deficit based[38]. It is crucial that the client determines what recovery looks like for them.

Central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.[39]

There are many definitions of the components of recovery from an eating disorder[40]. Bjork and Ahlstrom[41] suggest there are five important factors:

- **having self-acceptance**
- **accepting one's body**
- **having a relaxed attitude to food**
- **having a functioning social life**
- **being in contact with and having courage to express emotions.**

Costin & Grabb[42] outline 10 phases of recovery from an eating disorder that incorporate the stages of change outlined in motivational interviewing approaches[43]. This is valuable information for workers in this sector to understand the process of change for clients and how we can assist in facilitating their recovery. Included in this are helpful understandings about the nature of resistance and ambivalence in the change process. Resistance and ambivalence to change are features of work with clients with eating disorders, especially anorexia nervosa. It is unfortunate that these characteristics have also been interpreted as constituting difficult-to-treat clients[44]. An alternate view is both possible and more therapeutically valuable as we consider the stages of change and the difficulties for many clients in moving from pre-contemplative and contemplative stages of change to achieving sustainable change.

It is critically important to recognise that eating disorders do not develop for no reason and that they serve important adaptive functions, often related to experiences of trauma in a person's life. This includes the mitigation of profound distress[45].

18. The process of therapy is valued.

The process of therapeutic work must be valued as much as the outcome. This is a key principle of feminism. The way we go about doing our work is as important, if not more important, than the outcome that is achieved. It is suggested that an outcome achieved through a harmful or disrespectful process, must be questioned.

This is an integrity issue and, in direct practice with clients, it is important that actions are consistent with values. Therefore, all the strategies employed must be consistent with the overall aims and values of the organisation.

19. Explore the use of creative and expressive therapies in sessions.

Expressive and creative therapies provide a very positive contribution to the strategies available to therapists for work with clients with eating disorders. *For people who develop eating disorders, the ability to access and put feelings into words is blunted and poorly developed*[46].

Creative arts therapies, which include art therapy, music therapy, drama therapy and dance / movement therapy, each share an appreciation of the non-verbal aspects of communication and understand the use of imagery,

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[32] Catanzaro, J. et al. (2019) 'IFS (Internal Family Systems) and Eating Disorders', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders*, Springer Publishing: New York, 209 – 220; Schwartz, R. C., & Sweezy, M. (2020) Internal family systems therapy, 2nd edition, The Guilford Press.
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[35] Costin, C. & Grabb, G.S. (2012) *8 Keys to Recovery form an Eating Disorder: Effective strategies from therapeutic practice and personal experience,* W.W. Norton & Co.
[36] Bardone-Cone, A. M. et al. (2010) 'Defining Recovery from an Eating Disorder: Conceptualization, Validation, and Examination of Psychosocial Functioning and Psychiatric Comorbidity', *Behaviour Research and Therapy,* 48:3, 194–202.
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[39] Australian Health Ministers' Advisory Council (AHMAC) (2013) *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers, pp. 11.*
[40] Bardone-Cone, A. M. et al. (2010) 'Defining Recovery from an Eating Disorder: Conceptualization, Validation, and Examination of Psychosocial Functioning and Psychiatric Comorbidity', *Behaviour Research and Therapy,* 48:3, 194–202; Bjork, T., & Ahlstrom, G. (2008) 'The Patient's Perception of Having Recovered from an Eating Disorder', *Health Care Women International,* 29:8, 926-944.
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[43] Miller, W.R. & Rollnick, S. (2013) *Motivational Interviewing: Helping people to change,* 3rd edition, Guilford Press.

symbolism, and metaphor as a link to psychological / emotional states. They acknowledge the need to work safely in the presence of a secure therapeutic relationship, guided with interventions that are based on the therapeutic aims of the specific individual as well as the client population[47].

Many different approaches that can be used to great benefit, but art therapy has a particularly strong history in work with clients with eating disorders. In verbal therapy sessions, clients often experience difficulty in finding the words to express confusion and pain. Art therapy, by contrast, is an effective means for clients to tell their personal story, safely and indirectly[48].

20. Power and control are central issues for anyone experiencing an eating disorder and must be addressed in therapy.

One of the features of the therapeutic relationship in this form of therapy is that the power imbalances are broken down by having a non-clinical approach. We meet the client as another human being rather than as an eating disorder. Feminist approaches to therapy are collaborations, partnerships between the client and the therapist, rather than relationships based just on client need and therapist expertise.

21. It is the worker's responsibility to ensure appropriate boundaries are in place in all client work.

Ensuring appropriate boundaries in the therapeutic relationship is the responsibility of the worker. All workers in this sector should hold professional qualifications and be registered with their professional association. Workers should adhere to the boundaries prescribed by their profession and their codes of ethical practice[49].

This also highlights the importance of workers engaging in regular professional clinical supervision with an external professional who is experienced in eating disorders work[50]. Each organisation has a responsibility to provide workers with high levels of supervision and support in recognition of the complexity of this work.

22. Language is important.

Pathologising language is inherent in the medical model's approach to eating disorders. The impact of this on clients can be significant. From a feminist perspective eating disorders are not seen as 'disorders' but rather as 'issues' that result from meanings made of experiences, many of which are the product of our social system.

We are always attempting to challenge the shame and stigma attached to eating disorders, so we must use language that is accessible to clients and that encourages a more compassionate perspective. At times it is important to adapt our language to the client's preference, but if the client is using disrespectful and negative language to describe themselves and their eating disorder, it is important to discuss this and provide a safe challenge to their use of language.

23. Fast-track services for early onset intervention.

Ensuring early onset for intervention, especially with young people, indicates a shorter duration for all eating disorders[51]. With early detection and intervention prospects of recovery from eating disorders are high[52]. This requires services to fast-track young people who are at the early stages of their eating disorder.

This is the case for a range of mental health issues where it is clear that if treatment commences at the earliest possible time, interventions are more effective and recovery time is shorter[53].

24. Psychoeducation is a valuable addition to therapeutic interventions.

Clients need to have an accurate understanding of the nature of eating disorders and the underlying causes that may be relevant to them. This may mean providing information to clients in sessions and / or encouraging them to access a range of psychoeducational groups that provide information about eating disorders and recovery.

25. Appropriate use of self-disclosure is a useful strategy when it is purposeful.

Self-disclosure from workers can be a useful strategy in counselling if the worker is clear about the purpose and intention of their sharing. Self-disclosure reduces the inherent power imbalances between counsellor and client and normalises many of the client's experiences in a safe relational way.

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[50] Hurst, K. et al. (2020) 'Practice and Training Standards for Mental Health Professionals Providing Eating Disorder Treatment', *Journal of Eating Disorders*, 8:1, 1–58.

26. Advocate for multidisciplinary treatment.

The value of a multidisciplinary treatment team is clear[54]. Ideally the client will have a range of supports accessible to them including medical, nutritional, exercise physiology, and counselling. At a minimum, clients who are seeking counselling for their eating disorder should always have a general practitioner overseeing and actively monitoring their physical health condition.
As workers, we must ensure we have consent from our clients before engaging with the treatment team.

27. Plan for transitions.

The average time for people to recover from their eating disorder once they have sought professional help is between one and six years[55]. Most therapists are unable to provide an unlimited number of appointments for clients, especially if the client requires low- or no-cost sessions. It is therefore important to be transparent about the time limited nature of these sessions and to explore options for future support if needed.

If the organisation can offer a range of services, the client may move between these different programs to continue their recovery. Clients should be made aware of the range of services and programs available to them. This is an important aspect of the transition for clients as organisations ensure that programs are provided to suit the client's recovery journey and stage of change.

28. Acknowledge weight stigma and societal impacts to eating disorders.

A key part of a bio-psycho-social approach to eating disorders is to acknowledge the impacts that our social system has on our clients' eating disorder. How the clients' experiences sit within a broader picture of society is a useful addition to the therapeutic process.

In particular, the negative impacts of weight stigma / fat phobia on both physical and mental health have been well documented[56]. Experiences of weight stigma have very strong correlations to restriction, purging, and binge eating[57]. There is also evidence that disordered eating behaviours including severe dietary restriction are often misdiagnosed, unrecognised, or otherwise overlooked when the client has a higher body weight[58].

[51] van Son, G. E. et al. (2010) 'Course and outcome of eating disorders in a primary care-based cohort', *International Journal of Eating Disorders*, 43, 130-138.
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3. THERAPEUTIC GROUP WORK

The therapeutic group program is a core component of Eating Disorders Queensland's (EDQ) approach to service delivery.

EDQ runs two therapeutic groups – the 10-week therapeutic group and the Community Table. These groups are open to people of all genders from the age of 16 years.

10-Week Therapeutic Group:

The 10-week therapeutic group aims to create a safe and supportive environment. This allows people to explore underlying reasons why they might be struggling with eating disorders. The groups cover a range of topics including feelings and needs, relationships and communication, body image and gender roles, cultural and family expectations. The group explores these different topics through discussions and expressively-based therapeutic activities. These serve to increase insight and build support networks, skills and resources in the recovery journey. At EDQ the 10-week therapeutic group is run either in person or online via telehealth.

Community Table:

Community Table is a community-based meal support group for those who are recovering from an eating disorder. The group provides a safe, supportive environment where participants can work through the challenges associated with eating. The group is facilitated by qualified eating disorder practitioners and is a closed group of 6-8 individuals who meet once a week for 5 weeks. The group runs for 3 hours over the lunch period. The Community Table is designed for those with a variety of eating disorders. As a part of each session, the group shares a meal provided by EDQ. The group uses a semi-structured approach allowing time for pre- and post-meal activities as well as flexibility to explore a variety of different topics and skills that may be beneficial to recovery.

29. Ensure safety for participants at all times.

Safety is a primary principle of therapeutic group work. This includes safety for participants during the group sessions as well as skills and strategies to manage distress at other times when group facilitators are not present. Safety planning should be undertaken with all group participants and these plans should be adapted and reviewed when required.

Participants should be encouraged to access formal and informal supports during their participation in the group program. This may include access to individual counselling and support, as well as connection with peers and supportive family members and friends. Group members need clarity about the nature of confidentiality and the group agreement about these issues. For online groups this can present some complexities, but it is critical that confidentiality is discussed and agreed to.

One of the other key aspects of safety relates to language. It is important to discuss what language participants consider safe and what feels unsafe to them. There may be topics or discussions that some participants consider inappropriate and off limits. Trusting that disrespectful language or judgements will not be used can assist all participants in feeling safe to contribute and benefit from the group.

30. Create a warm and welcoming environment.

It is a well-established principle that creating a warm and welcoming environment enables a sense of safety for group participants. The group environment should be accessible and comfortable. Many things that can be done to ensure that the environment is informal and non-clinical. For example, the use of plants, diffusers, a variety of seating options, all assist in creating a sense of comfort and ease.

31. The intake and assessment process should ensure the group is inclusive of all people and their experiences.

Therapeutic groups have a specific focus and purpose, and this should be clearly explained to participants during the intake process. The intake process should be a time when participants learn about the nature of the group and the facilitators learn about the goals and expectations of the participants[59].

In general, therapeutic groups for people with eating disorders should achieve a balance between incorporating a range of different presentations while also being mindful of the connections that are formed from sharing similar experiences. While the intake process aims to ensure inclusivity of all people and their eating disorders, this must be balanced with each person's readiness for group work and their stage of recovery.

Risk assessment is a key part of the intake and assessment process and should be undertake in consultation with the person seeking to join the group.

32. Group sessions are recovery focused and ensure high levels of client empowerment, choice and participation.

The invaluable therapeutic benefits, relative cost-effectiveness, and short-term duration of many groups arguably distinguish this healing modality as a critical and primary source of therapeutic intervention[60].

Group work is a particularly useful approach in working with people with eating disorders from a feminist perspective given the possibilities for minimising power imbalances and increasing client control and empowerment. Given the importance of these issues for people with an eating disorder, group participants are invited to participate in all aspects of the therapeutic group from setting up, choosing activities and deciding on their level of participation in the group. Decision making is ideally shared between facilitators and group members in an equitable and balanced way. It is important that participants have a shared sense of ownership of the group.

The therapeutic group is recovery focused and clients are invited to think about what recovery means for them. Group participants are encouraged to share their stories in whatever way they feel is most suited to them.

Again, the level of their participation is their choice and group members are empowered to make their own decisions about their contribution. Group facilitators should intentionally engage participants to highlight their shared experiences and learnings so that a greater understanding of their eating disorders is developed in the group.

The group should provide space for connection between participants and to allow the group dynamics to develop over time. At times the facilitators will intervene to ensure there is safety in the group, and at other times they will allow the group to self-regulate.

33. Groups build a sense of community and storytelling.

The sense of community created in the groups and the story sharing by participants support people to counter the sense of shame, guilt and isolation that can come with an eating disorder. Connection, relationships and support are key features of recovery from eating disorders given the many ways in which eating disorders inherently disconnect people from their existing support systems[61].

Given the length of time participants are together, the development of group cohesion and understanding assists in establishing a sense of community within an organisation. This is important as clients will ideally move between the different services which are offered at different times in their recovery journey.

Group work enables women (sic) to come together to support one another and create a counterculture where diversity is accepted and celebrated and competition is challenged[62].

[59] Hartman McGilley, B. (2009) 'Sacred Circles: Feminist-Oriented Group Therapy for Adolescents with Eating Disorders', in Main et al eds., *Effective Clinical Practice in the Treatment of Eating Disorders: The heart of the matter,* Routledge: New York, 111-126.
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[62] Black, C. (2000) *Setting the Table Straight: A resource manual for working with women with eating issues,* Isis: Centre for Women's Action on Eating Issues Inc.

34. Group content and process should reflect key themes for clients and include the use of a range of different mediums for expression.

The structure for the 10-week therapeutic group should include a focus on group process and building relationships within the group. This is a central aim of the group given the importance of connection and community. It is also an important way of ensuring safety in the group. Facilitators must ensure that participants feel safe to openly express their feelings in the group as they share emotional aspects of their story. There must be a recognition of the courage it takes to become vulnerable in front of others when we share our story[63].

In addition to this, the group should explore issues that are relevant to participant's experiences such as:

- **Awareness of our bodies.**
- **Our relationship with ourselves and how we feel about ourselves.**
- **Awareness of the relationship between our feelings and our bodies.**
- **Getting to know our inner nurturer.**
- **Grounding and mindfulness.**
- **Understanding emotions and personal issues and how these might contribute to food, body and weight issues.**
- **Recognising our internal critical voice and the role it plays in the eating disorder.**
- **How gender roles, cultural and family expectations might influence the development of an eating disorder.**
- **Why diets don't work.**
- **Understanding that recovery is a process.**

Similarly, to individual therapeutic work, research has found that the use of creative and expressive therapies in group therapy for people with eating disorders is a highly effective means of expression and connection[64].

A wide variety of different mediums that can be easily employed in group work to assist participants to safely express themselves and share their stories. Mediums such as art[65], movement[66], and music[67], provide accessible ways of connecting to and expressing emotions.

35. Facilitators must be aware of group dynamics and the importance of clear boundaries

Therapeutic groups should always be co-facilitated. The facilitators' role is primarily to ensure a safe space for participants and to ensure that the group meets its overall purpose. A certain degree of flexibility and spontaneity is required so that the process can evolve organically in addition to meeting the plan for the session. Facilitators need to ensure consistency and predictability and combine this with an informal and warm approach.

It is important that facilitators are clear about their role and appropriate boundaries. In the spirit of minimising power imbalances, facilitators will participate in group activities and at times, share parts of their story and their own lived experience when it is considered both relevant and helpful to the discussion. Feminist-oriented groups view power and leadership as being shared among members and facilitators who are all considered to be experts of their own experience[68].

Facilitators should brief and debrief together before and after each session. These interactions will inform the process and structure of the following sessions as well as ensuring that client safety is maintained including a level of engagement in the group.

Given the complex nature of eating disorders, whether the eating behaviour improves is not the best measure of how useful the group has been. For many people, becoming aware of how they feel can result in the eating behaviour worsening as the underlying issues resulting in these eating behaviours are explored.

[63] Hartman McGilley, B. (2009) 'Sacred Circles: Feminist-Oriented Group Therapy for Adolescents with Eating Disorders', in Main et al eds., *Effective Clinical Practice in the Treatment of Eating Disorders: The heart of the matter,* Routledge: New York, 111-126.
[64] Good, D.A. & Davis-Hubler, C. (2019) 'Art Therapy: Images of Recovery', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders,* Springer Publishing: New York, 299 310; Hunter, M. (2016) 'Art Therapy and Eating Disorders, in Gussak & Rosal eds., *The Wiley Handbook of Art Therapy,* Wiley Blackwell: West Sussex, 387-396; Pasiali, V. et al. (2020) 'Music Therapy Programming for Persons with Eating Disorders, *Voices,* 20:3, 1-15.
[65] Good, D.A. & Davis-Hubler, C. (2019) 'Art Therapy: Images of Recovery', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders,* Springer Publishing: New York, 299-310.
[66] Kleinman, S. (2019) 'Discovering the Power of Movement: Dance/Movement Therapy in Treatment of Eating Disorders and Trauma', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders,* Springer Publishing: New York, 115-121.
[67] Mondanaro, J. & Loewy, J. (2016) 'Music Therapy with Adolescents in Medical Settings', in Edwards ed., *The Oxford Handbook of Music Therapy,* Oxford University Press: Oxford. 89-111; Pasiali, V. et al. (2020) 'Music Therapy Programming for Persons with Eating Disorders, Voices, 20:3, 1-15.
[68] Hartman McGilley, B. (2009) 'Sacred Circles: Feminist-Oriented Group Therapy for Adolescents with Eating Disorders', in Main et al eds., *Effective Clinical Practice in the Treatment of Eating Disorders: The heart of the matter,* Routledge: New York, 111-126.

4. PSYCHO-EDUCATIONAL GROUPS

Psycho-educational groups are an important component of the range of Eating Disorders Queensland (EDQ) services and are designed to provide a greater level of choice and flexibility in services being offered to clients throughout their recovery journey.

EDQ runs several psycho-educational groups for people experiencing eating disorders

Recovery Warriors Psycho-Education Group:

Recovery Warriors is a monthly group that includes activities and strategies for coping and staying connected. This group is facilitated by two practitioners and run online and in person. Careful consideration is made in facilitating this group as it can often be the first time a client engages with EDQ services and gets insight into the counselling interventions used and the community that exists at EDQ.

The group aims to support clients until they can move into more intensive therapy and support services. Participants are introduced to various therapeutic and support interventions as well as providing ongoing recovery skills and reminders to help their recovery pathway. This group is run in conjunction with the Recovery + Discovery Centre Mental Health Hub.

Trauma Informed Yoga Group:

Recovery from an eating disorder often involves a process of reconnection to the body. A yoga practice can be a way for people to make peace with the body, reclaim the body, and learn that the body can be reliable and safe again. Each group is run in person and six sessions are provided to participants. The sessions encourage connection with the body through practices of movement, breathing, meditation and relaxation.

Compassion and kindness for self are underlying principles for the practice and choice is provided for people to go at their own pace and comfort level. The yoga classes are taught from a trauma informed and mental health perspective and involve safety planning, which includes medical clearance by their treatment medical practitioner.

Wise Choices:

Wise Choices is an Acceptance and Commitment Therapy based group program that runs for 11 weeks. It is facilitated by two practitioners and runs either online or in person. The group supports people who experience eating disorders or body image concerns to learn strategies to flexibly manage difficult thoughts and feelings. Within a group setting, the program aims to support participants to develop skills to lead a life of healthy and meaningful relationships with self and others.

Events:

Events are hosted at various times throughout the year, and they typically involve informal activities that aim to connect the community, reduce isolation and increase awareness of eating disorders. These events are open to all people in the community, not just clients who received EDQ services.

36. Safety is always ensured.

Psycho-educational groups are an important way of ensuring the clients receive information about eating disorders and the various pathways to recovery. Research suggests that psycho-educational groups may increase the likelihood of people seeking support for their eating disorder as well as facilitating a reduction in symptoms[69].

Each psycho-educational group is designed to create a safe, intentional environment. Risk assessments must be carried out at the point of intake where all group participants are assessed for group readiness. This is a more complex issue for open rather than closed groups and facilitators may have to rely on their facilitation skills to deal with any unexpected issues and ensure the safety of the group. Similarly, confidentiality is an important aspect of ensuring safety in the group.

[69] Fursland, A. et al. (2018) 'A Single Session Assessment and Psychoeducational Intervention for Eating Disorders: Impact on treatment waitlists and eating disorder symptoms', *International Journal of Eating Disorders,* 51, 1373-1377.

Each group should have clear group agreements about confidentially and for open groups, these agreements must be reinforced at the beginning of each session.

The worker needs to be clear about the purpose and expectations of the group to ensure that all participants are aware that these are psycho-educational and not therapeutic groups. Group participants should be encouraged to reach out for support when required.

37. Each group is designed to build skills and capacity.

Psycho-educational groups should focus on supportive skill development rather than therapeutic work. This can be a difficult balance to achieve for the facilitators and highlights the importance of clearly stating the purpose of each group so that story telling is limited. These groups are generally more structured and intentional and frequently use existing evidence-based group programs.

There are a range of high-quality psycho-educational programs related to eating disorders that can assist workers in developing these group programs. For example:

- **Wise Choices** is a group work program based on Acceptance and Commitment Therapy. The Wise Choices group treatment program focuses on a series of psycho-educational sessions around mindfulness and acceptance, avoidance and struggle, values and choices.
- **8 Keys to Recovery from an Eating Disorder Workbook** is a companion book to the main text and includes a range of worksheets and exercises.
- **RAVES** is a framework that supports the development of positive food relationships and the progression toward intuitive eating practices. RAVES stands for Regularity Adequacy Variety Eating socially and Spontaneity.
- **Centre for Clinical Interventions** is a clinical psychology service in Western Australia. They provide a range of free psycho-educational resources including worksheets and information packages.

Group content should include the following topics:

- **Values**
- **Awareness of Thoughts**
- **Awareness of Emotions**
- **Mindfulness**
- **Acting on Values**
- **Avoidance, Obstacles and Choice**
- **Healthy Relationships**
- **Dominant Social Views of Weight and Body Images**
- **Managing Stress**

38. Empowerment, choice and participation are important in all groups.

Attention should be paid to the power imbalances inherent in group work and the ways workers can reduce these by participating in activities and ensuring the material is presented in an open way. Participants should be encouraged to always choose their level of engagement.

Connection through participating is a key purpose of these groups. This is more difficult to facilitate in an open group where rapport building can take more time if participation in the group is not consistent.

39. Groups are facilitated by experienced practitioners.

Each psycho-educational group must be co-facilitated. This ensures the safety of each member of the group and helps to ensure the group remains focused on its purpose. The facilitators must model the practical skills that are the focus of each group to ensure consistency between the content and the process of each group.

Groups should have a flexible format to ensure equitable access to those who are unable to attend in person. Groups can be run in person or online depending on interest and regional focus.

5. SUPPORT FOR CARERS AND KEY SUPPORTS

The family and carer team has a range of services and support options for family members, carers and key support people who are supporting a loved one with an eating disorder. The intention of these services is to provide information, support, skills, empowerment and connection for all carers and support people.

Individual coaching:

Coaching is provided for carers and key support people via the phone, face-to-face or online. Coaching assists in developing an understanding of eating disorders and ways in which the carer / key support can support the person with an eating disorder. Coaching sessions are solution focused and each session aims to collaboratively identify the key issues or challenges a carer is experiencing in supporting their loved one and to provide the carer with practical skills and strategies. Some carers engage in one or two coaching sessions, while others may attend more regularly.

Family coaching:

Family coaching sessions provide an opportunity for a carer and their loved one to collaboratively discuss practical strategies and action plans to enhance the individual's recovery. Family coaching sessions are also solution focused. The aim of each session is to collaboratively identify the key issues or challenges the individual and their carer / key support are experiencing in the context of their recovery process and to provide the carer and individual with practical outcomes and strategies. This service is available to carers / key supports and clients who are both receiving support from EDQ.

Carer peer mentor program:

This program connects and individually matches carers / key supports who are currently supporting a loved one in their recovery from an eating disorder with a carer mentor who has previously been through this journey and who would now like to provide connection, support and hope for other carers / key supports. The program follows a strengths-based model and recognises the value of a carer's lived experience specific to eating disorders, and the skills and knowledge developed as a result of their own caring role.

Carer / key supports Help Kit:

The Carer Help Kit aims to provide family members, carers and key support people with information and resources about eating disorders, treatment options and ways to assist those with eating disorders. It includes information about resources that might also be helpful for GPs and other health professionals with clients accessing support for eating disorders.

Fostering recovery workshop:

This is an evidence based one day workshop that assists family members, carers and key support people to increase their understanding of eating disorders and provides practical skills and strategies. It is based on the work of Janet Treasure and includes:

- **Understanding the Eating Disorder Mindset**
- **Stages of Change**
- **Carer Responses**
- **Meal Support Strategies**
- **Communication Approaches**
- **Problem Solving Strategies**

This program is also run online over three sessions providing state-wide access to the workshop.

Carer / key supports connect group:

The Carer Connect Group is a monthly psychoeducational group that provides a supportive and collaborative environment for family members, carers and support people to come together and connect with each other. The group runs monthly and focuses on different themes / topics each month with information and education provided, including guest speakers. To ensure equitable service provision to rural and remote areas of Queensland, this group rotates bimonthly between in-person and online sessions.

Re-connect events:

These groups run throughout the year and are an opportunity for carers who are currently engaged with EDQ to connect, as well as an opportunity for carers who may be new to EDQ to join a carer group. The intention of these evenings is to create a relaxed and supportive environment for carers / key support people with a focus on carer wellbeing and acknowledging carers' strengths.

Shared Table:

The Shared Table is a self-paced, online training program to assist carers / key supports in gaining knowledge and skills to improve confidence around meal support. This is a partnership between EDQ, Queensland Eating Disorder Service, and Child and Youth Mental Health Service Eating Disorder Program. It is funded by Metro North Hospital and Health Service LINK Innovation Fund.

40. Ensure safety and facilitate access to support for carers / key supports.

It is crucial to assess safety levels at all stages of involvement with carers / key supports. This includes assessing carer mental health and wellbeing at intake, following up with surveys and tools to assess carer stress and mental health on a quarterly basis, as well as regular reviews of carer / key support wellbeing. It is also necessary to discuss the pros and cons of engaging in services and to provide guidelines for establishing safety and group norms for carer / key support groups.

Ongoing discussions designed to normalise self-care and awareness of the impacts of carer / key supports, burnout, fatigue and stress are also essential to providing quality support for carers / key support people. At times it will be important to encourage carers / key supports to connect with additional supports and options for this should be provided if necessary.

Importantly, those who care for and support people with eating disorders need support themselves[70]. There are multiple impacts on the carer / key support people who support a family member or close contact who has an eating disorder[71]. This can be extremely stressful and the National Eating Disorders Collaboration (NEDC)[72] note the high levels of anxiety and depression that have been found amongst carers / key supports.

41. Embed respect for lived experience in carer / key supports services.

Families and carers, where available, are recognised as integral members of the treatment team and receive support, skills and strategies, education and information to enable them to support the person with an eating disorder and to maintain personal good health[73].

The wisdom and insight that carers / key supports bring must be held with deep respect for their experiences. It is vital that carers' strengths be both identified and valued, and it is from this point that these skills can be built upon[74]. It is from the lived experiences of these people that many carer / key support services have been developed. Feedback from carers / key support people should also be used to inform the need for future services and their development and implementation.

42. Empower carers / key supports through education and skill development.

Carers and key support people need for information about all aspects of eating disorders including possible treatments, support processes, meal support, and the recovery process as well as how they can access their own support and counselling[75].

Services provided to carers / key supports must be tailored to their unique experiences and this includes matching their loved ones' stage of change and treatment modality. These services should be delivered in structured, solution-focused ways that are also responsive to carer / key supports needs. The support offered must be practical and skills based including understanding eating disorders, developing insights into emotional and behavioural responses, and how to put skills and strategies into practice.

Carer groups and workshops provide structured psychoeducation combined with practical solutions as well as creating a sense of connection and community amongst carers / key supports. This is a crucial issue in improving the experience of those caring and supporting a person with an eating disorder. …many of the carers wanted to connect with other carers. *For those that had, many gained benefits from doing so, including feeling validated, 'not alone', and able to share advice*[76].

[70] Butterfly Foundation. (2019) *Raising the Alarm: Carers need care too. Maydays for Eating Disorders*, Sydney: Butterfly Foundation; Treasure, J. (2017) *Skills-based Caring for a Loved One with an Eating Disorder*, Routledge: London.
[71] Butterfly Foundation. (2019) *Raising the Alarm: Carers need care too. Maydays for Eating Disorders*, Sydney: Butterfly Foundation.
[72] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March.
[73] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March, pp. 65.
[74] Butterfly Foundation. (2019) *Raising the Alarm: Carers need care too. Maydays for Eating Disorders*, Sydney: Butterfly Foundation.

We know that providing specific skills for carers and key support people increases their confidence and ensures they can provide support as well as attend to their own needs[77]. It is therefore critical that workers seek to reduce any perceived barriers to engagement in services and empower carers / key supports to work collaboratively to establish the best options available for them and their loved ones.

43. Engaging the community.

An important component of support for carers and key support people includes engagement with the community to increase the visibility and awareness of eating disorders, and the programs offered in relevant services. In a recent survey from the Butterfly Foundation[78] it was reported that one of the biggest barriers for carers / key supports seeking help was a lack of awareness about existing services.

Many carers / key supports are passionate about early intervention and prevention and seek out opportunities to participate in programs such as the education of school students on healthy body image and eating behaviours. Carers / key supports involved in sharing their experiences must be provided with training and support including education around safe and de-stigmatising language.

[75] Honey, A., (2007) 'Support for Parents of Children with Anorexia: What Parents Want', *Eating Disorders*, 16:1, 40-51. 2008; Zucker, N.L. et al. (2006) 'A Group Parent-Training Program: A novel approach for eating disorder management', *Eating and Weight Disorders*, 11:2, 78-82.
[76] Butterfly Foundation. (2019) *Raising the Alarm: Carers need care too. Maydays for Eating Disorders*, Sydney: Butterfly Foundation, pp. 15.
[77] Hibbs, R. et al. (2015) 'Interventions for Caregivers of Someone with an Eating Disorder. *International Journal of Eating Disorders*, 48, 349-361.
[78] Butterfly Foundation. (2019) *Raising the Alarm: Carers need care too. Maydays for Eating Disorders*, Sydney: Butterfly Foundation.

6. LIVED EXPERIENCE

Many of those working in the sector have a lived experience of an eating disorder and Eating Disorders Queensland (EDQ) values the insights and learnings that these workers bring from their own experience to their work with clients.

EDQ also employs peer support workers. These workers complement other therapies and offer a safe, compassionate space to connect with a peer who understands the struggle involved in overcoming an eating disorder. In addition to this, there are three peer-specific programs run at EDQ.

Peer Mentoring Program:

The peer mentoring program supports people who are recovering from eating disorders by partnering mentees with mentors who have recovered from an eating disorder. Mentors must have been in stable recovery from their eating disorder for a minimum of two years and are provided with regular supervision to ensure their recovery is supported and maintained. Mentors are required to undertake thorough training through the EDQ program and must make a commitment to regular mentoring contact for a six-month period.

The design and structure of the peer mentoring program is based on best practice national and international standards from other mentoring programs including the Walking Together, Learning Together Indigenous Mentoring Program, Queensland Government Community Services Skilling Plan, 2009.

Peer Support Group:

The peer support group aims to provide an opportunity for those in recovery to connect with other peers who have shared similar experiences. Groups are facilitated by EDQ practitioners who also have lived experience and who will work alongside group participants to find solutions to common problems and help to navigate the pathway to recovery.

Speaker Program:

The EDQ speaker program began in 2016 and sits alongside the peer mentoring program. The speaker program recognises the power in hearing someone who is in recovery speak about their own recovery journey. Speaking events take place in a range of settings including within groups at EDQ and hospital services. EDQ provides speaker and storytelling training for all people who participate in the speaker program. Speakers are required to undertake mentor training and be in stable recovery for two years. We recognise that the telling of recovery stories can be triggering and our training provides safe guidelines for speakers and the audience[79].

44. Workers bring a diversity of experiences to their role as practitioners.

Many workers are motivated to work in areas such as eating disorders because of a personal experience, either their own or the experience of someone close to them. These experiences can be a positive contribution to their role as eating disorder practitioners. The NEDC[80] acknowledged that people with personal experiences of eating disorders should be involved at all levels of service development.

All workers must clearly articulate well-defined boundaries in client work, regardless of whether they have a lived experience of an eating disorder. Appropriately and purposefully sharing our lived experiences can assist client work in a range of ways, including by reducing power imbalances and by instilling a sense of hopefulness that recovery is possible.

An emphasis on ongoing professional supervision and training is imperative for all workers to ensure that our practice remains focused on the client and their journey to recovery.

[79] Training is based on the Mindframe guidelines. See https://mindframemedia.imgix.net/assets/src/uploads/NEDC-Mindframe-Reporting-Guidelines.pdfhttps://mindframemedia.imgix.net/assets/src/uploads/NEDC-Mindframe-Reporting-Guidelines.pdf

[80] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March.

45. Non-therapeutic support is a key component of the overall approach to service delivery.

There is a strong evidence base for the value of peer support programs in a range of clinical applications. As with eating disorder practitioners, peer workers provide a sense of hope that recovery is possible through the sharing of their experiences. Many clients identify peer support as vital in providing support and understanding as well as providing hope for the future[81].

Speaking to someone who has recovered [from an eating disorder] was identified as very helpful in motivating people to start or continue to engage with treatment[82].

Many clients say that peer workers may initially be more approachable because of the reduced power imbalances; this can facilitate a greater sense of involvement in the different aspects of the service. Peer support workers also become role models for clients especially in relation to meal sharing opportunities. There are many benefits for peer workers involved in client work. Many peer workers feel recognised and valued in a way they have not previously experienced. To be able to share their experiences with others in a beneficial way is an empowering and fulfilling experience.

46. Establish a community of peers.

Eating disorders are isolating issues. Being able to connect with others who have these lived experiences can provide a level of connection that clients may not experience in other parts of their lives. These connections are valuable in the recovery process. We know that the stigma of an eating disorder can be lessened through connection with others who have similar experiences.

A community of peers can create opportunities for clients to participate through sharing stories. It can create the feeling of having a voice and help the clients to move away from a reliance on professional practitioners. In addition to the sharing of life experiences and information, the community of peers is also about letting go and having some fun together as well as connecting on other issues unrelated to eating disorders.

Research suggests that peer mentees experience a significant decrease in stigma from their participation in a peer program as well as an increase in hope for the future and motivation for recovery[83].

Ensuring there is no judgement about diverse presentations or about relapse, is an important component of peer work. When we can acknowledge our humanness and meet others where they are at in whatever stage of recovery, we have created a healing space.

47. Peer work provides avenues for professional growth and development.

When lived experience is a key component of the provision of services, there can be progressive levels of opportunity for peer involvement. For example, clients can move into support roles through the peer mentoring program, from being a mentee to a mentor, and to facilitating the peer support group as well as taking up opportunities for participation in the speakers' program.

Research suggests that peer mentoring is a positive experience for peer mentors as well as peer mentees in a range of different ways. Peer mentor programs provide peer mentors with opportunities for reflection on their own recovery as well as increasing confidence and connection[84].

An important component of peer work is the provision of ongoing support as well as high levels of training and professional development opportunities. These opportunities can then create pathways to employment in these areas if desired.

The NEDC[85] acknowledges that one of the key barriers to peer participation in eating disorder services is a lack of training to allow them to participate effectively and safely. EDQ emphasises the importance of providing adequate training and support for peer workers.

[81] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March; Loth, K.A. et al. (2009) 'Informing Family Approaches to Eating Disorder Prevention: Perspectives of those who have been there', *International Journal of Eating Disorders*, 42:2, 146-152.

[82] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March, pp. 39.

[83] Wade, S. et al. (2014) 'Peer Support for Eating Disorders: A pilot open trial of peer support for children and adolescents with eating disorders', *Journal of Eating Disorders*, 2:2, 064-064.

[84] Beveridge, J et al. (2019) 'Peer Mentoring for Eating Disorders: Results from the evaluation of a pilot program', *Journal of Eating Disorders*, 7:13, 1-10.

[85] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March.

7. HEALTH IMPLICATIONS

Eating Disorders Queensland (EDQ) recognises the impact that eating disorders can have on the physical, emotional, cognitive and spiritual health of an individual.

We are aware of the serious consequences of a range of eating behaviours. It is therefore a requirement that all clients who access EDQ be involved with a medical practitioner of their choice.

Medical stability is important for a range of reasons including:

- To sustain life.
- To increase an individual's capacity to be present and engage in treatment.
- To engage cognitively and therefore reduce rigid and obsession thinking.
- To regulate mood and emotion.

48. Undertake regular and ongoing assessments for client risks and respond according to organisational policies and the guidelines and ethics of the relevant professional bodies.

All eating disorders have the potential for serious health and nutritional complications[86]. Of all the mental health issues, eating disorders have the highest incidence of physical health related issues[87].

Assessment and risk management occurs throughout the entire journey of recovery and includes attention to medical safety planning to reduce physical health risks and increase medical stability[88]. Safety plans may include verbal or written agreements and, at times, the involvement of third parties such as other health providers or family and carers.

Where significant risk of harm is identified these concerns should be discussed with the client's GP and treating team.

49. All client presentations must be responded to in a non-judgemental way.

All eating disorder presentations, including a range of eating behaviours such as restriction, purging, bingeing, excessive exercise, laxative use, as well as alcohol and other drugs (AOD) use, violence, and physical and emotional health issues, must be discussed in a non-judgemental way. The ongoing importance of the therapeutic relationship is particularly important in this regard[89]. The therapeutic relationship should encourage the client to be open about changes in their eating behaviours and medical stability. These relationships must be based on trust and respect to ensure clear communication when risks are identified.

50. Clients are encouraged to engage in a multidisciplinary team approach including support from carers and key support people where possible.

It is important to take a holistic view of recovery that actively seeks to provide linkages with other health professionals and carers / key supports as well as other related organisations and community services. This is particularly relevant given that therapeutic workers are not medically trained.

This may include appropriate referrals for a range of practitioners including GPs, psychiatrists, dieticians, exercise physiologists in both outpatient and inpatient settings where appropriate.

An integrative approach is required to ensure that medical stability and nutritional and psychological treatments progress together in order to reduce the risks of recurrence, premature mortality, chronicity and physical morbidity[90].

51. Duty of care responsibilities should be balanced with transparency and open communication.

Issues such as duty of care responsibilities and confidentiality must be explained to the client at initial intake, at which time a consent form should be signed by the client. It is important to provide education about the health implications of eating disorders and indicators of concern. Similarly, proactive communication with the client's treatment team regarding the best ways of responding to and managing identified risks should occur early in the client's involvement with the service.

Clients should be supported to make informed decisions regarding their health where possible. However, there may be times when this is not possible. At these times it is important to maximise client agency while balancing the need for medical intervention.

[86] Hay, P. et al. (2014) 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders,' *Australian and New Zealand Journal of Psychiatry,* 48:11, 1-62.
[87] Butterfly Foundation. (2018) *Improving Access to Evidence Based Eating Disorders Treatment through Primary and Allied Health Services,* Sydney: Butterfly Foundation; National Eating Disorders Collaboration (NEDC) (2020) National Practice Standards for Eating Disorders, NEDC.
[88] Butterfly Foundation. (2018) *Improving Access to Evidence Based Eating Disorders Treatment through Primary and Allied Health Services,* Sydney: Butterfly Foundation.
[89] Costin, C. (2019) 'The Centrality of Presence and the Therapeutic Relationship in Eating Disorders', in Seubert & Virdi eds., *Trauma-Informed Approaches to Eating Disorders,* Springer Publishing: New York, 45-56.
[90] Butterfly Foundation. (2018) *Improving Access to Evidence Based Eating Disorders Treatment through Primary and Allied Health Services,* Sydney: Butterfly Foundation, pp. 2.

8. ISSUES OF MARGINALISATION

At Eating Disorders Queensland (EDQ) we use a person-centred approach to tailor our services to ensure we meet the individual's needs and to reduce marginalisation.

We are committed to intentional health promotion to reach those experiencing marginalisation. We acknowledge the structural and cultural forms of marginalisation present in our society and actively work towards a more equitable social system.

The first guidelines here are general ones for approaching issues of marginalisation and valuing the intersectional nature of our life experiences. The following guidelines stem from the seven major forms of marginalisation that EDQ has identified and work with.

52. Become aware of relevant social / cultural / political beliefs in society that create marginalisation and the intersectional nature of their impacts.

Intersectionality is a concept first developed by Kimberle Crenshaw[91] to describe the ways in which privilege and disadvantage interrelate to create multiple forms of oppression through race, gender, disability, sexuality, class and other social categories[92].

The construct of intersectionality is rooted in the scholarship of Black feminists and critical race theorists who recognised that multiple social identities operate both independently and interactively to determine risk of discrimination, disadvantage, and disparity[93].

While it is true that eating disorders occur in both males and females, in children, adolescents, adults and older adults; across all socio-economic groups; and from all cultural backgrounds[94] the reality is more complex than this.

Access to services, finances, as well as a range of other forms of marginalisation, all impact to make both the eating disorder and the access to treatment more complex. Recent research suggests that there are definite advantages in adopting an intersectional approach to eating disorders and that it appears that the risk of developing an eating disorder is greater with the compounding effect of different identities co-existing[95].

Workers need to be aware of the many social and structural processes that create marginalisation as we work with clients from a person-centred approach. Workers should be encouraged to undertake training with other specialist services in a range of issues of marginalisation and to develop an awareness of the social issues that impact on client's lives. It is inevitable that all workers will carry some biases and at times will find themselves making judgements. A reflective approach to practice should be employed and these issues actively processed with supervisors. As workers, we can all learn a great deal from listening to the stories and experiences of our clients and advocating for their rights.

53. Each client is unique and is the expert of their own life and experiences.

Many clients with an eating disorder have been affected by multiple issues and infringements of their social and human rights and this understanding is crucial to the provision of quality service delivery. Workers must consider all factors that impact on a person's life and their experience of their eating disorder.

This means acknowledging that each person is the expert over their own lives and we as practitioners, cannot possibly know, or be aware of, the many life experiences that have formed who they are as a person[96].

Workers require a degree of humility in deferring 'to the client about the client'. Only the client can know what is best for them and we as workers bring a kind and compassionate curiosity to these interactions. As workers it is our role to develop a collaborative understanding of the meaning and impact of life events on the client's sense of self and to use this understanding to inform our approach to practice.

While workers acknowledge the different intersections that clients identify as central to their experience, we also carry hope that they will regain a sense of agency and freedom of choice in their lives.

[91] Crenshaw, K. W. (1989) 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics', *University of Chicago Legal Forum,* 139–67.
[92] Rice, C. et al. (2020) 'Bodies at the Intersections: Refiguring intersectionality through queer women's complex embodiments', *Signs,* 46:1, 177-200.
[93] Cole, 2009 cited in Burke, 2020:1605.
[94] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework,* Report to the Australian Government Department of Health and Ageing, March, pp. 2.
[95] Beccia, A. L. (2019) 'Risk of disordered eating at the intersection of gender and racial / ethnic identity among U.S. high school students', *Eating Behaviours,* 34, 1-7; Burke, N. L. et al. (2020) 'Where identities converge: The importance of intersectionality in eating disorder research', *International Journal of Eating Disorders,* 53:10, 1605-1609.
[96] Brown, L.S. (2018) *Feminist Therapy,* 2nd edition, APA: Washington.

54. Integrate an intersectional approach in practice.

There are several ways in which an intersectional approach to service delivery can be implemented. The diversity reflected in experiences of marginalisation should be evident at all levels of the organisation.

The following strategies are central to this aim:

- Acknowledgement of country is an integral part of the operations of the organisation; all groups, meetings, workshops and public engagements commence with a genuine and informed acknowledgement of country; recognition of country should be included in all signage and email signatures.
- Relationships with local Indigenous community and elders are valued; including a knowledge of the cultural importance and significance of this land and the original owners.
- Health promotion is specifically targeted to marginalised groups.
- Office space reflects the intersectional nature of people's lives where diversities are reflected and visible throughout the workplace; ideally clients should see aspects of their life experiences visibly reflected in the surroundings through posters and promotional materials inclusive of a range of different groups.
- Attention is paid to the use of language ensuring it is appropriate to all social groups; clients are consulted about the most appropriate language for them.
- Staff appreciate the multiple areas of marginalisation and are trained in working with clients from these groups.
- Clients are free to choose workers who identify as having life experiences that they relate to.
- Staffing in the organisation reflects different social groups (including culture, gender, sexualities, abilities, etc).
- Diversity is encouraged in all recruitment and employment.
- The various awareness weeks are acknowledged and celebrated.
- Policy directives are informed by an awareness of diversity.
- Participation in key events celebrating diversity is valued.
- Low or no cost services are prioritised to ensure access for low-income earners.
- A range of services are offered via Telehealth to allow for participation from those in rural and remote areas.
- The workplace is accessible to everyone regardless of mobility and physical capacity.

CULTURE

55. Acknowledge the diversity of cultural understandings and treatments for eating disorders and mental health issues.

Eating disorders occur in people from all ethnicities and cultural backgrounds[97]. There are differences in the incidence, nature, coping strategies and treatments in eating disorders across cultural groups and this is particularly the case in relation to the issue of weight stigma[98].

Most of the research relating to eating disorders to date has been focused on Caucasian populations, but recent research suggests that racial and ethnic groups experience eating disorders at equivalent or higher rates. However, it appears that people from different ethnic backgrounds tend to be diagnosed later and referred to services less than clients from the dominant culture[99]. There is also evidence that migrants are at a higher risk of developing eating disorders[100].

Pike & Dunne[101] note the increase in eating disorders across Asia and suggest that societal change in the form of industrialisation and urbanisation occurring independently from, or in tandem with, 'Western' influence are critical factors contributing to the rise of EDs in Asia. It appears that there has been a general and steady increase in eating disorders in non-Western countries in recent years[102].

In relationship to First Nations Australians, it appears that the incidence of eating disorders here is higher than the non-Indigenous population with approximately 28% of Indigenous high school students identifying with an eating disorder. The rate for non-Indigenous students is approximately 22%[103].

[97] Himmelstein, M.S. et al.(2017) 'Intersectionality: An understudied framework for addressing weight stigma', *American Journal of Preventive Medicine*, 53:4, 421-431; National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March; Pike, K.M. & Dunne, P.E. (2015) 'The Rise of Eating Disorders in Asia: A review', *Journal of Eating Disorders*, 3:33, 1-14; Schaumberg, K. et al. (2017) 'The Science Behind the Academy for Eating Disorders' Nine Truths About Eating Disorders', *European eating disorders review: the journal of the Eating Disorders Association*, 25:6, 432–450.
[98] Himmelstein, M.S. et al. (2017) 'Intersectionality: An understudied framework for addressing weight stigma', *American Journal of Preventive Medicine*, 53:4, 421-431; Pike, K.M. & Dunne, P.E. (2015) 'The Rise of Eating Disorders in Asia: A review', *Journal of Eating Disorders*, 3:33, 1-14.
[99] Bardone-Cone, A. M. et al. (2017) *Eating disorders in racial/ethnic minorities*, CRC Press; Cheng, Z. H. et al. (2019) 'Ethnic differences in eating disorder prevalence, risk factors, and predictive effects of risk factors among young women', *Eating behaviours*, 32, 23–30; Sim, L. (2019) 'Our eating disorders blind spot: Sex and ethnic/racial disparities in help-seeking for eating disorders', *Mayo Clinic Proceedings*, 94:8, 1398-1400.
[100] Bhugra, D., & Jones, P. (2001). 'Migration and mental illness', *Advances in psychiatric treatment*, 7:3, 216-222.
[101] Pike, K.M. & Dunne, P.E. (2015) 'The Rise of Eating Disorders in Asia: A review', *Journal of Eating Disorders*, 3:33, 1-14, pp. 1.
[102] Gordon, R.A. (2001) 'Eating disorders East and West: a culture-bound syndrome unbound', In: Nasser, et al eds., *Eating Disorders and Cultures in Transition*. Brunner-Routledge: New York, 1–16; Pike, K.M. & Dunne, P.E. (2015) 'The Rise of Eating Disorders in Asia: A review', *Journal of Eating Disorders*, 3:33, 1-14.
[103] Burt, A. et al. (2020) 'Prevalence of DSM-5 diagnostic threshold eating disorders and features amongst Aboriginal and Torres Strait islander peoples (First Australians)'. *BMC Psychiatry* 20, 449.

In addition, Indigenous young people are more likely to engage in activities to lose weight, increase weight and increase muscles than non-Indigenous peers[104].

56. Provide culturally sensitive practice.

In recognising the importance of culture and its impacts on understandings of eating disorders, direct practice must be informed by culturally sensitive practice. Practitioners should be curious and allow the client the space to explain their culture and how it has intersected with their experience of an eating disorder. It is crucial to understand the impact of culture and identity on wellbeing and recovery.

In services where meal support programs are running, these programs should include a range of culturally diverse foods.

57. Develop and maintain strong partnerships with culturally specific organisations.

Partnerships with culturally specific organisations are vital to ensuring that service delivery is culturally appropriate. At times, referrals to other practitioners who have specific cultural expertise will be required to meet the client's needs.

Reciprocal training opportunities can be negotiated where workers receive cultural competency training in exchange for the education and skill development of other workers in the sector.

GENDER

58. Service delivery is inclusive of all genders.

Most people with eating disorders are women, with over 63% of people with eating disorders in Australia identifying as female[105]. The gendered nature of eating disorders has been an issue of considerable concern to many who work in this area[106].

While some of the core socio-political aspects of causation of eating disorders have reflected women's experiences, such as loss of power and control, objectification of bodies, weight stigma and fat phobia, these issues also affect men and, as a result, we have seen a recent increase in both gay and straight men reporting eating disorders[107]. It appears that men have increased body image concerns with excessive exercise becoming a more common issue[108]. In fact, 40% of people with binge eating disorder are men[109].

While women still comprise the largest percentage of people with eating disorders it is worth noting that men with eating disorders are less likely to be diagnosed or identified as having eating problems[110]. This may be partly due to the differing presentations for men with disordered eating behaviours[111]. Nagata et al.,[112] suggest that disordered eating might be qualitatively different, rather than markedly less prevalent, in adolescent boys. They suggest that muscularity-oriented disordered eating behaviours are more common amongst men and existing assessment tools are not adequate to test for these behaviours.

Research also suggests that transgender people are more likely to develop an eating disorder than cisgender people[113]. It is clear from the relevant research that trans and non-binary clients have a high prevalence of eating disorders and this is often connected to body dysmorphia and stigma[114]. Although there is little research in this area, it appears that transgender people may develop an eating disorder as a form of gender dysphoria and as a means of aligning their body with their gender[115]. Clearly services should be targeted to all genders and any real or perceived barriers to accessing services must be addressed.

59. Language is important.

Language is an important factor in how we gender ourselves and each other. The use of pronouns is central to this. It is important to ask clients their pronouns recognising that these may change over time and may not be an actual reflection of the person's gender[116]. Using the correct pronouns creates feelings of affirmation and safety. Using incorrect pronouns diminishes a person's sense of identity, self-esteem and confidence.

[104] Butterfly Foundation. (2021) *Risks and warning sign*, Sydney: Butterfly Foundation. https://butterfly.org.au/eating-disorders/risks-andwarning-signs/
[105] Paxton S.J. et al. (2012) *Paying the price: The Economic and Social Impact of Eating Disorders in Australia*, Butterfly Foundation: Sydney.
[106] Brown, C. & Jasper, K. (1993) 'Why Weight? Why Women? Why Now?', in Brown & Jasper eds, *Consuming Passions: Feminist approaches to weight preoccupation and eating disorders*, Second Story Press: Ontario, 16-35; Lawrence, M. (1984) *The Anorexic Experience*, The Women's Press: London; Orbach, S. (1986) *Hunger Strike*, Faber & Faber: London; Maine, M. (2009) 'Beyond the Medical Model: A feminist frame for eating disorders', in Maine, et al. eds., *Effective Clinical Practice in the Treatment of Eating Disorders: The heart of the matter*, Routledge: New York. 3-18; Robertson, M. (1992) *Starving in the Silences: An exploration of anorexia nervosa*, Allen & Unwin: Sydney.
[107] Butterfly Foundation. (2020) *The reality of eating disorders in Australia*, Sydney: Butterfly Foundation.
[108] Strother, E. et al. (2012) 'Eating Disorders in Men: Underdiagnosed, undertreated and misunderstood', *Eating Disorders*, 20:, 346-355.
[109] Butterfly Foundation. (2021) *Risks and warning sign*, Sydney: Butterfly Foundation. https://butterfly.org.au/eating-disorders/risks-andwarning-signs/
[110] Strother, E. et al. (2012) 'Eating Disorders in Men: Underdiagnosed, undertreated and misunderstood', *Eating Disorders*, 20:, 346-355; Weltin, T.E. (2016) 'Treating Males with Severe and Enduring Anorexia Nervosa: Different to Females?', in Touyz et al eds., *Managing Severe and Enduring Anorexia Nervosa: A clinician's guide*, Routledge: New York.
[111] Nagata, J. M. et al. (2020) 'Eating disorders in Adolescent Boys and Young Men: An update', *Current Opinion in Pediatrics*, 32:4, 476-481.
[112] Nagata, J. M. et al. (2020) 'Eating disorders in Adolescent Boys and Young Men: An update', *Current Opinion in Pediatrics*, 32:4, 476-481, pp. 444.
[113] Watson, R.J. et al. (2017) 'Disordered Eating Behaviors Among Transgender Youth: Probability profiles from risk and protective factors', *International Journal of Eating Disorders*, 50, 515–522.
[114] Watson, R.J. et al. (2017) 'Disordered Eating Behaviors Among Transgender Youth: Probability profiles from risk and protective factors', *International Journal of Eating Disorders*, 50, 515–522.
[115] Diemer, E.W. et al. (2015) 'Gender identity, sexual orientation, and eating-related pathology in a national sample of college students, *Journal of Adolescent Health*, 57, 144–149; Watson, R.J. et al. (2017) 'Disordered Eating Behaviors Among Transgender Youth: Probability profiles from risk and protective factors', *International Journal of Eating Disorders*, 50, 515–522; Witcomb, G.L. et al. (2015) 'Body Image Dissatisfaction and Eating-related Psychopathology in Trans Individuals: A matched control study, *European Eating Disorders Review*, 23, 287–293.
[116] It is important to not make assumptions about a person's gender by their pronouns. For example, a person may use them / their pronouns but not identify as non-binary.

Workers may choose to state their own pronouns at the beginning of their work with a client[117], which then creates the opportunity for clients to state their pronouns if they choose. Workers will benefit from listening to the way that a client refers to themselves and then mirror this. At other times workers may ask directly what pronouns the client uses. This applies in both individual work and group work and at all times workers should avoid using terms such as 'hey guys' or 'ladies and gentlemen'.

60. Staff to be trained in developing their understanding of the various impacts of gender diversity.

Gender is a fluid category that may change for individuals over time. It is important to not make assumptions about gender but rather to ensure the client is supported to share their gender identity and the impacts on their experience of an eating disorder if they choose. Clients should be able to request a worker of a certain gender if they choose. If workers have not had specific training and experience in this area, they should be offered training from specialist organisations.

SEXUALITY

61. Service delivery is inclusive of all sexualities.

There are diverse sexualities and an inclusive space for people of all sexualities, identities and orientations should be provided. It is important for workers to avoid all assumptions and biases and to be curious about how a client's sexuality might impact on their eating disorder[118].

This is particularly important given that research suggests that lesbian, gay and bisexual people have greater rates of eating disorders than the general population[119].

62. Language is important.

Gender inclusive language is important in all interactions with clients including intake and assessment processes and all documentation. This issue should be approached gently, taking into account changes that may happen for the client over time and the importance of providing the client with a safe environment to discuss these issues.

63. Staff require training in developing their understanding of the various impacts of a diverse range of sexualities.

Staff will require a high level of competency in the diverse range of sexualities and their likely impact on eating disorders[120]. It is important to maintain an awareness of the relevant research and knowledge base in this area.

DIFFERING ABILITIES

64. Differing abilities should be acknowledged, and an inclusive space be provided for all clients.

Differing abilities may include a range of physical, intellectual and neurobiological abilities. These varying abilities need to be acknowledged at all stages of support to ensure the client's experience has been normalised. How these different abilities may impact on the individual's experience of their eating disorder is important in ensuring their support needs are met.

However, there is very little research on the relationship between disability, body image and eating disorders[121]. It is acknowledged that people with disabilities face disability-specific body image issues that may, in turn, link with the emergence and expression of eating disorders[122].

65. Language is important.

Again, the language that we use in our work is important for our clients. For people with differing abilities, language should always be person-first language as distinct from language that identifies the disability first. For example, each client is 'a person with a disability / different ability' as opposed to 'a disabled person'.

66. Stay curious and person centred.

All workers must have a person-centred approach to enabling appropriate support and be curious in their communication. This ensures the sessions are focused on what is helpful for the individual and in meeting their recovery goals.

[117] Workers may also include their pronouns in their email signature knowing that this signals a safe and welcoming environment for clients.
[118] For some people the impact may be positive and the eating disorder may be a protective factor in their life.
[119] Calzo, J.P. et al. (2017) 'Eating disorders and disordered weight and shape control behaviours in sexual minority populations', *Current Psychiatry Reports*, 19:8, 1-10; Watson, H.J. et al.(2016) 'Prevention of eating disorders: A systematic review of randomised, controlled trials', *International Journal of Eating Disorders*, 49:9, September, 833-82; Weltzin, T.E. (2016) 'Treating Males with Severe and Enduring Anorexia Nervosa: Different to Females?', in Touyz et al eds., *Managing Severe and Enduring Anorexia Nervosa: A clinician's guide*, Routledge: New York,231-245.
[120] Again, it is important to note that the impact of the eating disorder may be perceived as positive and may be a protective factor in the person's life.
[121] Cicmil, N., & Eli, K. (2013) 'Body image among eating disorder patients with disabilities: A review of published case studies', *Body Image*, 11, 266-274.
[122] Cicmil, N., & Eli, K. (2013) 'Body image among eating disorder patients with disabilities: A review of published case studies', *Body Image*, 11, 266-274, pp. 271.

67. Barriers to meeting client needs are minimised.

All aspects of the service must be easily accessible to all clients. This includes access to the building and the layout of various rooms. At times the use of sensory items will be useful in therapy. If the client has a support person and wishes them to be involved, this should be encouraged.

RURAL AND REMOTE

68. Address limitations to accessibility of services in rural and remote areas

Access to high quality service delivery for people with eating disorders must be improved in rural and remote areas and that technology can assist in the provision of these services[123]. There is a limited number of accessible services for clients with an eating disorder in rural and remote areas. This is a priority area for lobbying and advocacy to government.

Where possible, all client services should be offered to people in these regions via Telehealth. This includes individual counselling, coaching, peer support, therapeutic and psycho-educational groups and general information and referral.

69. Build relationships with rural and remote services to increase accessibility.

Telehealth is the primary service option for people living in rural and remote areas. These services have greatly increased accessibility for people living outside metropolitan areas. The National Eating Disorders Collaboration (NEDC) national standards for eating disorders note that:

There is evidence that video conferencing provides an effective vehicle for the provision of psychotherapy for people with eating disorders. A number of studies (e.g. Simpson, Knox, Mitchell, Ferguson, Brebner & Brebner, 2003; Mitchell, Myers, Swan-Kremeier, & Wonderlich, 2003; Mitchell, et al., 2004; Simpson, Bell, Britton, Mitchell, & Johnston, 2006;) have found video therapy (telepsychology) to be as effective as face-to-face therapy in terms of patient outcomes for people with bulimia nervosa. Video therapy has also been identified as a cost effective approach, particularly for people living in remote areas[124].

In addition to these services, accessibility can be increased by providing support and information to workers in other services in rural and remote locations.

MARGINALISED BODIES

70. Recognise the impacts of weight stigma and fat phobia.

Negative attitudes to weight gain and 'fat-negative' attitudes are now a common part of our society and of women's lives as fear of fatness and disdain toward fat bodies pervades attitudes about bodies and body size[125]. Research suggests that women experience fat stigma far more than men given that women are expected to be physically attractive and desirable[126].

The impacts of weight bias are widespread in the lives of women[127] including issues such as discrimination in employment, reduction in income, being less likely to have a partner, and the more insidious and dangerous issues where individuals are disliked and ridiculed[128]. Unfortunately, the common suggestions for addressing weight stigma relate more to self-discipline and control rather than the broader social, cultural, and political context of weight stigma[129].

The pervasive impact of weight stigma and fat phobia can affect accessibility of services for a variety of reasons. Clients often report that they do not feel they deserve support because they blame themselves for their eating disorder. It is important to challenge weight stigma in society and to positively contribute to the ongoing discourse about thinness and health.

[123] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March.
[124] National Eating Disorders Collaboration (NEDC) (2012) *An Integrated Response to Complexity: National Eating Disorders Framework*, Report to the Australian Government Department of Health and Ageing, March, pp. 59.
[125] Fahs, B. & Swank, Er. (2017) 'Exploring stigma of "extreme' weight gain: The terror of fat possible selves in women's responses to hypothetically gaining one hundred pounds', *Women's Studies International Forum*, 61, 1-8, pp. 1.
[126] Smith, C.A. (2012) 'The Confounding of Fat, Control, and Physical Attractiveness for Women', *Feminist Forum*, 66, 628-631.
[127] Fikkan, J. L., & Rothblum, E. D. (2011) 'Is fat a feminist issue? Exploring the gendered nature of weight bias', *Sex Roles*, 66, 575-592.
[128] Smith, C.A. (2012) 'The Confounding of Fat, Control, and Physical Attractiveness for Women', *Feminist Forum*, 66, 628-631.
[129] Matacin, M.L. & Simone, M. (2019) 'Advocating for Fat Activism in a Therapeutic Context', *Women and Therapy*, 442:1-2, 200-215.

71. Eating disorders come in all shapes and sizes.

Eating disorders are not about weight[130]. Eating disorders come in all bodies with a range of different shapes and sizes. There is also a range of physical body differences that can cause self-consciousness and restrict access to relevant services. This stresses the importance of psychoeducation for clients and community awareness campaigns more generally.

It is also important to challenge the notion that to access specialist eating disorder services, a client must have a diagnosis of an eating disorder. This includes the way in which some diagnoses are seen as more or less serious. For example, separating atypical anorexia nervosa from anorexia nervosa downplays the significance of the person's experience of their eating disorder[131]. If a person feels their relationship with food is causing them distress, they deserve access to quality services and practitioners who can assist them.

72. Proactively challenge body stigma through advocacy and education.

Challenges to body stigma are required at individual, service sector and structural levels in recognition that eating disorders affect all body types. It is important to reiterate that eating disorders are most commonly a response to some other problem in a person's life rather than solely being about eating and bodies. A variety of effective strategies can address these issues such as social media campaigns, public awareness campaigns, and community engagement activities including contact with schools and GPs.

FINANCIAL CAPACITY

73. Provide a diversity of service options according to financial capacity.

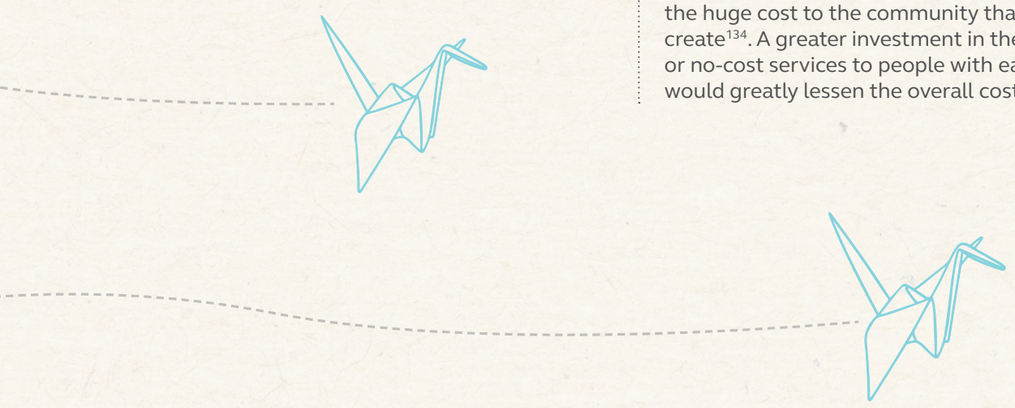
While there is no evidence to suggest that eating disorders occur more or less commonly in different socio-economic groups, there is no doubt that accessibility of services is limited with limited financial capacity[132].

Therefore it is important to provide a range of low- or no-cost services to ensure those most in need can access quality services[133]. These services may be provided through state government funded programs or through Commonwealth funded programs such as Medicare or NDIS funding. Organisations should advocate for a bipartisan approach to funding allocations across both state and Commonwealth funded programs.

Many low- or no-cost services are limited by high demand and long waiting lists and therefore it is difficult to offer long-term support where it is needed. This is partly due to a lack of available alternatives such as bulk billing practitioners.

74. Advocate to government for increased access to low or no cost options for clients with eating disorders.

Advocacy efforts to increase accessibility of services for those with limited financial capacity is essential. Increased funding for community-based and health services, in addition to ongoing review of the Medicare program for eating disorder specific services will ensure equitable access to specialist services for all people with eating disorders. This seems particularly relevant given the huge cost to the community that eating disorders create[134]. A greater investment in the provision of low- or no-cost services to people with eating disorders would greatly lessen the overall costs to society.



[130] Lawrence, M. (1984) *The Anorexic Experience,* The Women's Press: London; Orbach, S. (2016) *Fat is a Feminist Issue,* Arrow Books: London.
[131] Rastogi, R., Rome, E.S. (2020) 'Restrictive eating disorders in previously overweight adolescents and young adults', *Cleveland Clinical Journal of Medicine,* 87:3, 165-171.
[132] Hay, P. et al. (2014) 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders,' *Australian and New Zealand Journal of Psychiatry,* 48:11, 1-62.
[133] Mulders-Jones B. et al. (2017) 'Socioeconomic Correlates of Eating Disorder Symptoms in an Australian Population-Based Sample', *PLoS ONE,* 12(1).
[134] Deloitte Access Economics (2015) *Investing in need: cost-effective interventions for eating disorder,*. Report commissioned for Butterfly Foundation. Butterfly Foundation: Sydney.

9. WORKER WELLBEING

The Eating Disorders Queensland (EDQ) team strives for continuous improvement and the delivery of high-quality services. All practitioners undertake regular clinical, peer and external supervision and membership of a relevant professional association is a requirement of all workers. Practitioners ensure they are updated about the latest research through conferences and regular professional development. The overall wellbeing and mental health of workers is prioritised.

75. Worker wellbeing is valued and encouraged.

This is a complex area of work, and it is in the best interests of all clients that workers can sustain themselves in this work in a healthy and balanced way. We know that workers' longevity is impacted by conditions in the workplace[135]. If workers feel valued and have a voice in their workplace, they are less likely to experience the consequences of this complex work[136]. This is particularly the case in relation to experiences of vicarious trauma. Research has highlighted the importance of organisations providing a positive and supportive work environment and culture for staff to prevent worker stress, burnout and vicarious trauma[137].

Workers will ideally have a balance between the different levels of work including individual counselling, group work, community education, etc and are able to rotate through these to gain additional skills and to reduce the incidence of burnout[138].

76. Workers are supported through a culture of flexibility, autonomy and participation.

The organisation has a responsibility to treat workers as professionals and allow them the autonomy to do their job, with appropriate support being provided. This may include:

- Flexible working hours according to personal need and circumstance where possible.
- Encouragement to take mental health days when needed.
- The fostering of peer support.

Professional workers should be autonomous over their calendar management and have the ability to structure their days to meet client complexity and their individual needs[139].

77. Multiple opportunities for reflection are provided to all workers.

Regular supervision, including internal, external, peer based, individual and team; regular case review meetings; and training and professional development opportunities are prioritised to ensure worker health and development. The provision of multiple opportunities for workers to reflect and process their work is essential to worker wellbeing[140].

At times, debriefing should be provided to assist workers to process particularly challenging situations. This should include both formal and informal opportunities to process challenging work with colleagues and supervisors.

78. Worker authenticity is fostered.

To work effectively with clients, workers must be authentic and genuine in their approach. The same standards apply to collegial relationships where workers are encouraged to express their authentic selves in a variety of ways such as the way they dress, expressing their unique personalities and diverse interests and incorporating them in their work (such as yoga teaching, art, and music), and celebrating the strengths and existing skills of workers, including lived experience.

[135] Cohen, K., & Collens, P. (2013) 'The Impact of Trauma Work on Trauma Workers: A metasynthesis of vicarious trauma and vicarious post traumatic growth', *Psychological Trauma: Theory, Research, Practice and Policy,* 5:6, 570-580.
[136] Iliffe, G., & Steed, L. G. (2000) 'Exploring the Counselor's Experience of Working with Perpetrators and Survivors of Domestic Violence', *Journal of Interpersonal Violence,* 15, 393– 412.
[137] Cohen, K., & Collens, P. (2013) 'The Impact of Trauma Work on Trauma Workers: A metasynthesis of vicarious trauma and vicarious post traumatic growth', *Psychological Trauma: Theory, Research, Practice and Policy,* 5:6, 570-580; Harrison, R. L., & Westwood, M. J. (2009) 'Preventing vicarious traumatisation of mental health therapists: Identifying protective practices'. *Psychotherapy: Theory, Research, Practice, Training,* 46, 203–219; Rourke, M. T. (2007) 'Compassion Fatigue in Pediatric Palliative Care Providers'. *Paediatric Clinics of North America,* 54, 631–644; Saakvitne, K. W. & Pearlman, L. A. (1996) *Transforming the Pain: A workbook on vicarious traumatisation,* W.W. Norton & Company: New York.
[138] Benatar, M. (2000) 'A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse', *Journal of Trauma & Dissociation,* 1, 9–28; Harrison, R. L., & Westwood, M. J. (2009) 'Preventing vicarious traumatisation of mental health therapists: Identifying protective practices'. *Psychotherapy: Theory, Research, Practice, Training,* 46, 203–219; Saakvitne, K. W. & Pearlman, L. A. (1996) *Transforming the Pain: A workbook on vicarious traumatisation,* W.W. Norton & Company: New York.
[139] Harrison, R. L., & Westwood, M. J. (2009) 'Preventing vicarious traumatisation of mental health therapists: Identifying protective practices'. *Psychotherapy: Theory, Research, Practice, Training,* 46, 203–219.
[140] Iliffe, G., & Steed, L. G. (2000) 'Exploring the Counselor's Experience of Working with Perpetrators and Survivors of Domestic Violence', *Journal of Interpersonal Violence,* 15, 393– 412; Smith, A. J.M. et al. (2007) 'How Therapists Cope with Clients' Traumatic Experiences. *Torture,* 17, 203–215.

79. Workers may experience a range of personal and professional challenges in this work.

This is a complex area of work and at times workers will be challenged to explore the ways in which their own experiences have impacted on their view of bodies, food and the social images that objectify and judge bodies. Workers require multiple opportunities to check in with each other and discuss these challenges and what is required to remain sustainable.

A high level of self-care must be maintained by workers to sustain themselves in this work. This includes maintaining a balance between work and personal life, accessing social supports, taking regular breaks, engaging in supervision and other forms of reflection and support[141]. Research has suggested that self-care activities such as exercise, resting and meditating, engaging in pleasurable activities, and political activism assist workers to sustain themselves when working with complex trauma and related issues.

80. Workers ensure a high level of accountability to their clients, their organisation and their professional associations.

Workers must commit to a high level of accountability for their professional practice by:

- Ensuring their knowledge and skill base is continually updated.
- Engaging in regular reflective practice.
- Adhering to their organisations processes and requirements.
- Ensuring they are full members of their relevant professional association.
- Adhering to these professional practice standards and ethical guidelines.

81. Organisational integrity reduces the incidence of vicarious trauma for workers.

All the above points are designed to foster a work environment and culture where the most negative impacts of vicarious trauma are minimised. High quality service delivery is achieved by ensuring the same standards of work apply equally to workers and clients. This is an issue of organisational integrity – ensuring that there are no inconsistencies between the values of the organisation and the approach to managing workers.

Therefore, attention is required to the power imbalances inherent in a hierarchical organisation to minimise the degree to which leadership is separated from service delivery. Policies such as easy access to all leadership, including the CEO, and inclusion of staff in organisational processes such as planning, go a long way towards minimising these inherent imbalances.

Ensuring workers are supported to gain a positive balance between self-care and responsibility for client work as well as developing appropriate boundaries, can assist workers in managing the complexities of this work. Similarly, it is important for workers to have opportunities to enjoy each other's company at work and to have fun together. This greatly assists in creating a positive workplace culture.

[141] Cohen, K., & Collens, P. (2013) 'The Impact of Trauma Work on Trauma Workers: A metasynthesis of vicarious trauma and vicarious post traumatic growth', *Psychological Trauma: Theory, Research, Practice and Policy,* 5:6, 570-580.

10. SECTOR RELATIONSHIPS

Eating Disorders Queensland (EDQ) places a great deal of value on our relationships with other service providers within the sector. This ensures better service provision for clients through warm referrals and greater knowledge of the range of services available to clients and their families / key support people.

82. Service partnerships ensure the sharing of information and builds a strong service sector.

Forming strong partnerships with other related services in the eating disorders area ensures that information and knowledge is shared across the sector. This results in a stronger and more informed sector as we all work together to provide quality services to survivors and their loved ones. There are a range of ways in which these partnerships can be developed including:

- Providing education and training to workers.
- Offering reciprocal training across services.
- Presenting at national and international conferences.
- Building relationships with universities and other research institutions.
- Training employees and students who will work across the sector.
- Involvement with stakeholder advisory groups.
- Co-facilitation of groups and workshops with other related services.
- Being a part of national alliances such as Eating Disorders Alliance of Australia.

83. Service system integration enhances positive outcomes for clients.

Well-developed relationships across the sector ensure more positive outcomes for clients. Building relationships with workers and their organisations, both within the eating disorders sector and more broadly, ensures a well-developed understanding of the nature of services provided and creates a clear pathway for referral.

11. ADVOCACY AND SOCIAL CHANGE

Eating Disorders Queensland (EDQ) places a great deal of value on our relationships with other service providers within the sector. Community education, advocacy and social change are all part of Eating Disorders Queensland's (EDQ) commitment to preventing the development of eating disorders and encouraging early access to the appropriate treatment and support. This includes:

- Taking part in mental health forums and events.
- Making educational visits to schools.
- Attending and presenting at conferences.
- Media appearances.
- Guest speaking at forums.
- Contributing to professional working groups.
- Holding public awareness events on a regular basis.
- Lobbying policy makers and governments.

Social media is an important part of EDQ's approach to advocacy and social change. We maintain an active presence on social media and online platforms, ensuring our content targets a range of audiences. We undertake regular online awareness and advocacy campaigns, using social media to reach a wide audience, prompt discussion, and ideally mobilise change.

84. Social change efforts must be a core component of service delivery.

This is a significant and unique component of a feminist approach to practice. While feminism is committed to the provision of high-quality direct services to clients, there is also an acknowledgement that efforts are required at all levels of society – individual, familial, community, socio-cultural, political and structural. As a result, feminist services are committed to directing their efforts to each of these areas of change in recognition of the interconnectedness between individual activities and societal structures[142].

A distinguishing characteristics of the feminist approach is its recognition of the social, political, and economic forces that constitute the context in which eating problems among women (sic) are prevalent. Helping individual women (sic) resolve their problems with food and weight is important, but equally important are addressing and changing the broader social context[143].

85. Focus on early intervention and prevention.

Prevention programs present options for change in the social context. The politics of primary prevention, as well as successful therapy and recovery, require that we challenge major assumptions and values of our culture, recognise the depth and variety of needs related to eating disorders, and promote an understanding of the problem[144].

To reduce the incidence of eating disorders, early intervention and prevention efforts are critical[145]. This requires education in schools and the community more generally. It also requires significant advocacy to government and policy makers so that the broader social dynamics that contribute to eating disorders can be addressed. Most early intervention programs aim to reduce risk factors and enhance protective factors for individuals by targeting the early signs and symptoms of eating disorders[146].

While this is important work, these prevention programs often fail to look at the broader social and systemic factors that contribute to the culture of eating disorders in society and the ways in which eating disorders can be prevented. There is often little recognition of the culture of dieting, poor nutrition and unrealistic body ideals providing an environment conductive to the development of eating disorders, disordered eating and body dissatisfaction[147].

This is an important issue given that there is now widespread acknowledgement that societal factors, such as cultural standards, personal relationships, and community attitudes, play an important role in the prevention or heightened risk for the development of eating disorders, in early intervention and in support for people who have the illness[148].

86. Empower people to find their voice.

Research suggests that early intervention and prevention programs that focus on developing a sense of personal power can prevent the development of eating disorders and ameliorate body image issues[149].

One of the effective ways of developing personal empowerment is to provide opportunities for those with eating disorders and their carers / key supports to share their stories[150]. This is also an effective way of achieving change by raising awareness of these issues through hearing the stories of those impacted. It is also important that we ensure those more marginalised stories are heard. *Therapists and clients should consider how eating disorder-related activism can be incorporated as a part of their healing process to reduce further symptom development[151].*

87. Advocate with intention.

Advocacy efforts should be intentional with a clear focus on the quality of the message and the intended audience. It is important to identify the barriers to accessing services for more marginalised clients and to lobby for change in these areas.

Advocacy must be targeted to each level of influence including individuals, the broader community, policy makers and government. This is a fundamental component of feminist and trauma informed practice. Dialogue should be promoted to create conversations and awareness of eating disorders.

It is also important to note that advocacy work must include a willingness to speak up and advocate for issues of justice when they are first identified. Proactive change includes taking a leadership role in the many injustices in society and being willing to act first rather than when the issues is publicly palatable. This is a key component of EDQ's commitment to feminist practice and EDQ has a long history of advocating for justice for all in society.

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