



# Understanding Eating Disorders

The Eating Disorders Association Inc. (Queensland)

*Which one of these people has an eating disorder?*



*...they all do.*

Front cover by: Beth Mitchell Photography, Beth Mitchell photographer, Tim Orange assistant photographer, Begitta Stolk fashion stylist, Madison Colless assistant stylist, Fiona Claire makeup artist, Vanessa Mulkearns hair stylist.

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This booklet was first printed in 1992 and has since had four revisions. The booklet has been in constant demand by people throughout Queensland (and other states) who are seeking information relating to eating disorders.

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*Further copies of this booklet can be obtained from the EDA.*

This booklet was generously funded by the English Family Foundation. We thank members of the Foundation for making the update of this booklet possible and for giving us an opportunity to engage creatively with the community. Understanding the nature of eating disorders is key to recovery. We hope this booklet is helpful for all people and families affected by eating disorders, for the health professionals who support them and for the broader community.

The artwork and slogans used in the booklet were the result of months of consultations with the community and the Eating Disorders Association.

The theme of being underwater was used as a metaphor for living with an eating disorder; swimming to the surface and breaking through, a metaphor for recovery. We thank all the people involved in creating the concepts, slogans and wording for this booklet. The booklet is a collaborative community effort involving people with a lived experience of an eating disorder, their carers, health professionals and community supporters.

### Photographic acknowledgements

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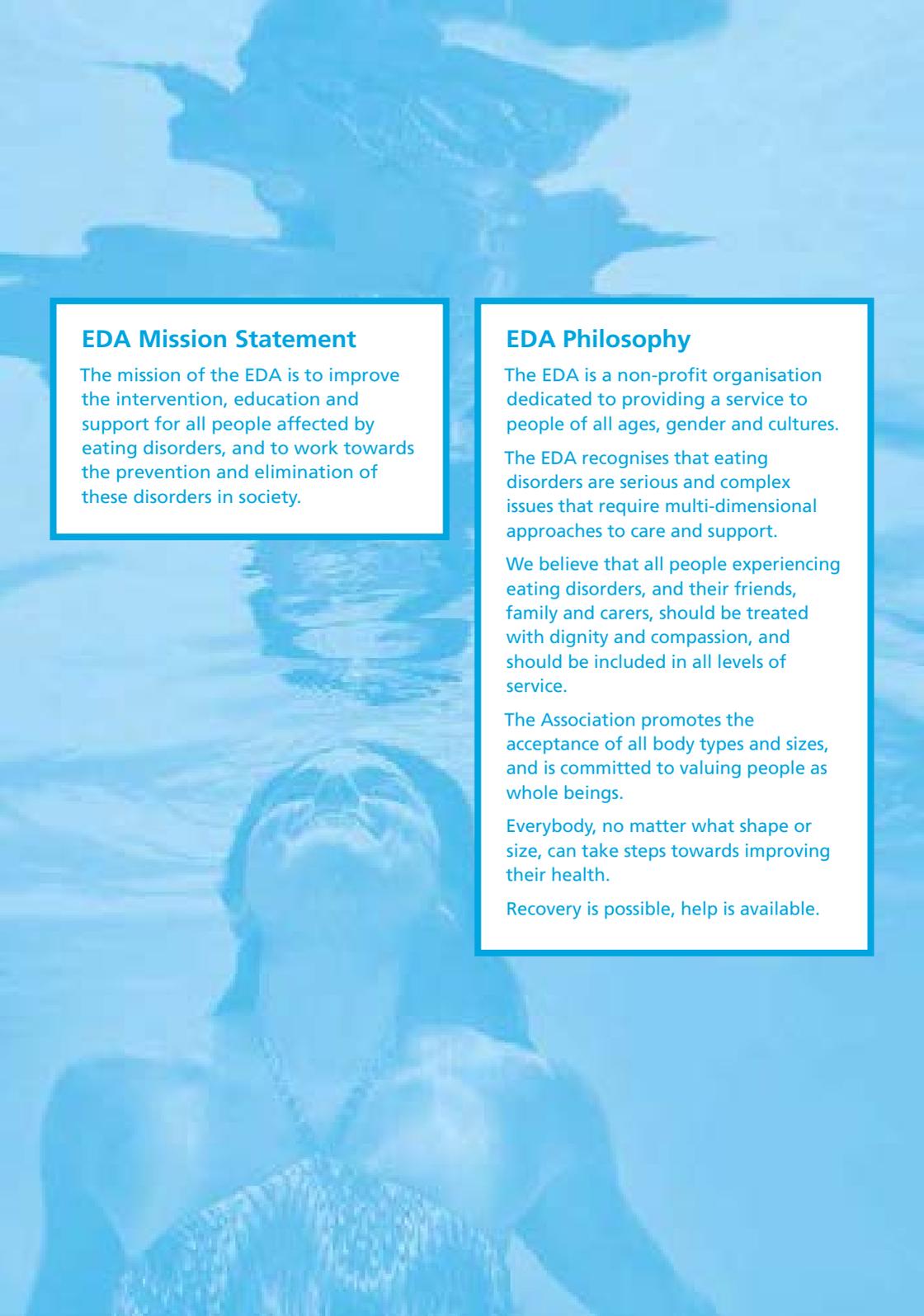
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## EDA Mission Statement

The mission of the EDA is to improve the intervention, education and support for all people affected by eating disorders, and to work towards the prevention and elimination of these disorders in society.

## EDA Philosophy

The EDA is a non-profit organisation dedicated to providing a service to people of all ages, gender and cultures.

The EDA recognises that eating disorders are serious and complex issues that require multi-dimensional approaches to care and support.

We believe that all people experiencing eating disorders, and their friends, family and carers, should be treated with dignity and compassion, and should be included in all levels of service.

The Association promotes the acceptance of all body types and sizes, and is committed to valuing people as whole beings.

Everybody, no matter what shape or size, can take steps towards improving their health.

Recovery is possible, help is available.

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# The Eating Disorders Association Inc. [EDA]

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**The Eating Disorders Association Inc (EDA) is a state-wide, not-for-profit organisation started by a group of people with a lived experience of eating disorders and carers. The EDA opened its centre in 1996 to all people affected by eating disorders and maintains a peer-orientated model of service delivery. The EDA welcomes the input of people affected by eating disorders in all aspects of the Association's initiatives and the services it provides to the community.**

The EDA provides Queensland-wide recovery orientated support, information and referral, including:

- + recovery orientated support, information and referral sessions — by telephone, email, face-to-face or using video conferencing — for individuals with eating disorders and for people who care about them. Face-to-face sessions are by appointment only.
- + support groups, workshops and peer-support groups, for people with eating disorders and for those who care about them.
- + after-hours support by volunteers who have recovered from an eating disorder, or carers who have supported someone to recover.
- + information packs about eating disorders.
- + referrals to health professionals with a special interest in treating and supporting people with eating disorders throughout Queensland.
- + A peer- and carer-driven monthly newsletter called *Through the Looking Glass*, with contributions from people with a lived experience of an eating disorder, people who

have recovered, and from carers. Included in the newsletter are personal experiences, recovery strategies, art work, book and media reviews, health professional contacts, eating disorder sector research, events and support group advertisements, and opportunities for people to get involved at the EDA and other organisations.

- + specialist eating disorder library.
- + community education about eating disorders, as a to improve the understanding and treatment of eating disorders, and to contribute to the prevention of these disorders in society.

## EDA Contact details

- + Opening hours: 9 am to 4 pm, Monday to Thursday
- + 12 Chatsworth Road, Greenslopes Q 4120
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## Other EDA publications:

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Your reflection may be distorted by socially constructed ideas of beauty and worth





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# Description Of Eating Disorders

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## What Are Eating Disorders?

**Eating disorders are serious and complex issues, with strong medical and psychological components, relating to negative body image, weight and shape concerns, problematic eating and compensatory behaviours, including starvation, bingeing, vomiting, compulsive exercise and the abuse of diuretics.**

A person with an eating disorder will often assess themselves negatively in terms of their weight and shape, and what they have eaten or not eaten. It is important to understand that even though eating disorders encompass harmful eating practices and related compensatory behaviours, they are often the outward sign of deeper psychological issues and ways that people have coped with life stressors. Recovery from an eating disorder is not as simple as the person recognising the need to 'just eat normally'. Eating disorders are complex mental health problems and are potentially life-threatening illnesses.

Eating disorders can have serious effects on all aspects of a person's life — physical, emotional and social. They are often very private and hidden problems, which can exist for a long time before they are recognised, particularly when the early warning signs are similar to the restrictive fad dieting that is so commonplace in western culture. People close to an individual may notice significant behavioural changes — such as heightened moodiness, anxiety, stress, depression, secrecy, obsessiveness or anger — without necessarily understanding the causes of the behaviours. Sometimes these behaviours are mistaken for

becoming an adolescent, an individual's personality, menopause, or going on a diet to be 'healthy'. As a consequence, it is only when someone becomes quite obviously unwell that treatment is sought.

Eating disorders often coexist with other mental health issues, such as depression, anxiety, body dysmorphia, mood disorders and obsessive-compulsive disorders.

Most people recover from an eating disorder and recovery is always possible regardless of age and length of illness. However, people with eating disorders are at a high risk of developing serious medical complications and dying from their illness. In fact, eating disorders have a higher death rate than any other mental illness. The earlier treatment is sought the greater the opportunity for recovery, therefore treatment is encouraged as soon as possible. A multi-disciplinary treatment team including a doctor, dietitian and therapist is recommended.

When someone with an eating disorder is approached about their concerning behaviours, they will often deny the existence or the seriousness of their behaviours and refuse to acknowledge any problem. Alternatively, they may recognise they have a problem, but choose to do nothing about it. Sometimes the shame around certain behaviours is so great that the individual feels they cannot be honest with anyone about what they are doing. This denial, ambivalence, or shame can be a source of real confusion and frustration for families and friends who want to support their loved one to get well.



## Men get eating disorders too.

*I'm a hairdresser and have been getting help to recover from anorexia nervosa. I now know that recovery is possible and support is available. I no longer suffer in silence and no one else needs to either.*

**Recovery is possible and support is available.**

- + *How do you get someone to a doctor if they refuse to go?*
- + *How do you encourage someone to eat when they don't want to?*
- + *How do you support someone to stop vomiting or binge eating, when they have been doing it for many years?*

Answers to these questions can be the cornerstone of supporting people to get well. Refusal or ambivalence about getting well, despite the threat to one's life, highlights eating disorders as serious mental health problems. The terms 'mental health', 'mental illness', 'eating disorder', 'eating issues', 'eating problems' and 'psychiatric conditions' will be used interchangeably in this booklet as an acknowledgement of the variety of ways people describe their problematic eating experiences.

Eating disorders are not lifestyle choices. No one chooses a mental illness, however one can choose to recover. Understanding the nature of eating disorders is vital to recovery. The more eating disorder information a person, their family, friends and health practitioners have, the better their understanding of how to recover and how best to support someone to recover. Reading recovery stories and connecting to other people who have been through similar experiences can give hope and be a great support. Gaining information about eating disorders, trying strategies that have helped others recover, understanding the pitfalls to avoid, finding the best evidenced based therapies, discovering useful ways to support someone and getting on-going support is encouraged.

A multi-disciplinary approach to recovery is recommended including seeing a doctor for a medical assessment and on-going physical monitoring, a dietitian for nutritional advice and a therapist for psychological recovery. In the first instance, a doctor is recommended to make an assessment. If you suspect a child is developing an eating disorder, trust your instincts and take them to the doctor as soon as possible. If you are supporting an adult, keep encouraging them to go to the doctor. Their life may depend on your support.

The medical profession defines the three most common eating disorders as *anorexia nervosa*, *bulimia nervosa*, and *binge eating disorder*, each with specific diagnostic criteria. People who suffer from complex eating issues and do not meet the diagnostic criteria are categorised as having an *other specified feeding or eating disorder*.

People with eating disorders can be any weight and do not have to be underweight to be suffering the effects of starvation. Most people with eating disorders are in the healthy weight range or above. 'Obesity' or being above your healthy weight range, is not classified as an eating disorder, however, eating disorder services internationally are starting to respond to people who are above their healthy weight range.

There is an increase in the number of people with eating disorders, an increase in people who are overweight or obese, and an increase in the amount of people who have a negative body image. With such a diversity of people with eating issues and body, weight and health concerns, we need to understand social and cultural factors that contribute to these problems.

Although some eating disorders present most commonly among young adolescent women in cultures influenced by western health and beauty ideals, women and men of any age, from any social and cultural background can develop eating disorders. Over the last decade, there has been an increase in young men, children and middle-aged people diagnosed with eating disorders.

Before a diagnosis, an individual, friends or family may sense that something is not quite right. We encourage people to trust their instincts and seek support as soon as possible. Unfortunately, many carers have had the experience of being turned away from health services because their children have been assessed as not being 'ill enough'. We encourage people to seek health professionals who understand how to treat eating disorders and what is needed to prevent mild cases developing into clinical disorders. The time and effort put into finding the right treatment team will be worth it. We also encourage doctors and health professionals to carefully consider the concerns of individuals and carers.

Although most people who develop eating disorders will recover, eating disorders can have serious consequences and often irreversible medical implications if left untreated. The sooner professional help is sought and treatment commenced, the greater the chance of recovery and a happier, more fulfilling life for the individual and their family.

A good start is to support adequate, regular and nutritious eating, and to take care with our words and actions. Be conscious of the body image and health messages we send and the way we talk about our own body and eating, and that of others.

## The Effects of Starvation and Refeeding

**Before explaining the nature of eating disorders, it is very useful for everyone to understand the effects of starvation on physical, social and mental health. A well-known starvation study carried out at the University of Minnesota (Keys et al, 1950) highlights that many symptoms of eating disorders are actually symptoms of starvation, and that anyone who engages in prolonged and severe dietary restriction can suffer serious physical, social and psychological complications.**

The study included a six-month period of food restriction for 36 young, healthy, psychologically normal men. The men ate about half of their normal food intake (approximately 1560 calories, or 6552 kilojoules, a day) and lost about 25 per cent of their former weight. The men were then gradually re nourished during the following three months.

### ***Changes in the men after six months of semi-starvation***

- + Despite little interest in food or food preparation prior to the experiment, there was a dramatic increase in food preoccupation, including incessant and intrusive thoughts about food, menus, food preparation and eating, including dreaming about food.
- + Abnormal and ritualistic behaviours around food increased, including making strange food combinations and concoctions.
- + There were often conflicting desires between wanting to gulp food down ravenously and prolonging the time taken to eat food, sometimes for hours.
- + A significant increase in the use of salt, spices and gum chewing. Drinking of coffee and tea increased so dramatically they had to be limited to nine cups a day!
- + Some had a complete breakdown in control, unable to stick to their restrictive diets and reported episodes of binge eating followed by emotional upset, self-reproach, disgust, self-criticism and vomiting. One man left the experiment after developing a dangerous a starve–binge–purge cycle.
- + Stress, anxiety, depression, mood swings, irritability, disorganisation, hysteria, hypochondria, outbursts of anger and severe emotional distress increased.
- + Some men became neurotic and psychotic. One man mutilated himself by amputating three of his fingers with an axe.
- + The men became more withdrawn and isolated, with growing feelings of social inadequacy. Humour and mateship diminished. Social contacts became strained and declined, and sexual interests drastically reduced.
- + Concentration, comprehension, alertness and judgement became increasingly impaired; however, there seemed to be no signs of diminished intellectual abilities.
- + Physical changes included hair loss; dizziness; headaches; hypersensitivity to noise and light; increased sensitivity to cold temperatures; cold hands and feet; reduced strength; poor motor control; gastrointestinal problems; decreased need for sleep; oedema (excessive fluid causing swelling); visual disturbances, such as an inability to focus; aching eyes or seeing ‘spots’; auditory disturbances, such as ringing in the ears; and tingling or prickling sensations.
- + An overall slowing of the body’s physiological processes occurred, such as decreases in body temperature, heart rate, and respiration, as well as in basal metabolic rate, which is the amount of energy burned at rest.
- + Most of the men eventually became tired, weak, listless, and apathetic, and complained of lack of energy. Some maintained exercise regimes and some attempted to lose weight by excessive exercise in order to obtain more food, or to stop a reduction in their food rations.
- + Apathy also became common, and some men neglected various aspects of personal hygiene when previously they had taken great care.



**I will feed myself and fight this illness, not feed this illness and fight myself.**

**Your body hears everything your mind says.**

During the three months of the renourishment, most of the emotional disturbances, abnormal attitudes and behaviours in regard to food continued to be quite severe. Particularly in the first six weeks, some men actually became more depressed, irritable, argumentative and negative than they had been during the semi-starvation. After between five and nine months of renourishment, most men had returned to normal body weight, normal eating patterns and physical, psychological and social functioning was restored. A few were still binge eating; although,

the study did not identify why. The fact that serious binge eating developed in a small subgroup of men supports research indicating that people who regularly diet by restricting food, develop binge eating behaviours.

Although the effects of starvation are very clear from this study, the men were voluntary research subjects. If we are to understand why eating disorders develop, we also need to understand why individuals engage in self-imposed starvation.

## Why do People Develop Eating Disorders?

**Eating disorders develop from a complex interplay of many factors. There is ‘no one’ cause for developing an eating disorder, or for self-induced starvation and its consequent effects on the individual. No individual or parent is to blame.**

We will highlight some issues that people who have recovered identified as contributing factors to the development of an eating disorder and some strategies that have been shared with us regarding recovery. It is important to note that not all conditions are experienced by everyone who has a lived experience of an eating disorder. They are meant to give an insight into some commonalities and to offer some understanding about the complexities of why a person may develop an eating disorder, in the context of having no clinical evidence to that end.

### Risk factors

#### *Societal and cultural factors*

Eating disorders are most prevalent in western cultures and in those becoming westernised. The way our society adversely affects our health is too broad to detail in this booklet, so we have made a list of things that culturally contribute to low self-esteem, negative body image, problematic eating behaviours and poor mental health. This list is not exhaustive. It comes from the common stories individuals have shared with us about being affected by eating disorders.

We are all influenced by social institutions. Social institutions include human languages; governments, the family, education, health, the law, and business including advertising, food and media corporations. Our society affects the way we speak, think and relate to each other.

Societal influences that may affect the development of eating disorders include the importance that is placed on our appearance, what is considered beautiful and what defines healthy eating. The ideals of beauty change over time. The present beauty ideal is considered young, white, tall, thin and/or well-muscled, with flawless skin. Images we see in popular media have been digitally altered

to meet this ideal. Society tells us that to be happy, successful and desirable, we need to meet this single beauty ideal, which often is so digitally altered it does not reflect anybody's reality.

Trends in the fashion and media industries have created the ideal as being underweight, despite the health risks of malnutrition. Digital modification of images has also created an unrealistic over-muscular beauty ideal for men. People have a diversity of backgrounds and come in all shapes and sizes, and most do not physically meet these narrow unrealistic definitions of beauty. Beauty ideals used as a standard of comparison, can cause dissatisfaction, low self-esteem and a lack of self worth when not achieved.

The fad diet industry sells the ‘thin as ideal’ concept, and promotes diet products, artificial sweeteners, diet pills, diet shakes, food group restriction, fad super foods, protein shakes, processed food, and the like, as a way to make money from people's feelings of inadequacy. Not everyone who diets goes on to develop an eating disorder, but most people who have developed an eating disorder have dieted. Weight is seen as ‘the’ measure of health, instead of being one measure among various health measures.

Other complex factors that influence our body image, how we eat and what we think include the following topics, too broad to cover thoroughly in this booklet.

- + Our culture shames people into improving their health at the same time as having a vast array of conflicting nutritional information.
- + “Fat phobia” promotes the myth that all overweight people are unhealthy, unhappy, eat junk food, and are lazy, which is not the case.
- + The advertising industry promotes the idea that we are incomplete and need to purchase a product to be happy. This idea of being flawed, or incomplete, has seen the demand for cosmetic surgery grow and a proliferation of cosmetic surgery procedures.
- + Hand-held computers with cameras, the arrival of the digital age, and the general acceptance of social media has increased the amount of ‘selfies’ being published. How you look and what you are doing is documented online.
- + Patriarchy, sexism, racism, homophobia, ageism and seeing abled bodies as ideal.



## Beauty and Worth Cannot Be Measured

**Break free. Start a revolution. Love your body.**

Society perpetuates one unrealistic, often digitally altered, beauty ideal that most people don't measure up to. Many industries make money from people feeling inadequate or not good enough. Don't be bound by society's beauty ideals. Every body is unique, beautiful and valuable regardless of weight, shape and size.

- + The sexual objectification of women and children, and the increasing sexual objectification of men
- + The 'pornification' of human relations and sexual relationships.
- + Access to an abundance of food, including convenient, unhealthy processed food, which is high in salt, sugar and trans fats. These are often marketed to children.
- + Plate and portion sizes have increased in a super-size-me fast-food culture.
- + Industrial farming and agriculture produces food with fewer nutrients and encourages an over-consumption of animal products.
- + We moralise about our food, declaring it is 'good' or 'bad', which manifests in judging ourselves on what we eat.
- + Many people judge themselves and others largely on their physical appearance. 'Body bullying' is increasing and has become more harmful, particularly in the new realm of cyber bullying.
- + The increase in steroid abuse for body image instead of athletic performance enhancement.
- + 95% of people who engage in restrictive dieting fail to maintain their weight loss, over time putting their lost weight back on and more.

Our social messages are wrong if young men are turning to protein shakes and steroids for a 'healthy' body image ideal, or if young women are saving for cosmetic surgery, having botox birthday parties at

the age of 15, or joining no-eating clubs at the age of eight.

According to the annual Mission Australia Youth Survey, the largest youth survey in Australia, young people consistently rank body image as being one of their top three concerns, along with family violence, and drug & alcohol issues.

- + Body dissatisfaction in Australian adolescents is at least 75% for girls and 50% for boys.
- + Approximately 50% of girls and 33% of boys in Australia, believe they are overweight, when they are at a healthy weight and
- + One in five girls try to lose weight through dangerous behaviours like not eating for two days, taking laxatives, vomiting and smoking. *(Wade and Wilksch, 2009)*

Research shows that teaching young people media literacy about body image helps prevent risk factors that lead to the development of eating disorders. *(Wade and Wilksch, 2009)*. There is also much evidence to suggest that health changes motivated by self-love and self-compassion are more successful than those motivated by self-hatred.

Sociologists have said that people who develop eating disorders are like the 'canary in the coal mine', in that they indicate how society's messages are affecting us all. Children are not born hating their bodies, they learn that from society. What can you do to help reverse this process?

## **Genetics and personality traits**

There may be a genetic predisposition to eating disorders and research is being gathered internationally to identify possible links with certain genes. The Anorexia Nervosa Genetics Initiative (ANGI) is a global effort to identify the genes that may contribute to eating disorders. The goal of the study is to transform our knowledge about the causes of eating disorders and to work towards greater understanding and ultimately a cure for eating disorders. Researchers in the United States, Sweden, Australia, and Denmark will collect clinical information and blood samples from more than 8000 individuals, both with and without eating disorders. If you have suffered from anorexia nervosa at any point in your life, you can help achieve this goal.

To become part of this important research go to [www.angi.qimr.edu.au](http://www.angi.qimr.edu.au) for the online survey.

Genetics may help explain why eating disorders can develop when there are certain factors present like a family history of eating disorders, anxiety, depression, obsessive compulsive disorder, substance abuse, or other mental health conditions. A predisposition to these issues may explain why one person develops an eating disorder and another doesn't. It may explain why some men in the starvation study made a full recovery, while others developed binge eating. Genetics may explain if comorbidities develop or are exacerbated by the effects of starvation. For example, some people may have depression before developing an eating disorder, while others develop depression as a consequence of their eating disorder. Either way, starvation exacerbates depression and other eating disorders issues, such as bingeing and purging. Brain imaging research indicates that people who develop anorexia have major differences in their brain functioning compared with control populations. Perhaps genetic research can help unlock information about genetic predispositions and the effects of starvation on the brain.

An individual's temperament or personality may also indicate a predisposition to developing an eating disorder, including the following traits:

- + a perfectionist
- + high achiever
- + disciplined
- + obsessive compulsive
- + rigid thinker
- + sensitive
- + unassertive or passive
- + avoidant or detached
- + eager to please
- + anxious
- + depressive
- + stubborn or strong willed

Some of these traits can be seen as assets, however, when coupled with restrictive dieting they may hasten the adverse effects of starvation and contribute to an increase in problematic eating disorder behaviours.

## **Triggers for the onset of eating disorders**

Common factors indicated as contributing to the onset of eating disorders often involve a change, loss or trauma of some description, along with related stress, anxiety, depression and difficult emotions. Despite having genetic or personality predispositions to developing eating disorders, not everyone with these predispositions will go on to develop an eating disorder. Sometimes trigger events are described as contributing to self-starvation and the development of eating disorders, and eating disorder behaviours are often described as ways to cope with life stressors.

Some of the stressors that can trigger eating disorders include the following:

- + **Major life changes or life stressors:** adolescence, becoming an adult, menopause, ageing, changing schools, entering high school or university, marriage, divorce, changing jobs, moving house, and so on.
- + **Trauma:** death of family member, grief, loss, bullying, being a victim of crime, sexual violence, etc.

- + **Occupational stress on body image:** acting, performance, dance, modelling, gymnastics, athletics, sport and fitness, or careers with an emphasis on your physical appearance.
- + **Physical illness that impedes appetite:** cystic fibrosis, diabetes, celiac disease, viruses, glandular fever or tonsillitis, etc.

Triggers can result in food restriction and weight loss because people do not feel well enough to eat. Losing weight from grief, loss or illness may push the individual into a state of malnutrition along with its detrimental effects on the mind and body.

Low self-worth, low self-esteem and the inability to cope with difficult emotions and life stressors, are very common for people with eating disorders. Food can be used as a means to cope emotionally.

Some may feel their eating patterns are the only thing that they can control when other aspects of their life seem out of control. As we receive cultural validation for food restriction and weight loss, people may continue to restrict or control food intake to try and increase positive worth and self esteem.

Others may use food to reflect on how they feel, so low self-esteem and feeling out of control can be mirrored in their relationship with food. Starvation, bingeing and purging can reflect a low self-worth and feelings of guilt, shame or disgust in oneself.

Therefore strict control and loss of control over food and compensatory behaviours, can be seen ways to cope with upheavals in one's life, difficult emotions and a low self-esteem.

### ***Family problems and peer pressure***

Most people with eating disorders come from loving, nurturing and functional families with supportive peer groups. When someone develops an eating disorder the whole family and friendship circle can be affected, because eating disorders often pose a serious threat to life. It is important to understand that no one chooses to develop an eating disorder and neither parents or carers are responsible for the development of an eating disorder. However, there can be a range of peer and family problems that contribute to complex

emotional, social and behavioural issues. These problems are not likely to be the experiences of families who actively seek to support their children, however, some family and peer problems identified by people in recovery include:

- + having to deal with difficult decisions, or difficult emotions within the peer group or family
- + domestic violence, verbal abuse, sexual abuse, relationship difficulties
- + family or peer group drug and alcohol issues
- + bullying, including body bullying and cyber bullying
- + peer pressure to starve, vomit, use harmful diuretics or steroids
- + pressures around physical appearance, body weight and shape or an over-emphasis on fitness in the family home, at school or in peer groups
- + high expectations to succeed in sport, creatively, academically or with a body image ideal
- + authoritarian parenting
- + dynamics that foster a fear of growing up, a desire to disappear or a desire to be noticed
- + identity confusion driving behaviours to fulfil a sense of belonging or driving behaviours to express a sense of not belonging
- + role models who do not have a positive body image
- + family or peer conflict, confrontation or poor communication.

People have described the above issues as impacting on the development of their eating disorder, but ***no one issue or person is responsible for an eating disorder***. An inability to develop one's own identity as separate from parents, other family members or peers, can leave a person unsure of who they are and what they are capable of. These issues and other complex factors underlying the reasons for developing an eating disorder are best addressed through therapy. Most families want the best for their loved one and there is no doubt that supportive friends and family can be vital to recovery.

## Factors that maintain an eating disorder

### ***Reinforcing aspects of weight loss creates an ambivalence to get well***

Weight loss can change your relationship to mind, body and food in negative ways. For much of human history food has been scarce and our minds focused on food for our survival. Today, despite an abundance of food in Australia, cultural messages say only a thin body is healthy. Being praised for weight loss can give a sense of achievement, success, strong will power and feelings of being special and happy. It is easy to want more validation and continue with restrictive eating, dieting rituals of calorie counting, weighing food, excessive exercising and engagement with harmful practices like vomiting or diuretic abuse.

### ***Developing a mental illness and phobias***

There comes a point when one's physical and mental health becomes severely compromised by starvation and related compensatory behaviours. The effects of starvation on healthy bodies and healthy minded people has been well documented, and demonstrates that levels of anxiety, depression, moodiness, obsessiveness, compulsivity, rigidity, bingeing, purging and over-exercising can become exacerbated after severe food restriction. **The effects of starvation can develop even if the individual is not underweight.** It is easy to deduct that people who are predisposed with certain genes or to the personality traits of perfectionism, obsessiveness, rigid thinking or anxiety for example, may experience the effects of starvation more readily or intensely. Understandably, the intellect is one of the last qualities to be affected as we have evolved from people who needed their intellect in time of food scarcity. It is common for a person to be very unwell from starvation but continue to be a high academic achiever.

For some individuals who develop eating disorders, their mental health can be so compromised that they develop an increasingly negative body image or a distorted body image, for example the thinner they get, the larger they feel. Delusions can manifest, like the belief you will absorb calories by holding food, or that water or the air you breathe contains calories. Phobias can

develop around gaining weight. In fact the fear of gaining weight can be a much stronger motivator than the reality of being physically compromised or dying from starvation. Hours can be spent looking into mirrors with self-disgust. To avoid gaining weight, compensatory behaviours like purging or compulsive exercising can develop, despite being malnourished and medically compromised from starvation. Although adequate, regular nutrition is vital for eating disorder recovery, adequate support is not as simple as saying 'just eat' any more than it is to tell someone with a spider phobia that they step into a room full of spiders to get well. Sometimes fat phobias can be so strong that the idea of gaining weight in order to get well increases anxiety levels, which can be disabling and counter to recovery. Consequently, when starvation has been the self imposed goal for such a long time the brain changes in ways that are unhealthy, including an ambivalence to get well despite serious risks to health.

### ***Starvation–binge–purge cycle***

Most people who struggle with eating issues engage in 'black-and-white' thinking. This means moralising food as being 'good' or 'bad'. Food morals then affect our behaviour and the way we think about ourselves. We are good when we eat good food, and we are bad, or failures, when we don't. We alternate between seeing ourselves as either good or bad, perfect or a failure, on or off our diet. The dieting industry tries to convince us that eating one piece of anything 'bad' will make us fat, and if we are fat we are bad. In reality, one piece of anything doesn't make anybody fat. And fat doesn't mean bad. Absolutely everybody is valuable.

It is a fairly common story that when a person feels pressured to lose weight or to get healthy they immediately think of restricting food or only eating 'good' food. What constitutes good or bad food can depend on the fad diet being promoted at the time and sometimes staple food such as bread and essential fats are considered 'bad'. Most people cannot maintain severe food restriction and extreme hunger. It is very common for people to eat too quickly and eat too much when extremely hungry. When starvation leads to bingeing it can evoke feelings of guilt and self-loathing. 'Breaking'

our diet and eating something 'bad' means we have 'blown it' leading to feelings of being out of control. Of course, bingeing makes one feel 'bad' and so the cycle to be 'good', get healthy and lose weight begins again, usually on a Monday. Bingeing can also lead to purging behaviours like compensatory exercise, vomiting or laxative abuse with an ethos of redemption to 'rid' the amount of food eaten in the binge.

People can spend decades being on and off diets and, as a consequence, feeling inadequate. The diet-binge-purge cycle is maintained because this way of life can become habitual and can help deal with underlying uncomfortable feelings. For example, purging can bring with it a feeling of self-disgust, but also a sense of relief. It can be easy to fall into familiar coping patterns and can mean an inability to see yourself changing or getting better.

### ***Strong identity with the eating disorder***

Someone with an eating disorder is often spending a lot of time obsessing about their weight and shape, and about food. Eating disorders may be masking underlying issues, including why self-starvation was imposed. Starvation can shift the focus of one's life to incessant and intrusive thoughts about food and eating disordered behaviour. These incessant thoughts are often interpreted as the 'self' rather than seeing the thoughts and behaviours as being the result of the effects of starvation. The eating disordered thoughts or behaviours can become a means of coping with other issues, and can create a false sense of security and perceived control over life.

Separating or externalising the eating disordered thoughts and related behaviours can be very useful in recovery. We all have negative thoughts but often they are balanced with positive thoughts. Sometimes when someone develops an eating disorder, the healthy self, true self, or the positive thoughts are overpowered by incessant critical thoughts that rule one's behaviour. When these negative thoughts become fused with one's identity, there can be a denial that there is a problem and an ambivalence to change.

If a child is affected by a cancerous tumour, it is easy to see that the child's ill health is a consequence

of the cancer. Similarly, it can be useful to see the eating disorder as the reason for the individual's ill health, not the individual or the family being the reason for it. For example, when someone is in a state of high anxiety at a weigh in, thinking they have gained weight when in reality they have lost weight, it offers an opportunity to highlight how the illness or the eating disorder affects their perception. When someone throws a tantrum about eating a meal, it often means the illness is having a powerful affect at that moment. With meal support it can be useful to think we need to support our child to eat more than the illness allows them to eat. It is the illness that can make someone with anorexia upset about the weight restoration that is needed for their survival. This separation can help carers understand the illness and also help the individual separate the illness from their identity. Glimpses of recovery are apparent when the individual's true personality returns as a result of regular, adequate nutrition.

### ***Malnutrition***

Eating disorders are extremely complex medical conditions, exacerbated by the profound effects of malnutrition within the brain. Only recently have scientists had brain-imaging tools to examine the neurobiology of eating disorders. Starvation or malnutrition, bingeing and purging and other harmful behaviours can be maintained because of the physiological responses compounding mental illness and problematic behaviours. For example, the starving brain loses volume and regresses, and vitamin and mineral deficiencies can create hormone loss, electrolyte imbalances, altered serotonin and dopamine metabolism, and sleep disruption, which can affect our fear and stress response to food, anxiety, mood, body image distortion and further mental health problems. More research is being conducted to ascertain the causes of differences in brain imaging for people with eating disorders in hope for new treatments. Many people with eating disorders are relieved to know that their brains are working differently to control groups. The discovery of neuroplasticity, that our thoughts can change the structure and function of our brains, is an important breakthrough in our understanding of the brain and means that despite the effects of eating disorders on the brain, most people can and do recover.



## Eating disorders run deep

*The deeper you sink under the weight of an eating disorder the darker it gets. It's like being tied to an anchor, it happens so fast that it blindsides you. The impact of the negative rigid thinking of an eating disorder, interprets things as all or nothing, black or white, perfect or a failure, rather than a sea of possibility.*

**Recovery can mean finding your worth and realising that no one is perfect.**

# Clinical Diagnosis Of Eating Disorders

## What Is Anorexia Nervosa?

**The most obvious characteristic of someone who has developed anorexia nervosa is significant, deliberate, self-starvation and consequent weight loss, together with an intense fear of being fat irrespective of their current weight and shape. Initially, behaviour around developing anorexia may be difficult to distinguish from normal dieting, but it soon becomes obvious that the behaviour has an abnormal drive and resolve to it, and it is relentless. Anorexia nervosa is a serious and complex mental health condition and people may die if it is left untreated.**

To be diagnosed with anorexia nervosa using the DSM-5 Diagnostic tool, a person will meet the following criteria:

- + Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- + Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though the person is at significantly low weight.
- + Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

**There are two subtypes of anorexia nervosa:**

### 1. Restricting type

During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (specifically, self-induced vomiting, or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

### 2. Binge eating or purging type

During the last three months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (specifically self-induced vomiting, or the misuse of laxatives, diuretics, or enemas).

The minimum level of severity is based, for adults, on current body mass index (BMI) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults. For children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild Anorexia:  $\geq 17$  BMI

Moderate Anorexia: 16–16.99 BMI

Severe Anorexia: 15–15.99 BMI

Extreme Anorexia:  $< 15$  BMI

*(American Psychiatric Association, 2013)*

## BMI vs Body Mass Composition

**Body Mass Index ( BMI ) is a measurement of a person's weight in relation to their height.**

The world Health Organisation BMI scale indicates;

Underweight: < 18.5 BMI

Health weight range: 18.5–25 BMI

Overweight: 25–30 BMI

Obese: 30 + BMI

The problem with BMI is that it does not reflect the changes in body composition when weight changes. Body mass composition indicates what percentage of the body is fat, water, protein, mineral, bones, organs, etc. Malnutrition can be defined as a loss of body cell mass which includes non-fat cellular components of tissues, skeletal muscle, internal organs, blood and brain. The BMI measure does not give you this figure. For example, two people with a BMI of 20 may have different body compositions, one may be suffering from malnutrition and the other may not.

### Warning signs of anorexia nervosa

Contrary to popular myths, most people with anorexia nervosa do eat, just not enough to sustain themselves. Although the term 'anorexia nervosa' is derived from the Greek word meaning loss of appetite, a person can retain an intense appetite and interest in food.

The warning signs of anorexia nervosa can be physical, psychological and behavioural and include:

#### **Physical signs**

- + rapid weight loss or frequent changes in weight
- + fainting or dizziness
- + feeling cold most of the time, even in warm weather (caused by poor circulation)
- + feeling bloated, constipated, or developing intolerances to certain foods
- + feeling tired, lethargic and not sleeping well
- + facial changes to pale looking, sunken eyes, brittle hair

- + fine hair appearing on face and body (bodies response to stay warm)
- + loss or disturbance of menstrual periods in females
- + decreased libido.

#### **Psychological signs**

- + preoccupation with eating, food, body shape and weight
- + feeling anxious and/or irritable around meal times
- + an intense fear of gaining weight
- + refusal to maintain a normal body weight for the person's age and height
- + depression and anxiety
- + slowing down of thinking and an increased difficulty concentrating
- + 'black-and-white' thinking or rigid thoughts about food being good or bad, which extends to feelings of being perfect or a failure
- + having a distorted body image (for example, seeing themselves as fat when in reality they are underweight)
- + low self esteem
- + increased sensitivity to comments relating to food, weight, body shape, exercise
- + extreme body image dissatisfaction.

#### **Behavioural signs**

- + dieting behaviour, for example, fasting, skipping meals, counting calories/kilojoules, and avoiding food groups such as fats and carbohydrates. Becoming a vegetarian is common, but is often more aligned with restricting food groups than for animal liberation reasons. Other radical changes can include suddenly disliking food they have always enjoyed, and reporting of food allergies and intolerances
- + laxatives, appetite suppressants, enemas and diuretics misuse

- + repetitive or obsessive behaviours relating to body shape and weight. For example, weighing themselves repeatedly, looking in the mirror obsessively and preoccupation with looking into the mirror to highlight negative body image.
- + antisocial behaviour, spending more and more time alone
- + eating in private and avoiding meals with other people
- + secrecy around eating. For example, saying they have eaten when they haven't, hiding uneaten food or secret disposal of food.
- + compulsive or excessive exercising and experiencing distress if exercise is not possible, in spite of sickness, injury or scheduled events.
- + obsessive rules, rituals and rigid thinking around food preparation and eating. For example, eating very slowly, cutting food into very small pieces, insisting that meals are served at exactly the same time every day, only eating food that is one colour or eating one colour at a time or not allowing any one else to prepare meals
- + preoccupation with preparing food for others, and with recipes and nutrition
- + self-harm, substance abuse or suicide attempt
- + for binge-purge types, evidence of binge eating with the disappearance or hoarding of food and self-induced vomiting.

low blood pressure; dry skin and hair; brittle hair and nails; hair loss; hypotension; hypertension; anaemia or iron deficiency; low platelet count; low or elevated blood sugars; diabetes; ketoacidosis; kidney infection and failure; osteoporosis; arthritis; dental problems, including decalcification of teeth, erosion of tooth enamel, severe decay, and gum disease; liver failure; bad circulation; slowed or irregular heartbeat, arrhythmias, angina, or heart attack; infertility; depression; anxiety; obsessive compulsive disorder; body dysmorphia; low body temperatures; intestinal problems; cramps; bloating; constipation; diarrhoea; incontinence; abdominal pain caused by ulcers, pancreatitis, and digestive difficulties; weakness and fatigue; seizures; reduced or compromised immune system function; loss of or disturbance of menstrual periods in girls and women; organ failure; and death.

### ***Mortality rates of anorexia***

It is estimated that after having anorexia nervosa for 10 years, 10% will die from the illness. After 30 years, up to 20% will die, a fifth of these from suicide. Death rates for young women aged between 15 and 24 with anorexia, are six to 12 times higher than the annual death rate from all causes. Anorexia has the highest morbidity and mortality of any mental health disorder.

### ***Self harm and suicidal thoughts***

As eating disorders harm your health and body they can be considered a form of self-harm. Other self-harming behaviours and suicidal thoughts are also prevalent in approximately 25% of people with eating disorders. Many also engage in self sabotaging behaviours when not motivated to change. The relationship between harming behaviours is complex and varies from individual to individual. Self-harm was an apparent effect of semi-starvation in the Starvation Study. People who have recovered have identified prolonged regular nourishment as key in reducing suicidal thoughts and self-harming behaviours. (*Self Harm UK, 2013*)

## **What are the risks associated with anorexia nervosa?**

The risks associated with anorexia nervosa are severe and can be life threatening.

People with anorexia nervosa may experience: malnutrition; dehydration; electrolyte imbalances; hyponatremia; refeeding syndrome; languigo or soft downy hair on the face, back and arms; oedema or swelling; muscle atrophy; impaired neuromuscular function; muscle weakness; reflux; oesophagus tears from vomiting; gastrointestinal problems; cancer of the throat or voice box (due to acid reflux disorders); crippling fatigue; hyperactivity; bruising;



## Eating disorders can warp your perception of yourself

Delusional thoughts or excessive concern about a perceived defect in one's appearance can cause psychological distress and hold one back from a quality of life.

Eating disordered thoughts do not always reflect reality. Sometimes we need to trust others for reality checks.

**Surrounding yourself with people who care, others who have recovered and a health professional team of a doctor, dietitian and therapist can really help.**

### Involuntary treatment orders

Anorexia nervosa is a serious mental health problem, typified by the inability to nourish one's body adequately. It is important to be able to support someone to seek help in a way that supports their own agency, which means to support them in making decisions for themselves. Of course treatment will be easier when someone cooperates. However, the pathology of anorexia may not allow this to happen and some people who suffer with anorexia nervosa may refuse to comply with treatment; without intervention some may die from this illness. If someone refuses to go to a doctor for a medical, it can be a sign that they are in denial about their illness or are not motivated to change. In some instances, an Involuntary Treatment Order (ITO) maybe needed to save a life. An ITO is an order made under the *Mental Health Act* by an

authorised doctor for the treatment of a person with a mental illness, without that person's consent. An ITO can authorise the involuntary detention of the person receiving treatment at a mental health facility, or it can authorise community-based treatment.

It is important that the individual and their family understand the *Mental Health Act*, the Mental Health Review Tribunal and Patient Rights under the *Mental Health Act*. The *Mental Health Act* can be accessed at [www.legislation.qld.gov.au](http://www.legislation.qld.gov.au).

The Mental Health Review Tribunal's website is [www.mhrt.qld.gov.au](http://www.mhrt.qld.gov.au). For a flowchart on involuntary assessment and treatment in the Queensland mental health system, see Queensland Public Interest Law Clearing House Incorporated at [www.qpilch.org.au](http://www.qpilch.org.au).

## What is Bulimia Nervosa?

**Bulimia nervosa usually begins after a period of prolonged dieting. The individual may break the diet and binge eat, feeling they have no control over the amount of food they are consuming. The urge to binge is a normal physiological response to starvation. Large amounts of food, usually high in calories are eaten quickly, most often in secrecy.**

As with anorexia nervosa, the person with bulimia nervosa has an extreme fear of becoming overweight and will engage in some form of purging behaviour. This can include vomiting, using laxatives or diuretics, exercising excessively or fasting, as well as following a rigid diet plan. These behaviours throw the body into metabolic chaos and perpetuate the urge to binge. Binging may also occur in response to psychological factors or feelings that are difficult for the individual to cope with, such as depression, loneliness or anxiety. The person can very easily feel trapped in the binge-purge cycle that develops and become depressed, irritable, and feel full of self-disgust, anger and bitterness at their behaviour and lack of self-control.

To be diagnosed with bulimic nervosa using the DSM-5 Diagnostic tool, a person will meet the following criteria:

1. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - a. eating in a discrete period of time (for example, within any two-hour period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
  - b. a sense of a lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating).
2. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

The minimum level of severity is based on the frequency of inappropriate compensatory behaviours (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

**Mild Bulimia:** An average of 1 to 3 episodes of inappropriate compensatory behaviours a week.

**Moderate Bulimia:** An average of 4 to 7 episodes of compensatory behaviours a week.

**Severe Bulimia:** An average of 8 to 13 episodes of inappropriate compensatory behaviours a week.

**Extreme Bulimia:** An average of 14 or more episodes of inappropriate compensatory behaviours a week.

*(American Psychiatric Association, 2013)*

The term 'binge' is used a lot in today's society, and most people would be able to relate to overeating or having a food 'binge' at some point. For people with eating disorders, a binge on food is accompanied by the feeling that the eating is out of control and they cannot stop themselves. The type of food consumed during binges will vary from person to person, and sometimes from binge to binge. However, most people will binge on foods that are high in calories, fat and protein (for example, ice cream, cake, potato chips, chocolate). Binges usually include foods that are 'forbidden' in the dieting regime and take very little or no prior preparation. A binge may start by having one portion of a forbidden food (such as one piece of chocolate) and then the individual begins feeling guilty. Often the 'all or nothing' thought processes mean they decide that as they have ruined their 'good' eating, they might as well continue to over-eat, so starting a binge episode. Individuals



## Break the silence about eating disorders

*I'm a soccer mum and kept my bulimia secret for 10 years. During these years I engaged in harmful behaviours to lose weight.*

*Telling someone supported me to deal with depression, accept my body and return to regular healthy eating. I learnt that weight was not the most important measure of health.*

**Break the silence and find the strategies you need to recover.**

will also report feeling an intense drive or desire for a binge. They feel their body crave it, and the feelings become so intense that the only way to relieve these feelings is to engage in a binge. Initially, the binge provides feelings of pleasure and relief. However this is soon overtaken by feelings of guilt, self-disgust and loathing, particularly after the binge episode has finished. This will lead the person to engage in some form of purgative behaviour as a way of lessening their physical and psychological discomfort and controlling the fear of weight gain. So the cycle perpetuates itself.

Individuals with bulimia nervosa are generally very ashamed of their eating behaviours and will usually go to great lengths to hide it. Because of feelings of shame and secrecy, individuals will struggle to tell people about their eating problem, because they fear they will be judged, blamed or criticised.

It is not uncommon for someone to have bulimia nervosa for eight to 10 years before seeking help. However a person with bulimia nervosa will often acknowledge that there is a problem and feel that their eating is out of control. Therefore, they are, generally, more willing than the person with anorexia nervosa to seek help.

Unlike anorexia nervosa, most people with bulimia nervosa are within the normal weight range. There is usually a history of weight fluctuation.

Individuals with bulimia nervosa are less likely to require hospitalization, however those with disordered blood chemistry including electrolyte imbalance, nutrient deficiency, chaotic eating patterns or who are depressed and suicidal may still need to be hospitalised.

## What is Binge Eating Disorder?

**Binge eating disorder is similar to bulimia nervosa in that the individual feels a sense of lack of control over their eating, but they do not engage in purging as a means of weight control. The individual can feel overwhelmed with the fear of gaining weight and the consequent physical and medical complications that exist.**

Not all people with binge eating disorder will be overweight. In fact, only about half will be overweight. It is believed that there is a higher prevalence of binge eating disorder than of bulimia nervosa, and more males will have binge eating disorder than any other eating disorder (Fairburn, 1995).

To be diagnosed with binge eating disorder using the DSM-5 Diagnostic tool, a person will meet the following criteria:

1. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - a. eating, in a discrete period of time (for example, within any two-hour period) an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances.
  - b. a sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating).
2. The binge eating episodes are associated with three (or more) of the following:
  - a. eating much more rapidly than normal
  - b. eating until feeling uncomfortably full
  - c. eating large amounts of food when not feeling physically hungry
  - d. eating alone because of being embarrassed by how much one is eating
  - e. feeling disgusted with oneself, depressed, or very guilty after overeating.
3. Marked distress regarding binge eating is present.

4. The binge eating occurs, on average, at least once a week for three months.
5. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa, and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

**Mild:** An average of 1 to 3 episodes of inappropriate compensatory behaviours a week.

**Moderate:** An average of 4 to 7 episodes of compensatory behaviours a week.

**Severe:** An average of 8 to 13 episodes of inappropriate compensatory behaviours a week.

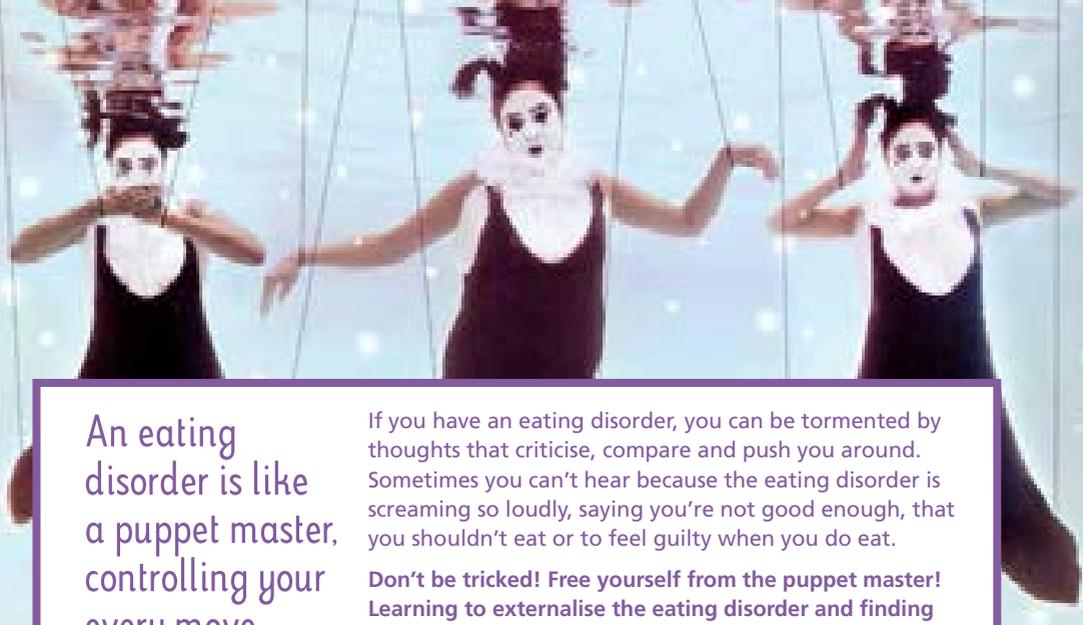
**Extreme:** An average of 14 or more episodes of inappropriate compensatory behaviours a week.

*(American Psychiatric Association, 2013)*



*I'm a lawyer and have been struggling with binge eating for six months.*

**Eating disorders can affect anyone. It's never too early or too late to reach out for support.**



An eating disorder is like a puppet master, controlling your every move.

If you have an eating disorder, you can be tormented by thoughts that criticise, compare and push you around. Sometimes you can't hear because the eating disorder is screaming so loudly, saying you're not good enough, that you shouldn't eat or to feel guilty when you do eat.

**Don't be tricked! Free yourself from the puppet master! Learning to externalise the eating disorder and finding ways to cope with life stressors can be the key to recovery.**

## Other Specified Feeding or Eating Disorder

**This category applies to presentations in which symptoms characteristic of a feeding and eating disorder predominate, and which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.**

The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder.

Examples of presentations that can be specified using the 'other specified' designation include the following:

- + **Atypical anorexia nervosa:** all of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
- + **Bulimia nervosa (of low frequency and/or of limited duration):** all of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory

behaviours occur, on average, less than once a week and/or for less than three months.

- + **Binge eating disorder (of low frequency and/or limited duration):** all of the criteria for binge eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than three months.
- + **Purging disorder:** recurrent purging behaviour to influence weight or shape (for example, self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
- + **Night eating syndrome:** recurrent episodes of night eating, as manifested by eating after awakening from sleep, or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge eating disorder or another mental disorder, including substance abuse, and is not attributable to another medical disorder or to an effect of medication.

## Unspecified Feeding or Eating Disorder

**This category applies to presentations in which symptoms characteristic of a feeding and eating disorder predominate, and which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.**

The unspecified feeding or eating disorder category is used in situations in which the clinician chooses not to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (for example, in emergency room settings).

### Pica

#### **Diagnostic criteria**

1. Persistent eating of non-nutritive, non-food substances over a period of at least one month.
2. The eating of non-nutritive, non-food substances is inappropriate to the developmental level of the individual.
3. The eating behaviour is not part of a culturally supported or socially normative practice.
4. If the eating behaviour occurs in the context of another mental disorder (for example, intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia, or [other] medical condition [including pregnancy]), it is sufficiently severe to warrant additional clinical attention.

### Rumination Disorder

#### **Diagnostic criteria**

1. Repeated regurgitation of food over a period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spat out.
2. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (for example, gastroesophageal reflux, pyloric stenosis).
3. The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia

nervosa, binge eating disorder, or avoidant or restrictive food intake disorder.

4. If the symptoms occur in the context of another mental disorder (for example, intellectual disability [intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

## Aviodant or Restrictive Food Intake Disorder

### **Diagnostic criteria**

1. An eating or feeding disturbance (for example, apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - a. significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
  - b. significant nutritional deficiency
  - c. dependence on enteral feeding or oral nutritional supplements
  - d. marked interference with psychosocial functioning.
2. The disturbance is not better explained by lack of available food or by associated culturally sanctioned practice.
3. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
4. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

*(American Psychiatric Association, 2013.)*

## What is the Overlap of the Different Types of Eating Disorders?

**Anorexia nervosa, bulimia nervosa, and binge eating disorder are the most prevalent eating disorders and are not mutually exclusive.**

**Individuals can move between categories or have characteristics of anorexia nervosa and bulimia nervosa together for instance.**

Such a combination can be extremely dangerous. About half the people with anorexia nervosa have episodes of binge eating and purging, and a significant number of people with bulimia nervosa have a past history of anorexia nervosa.

### Sub-clinical conditions

Many people, particularly adolescent women, become preoccupied with thinness and begin to restrict their food intake and lose weight without meeting the criteria for a diagnosis of anorexia nervosa. Their symptoms may represent an early stage of an eating disorder. Many of these people will go on to lead normal, healthy lives without professional intervention. Unfortunately, at this stage, health professionals are unable to accurately predict who of these individuals will go on to develop a clinically diagnosable eating disorder.

It is advisable for those concerned about such behaviours, either individuals, or their family or friends, to observe the progress of weight loss and other behaviours. These behaviours must be taken seriously during this early stage and if weight loss goes beyond about 10 per cent of the individual's original weight, or if bingeing, vomiting, or laxative abuse is suspected, or if the individual appears to be becoming socially withdrawn, unusually depressed or irritable, professional help should be sought as soon as possible. An eating disorder is not a passing phase that the individual will just 'grow out of'!

### Warning signs of an eating disorder

Significant changes in behaviour and personality are reported most commonly by friends, family and others who come into contact with a person with an eating disorder. A range of behaviours that are

often noticed are listed below. It is important to keep in mind that if you suspect that someone has an eating disorder you are looking for an overall theme. The behaviours exhibited will vary from person to person.

#### *Dieting*

- + not eating as much or as often as usual
- + crash dieting, fad dieting, severe food restriction
- + cutting out complete food groups
- + becoming a vegetarian, without ethical reasons concerning animal rights
- + not eating meals with the family or isolating themselves at meal time.

#### *Unusual eating habits*

- + playing with food
- + cutting food into small pieces
- + using abnormal utensils (for example, a teaspoon to eat cereal)
- + extreme dawdling over meals
- + making unusual concoctions by mixing food together
- + increased condiment and spice use
- + increased coffee, tea, and fluid consumption
- + increased gum chewing
- + refusal to eat with others or wanting to eat in privacy, or in a particular place.

#### *Intense preoccupation with food and eating*

- + collecting recipes, cookbooks and menus
- + obsession about calorie or fat counting, and dieting
- + excessive thinking and conversation about food
- + food-related dreams
- + hoarding of food
- + cooking great amounts for others
- + anger when food is thrown out or others do not eat.

### **Personality, behavioural and intellectual changes (which the individual may or may not recognise)**

- + irritability and mood swings
- + depression, self-loathing and anxiety
- + social withdrawal
- + compulsive behaviour (for example, having to eat from a certain plate, in a certain order, or at a particular time)
- + obsessional, rigid and inflexible thinking: black-and-white thinking, there is no grey
- + difficulty coping with changes in routine and decreased ability to cope with frustration.

### **Other symptoms**

- + difficulty in thinking clearly and making decisions
- + decreased concentration, alertness, judgement, memory, creative capacity and comprehension (for example, difficulty in understanding and recalling written material that once caused no problems)
- + restlessness, hyperactivity, and inability to settle
- + apathy
- + hypersensitivity to noise and light
- + bingeing or perceived overeating
- + stealing and petty theft
- + muscle weakness, decreased coordination and increased proneness to accidents
- + decreased cold tolerance
- + decreased sexual interest
- + difficulty sleeping, lethargy, continual tiredness.

Up to 50 per cent of people with eating disorders abuse illicit drugs and alcohol.

*(Butterfly Foundation, 2012)*

### **Complications of eating disorders**

Eating disorders can have distressing emotional and psychological components. There are also physical consequences that need to be taken very seriously. It is important to remember that most medical complications are reversible, particularly if they are detected early. However, in the worst-case scenario, the consequences of an eating disorder can result in death. It is important that the person with an eating disorder seek help, even if it is only to monitor these physical symptoms. People with anorexia nervosa, bulimia nervosa and binge eating disorder can all experience problems with their physical health.

### **The physical signs and complications of an eating disorder can include**

- + weight loss or weight fluctuation
- + reduced metabolic rate leading to slow heart rate, low blood pressure, reduced body temperature, increased sensitivity to cold and bluish-mauve extremities
- + thinning and drying of scalp hair (hair seems to come out in clumps when being brushed or running fingers through it)
- + dry, rough, cracked skin
- + ridged, broken or cracked nails
- + growth of fine downy hair over face and arms (lanugo)
- + loss or irregularity of menstrual periods
- + muscle wasting or weakness
- + constipation or diarrhoea
- + oedema (retention of body fluid giving a swollen, puffy appearance, especially around the ankles)
- + easy bruising
- + anemia (lack of iron)
- + feelings of 'blacking out' or fainting
- + slowed stomach emptying after meals (leading to a feeling of bloating and discomfort)
- + heartburn and abdominal pain

## Distorted body image and dieting puts people at risk of developing eating disorders

Eating disorders often start with a negative body image and restrictive dieting. Many symptoms of eating disorders are actually symptoms of starvation.



- + stunting of height (if onset is before puberty or in early adolescence)
- + osteoporosis (thinning of bones)
- + salivary gland swelling
- + hypoglycaemia (low glucose level in the blood) that can cause confusion, clouded thinking, shakiness, irritability and extreme tiredness (in extreme cases, the effect of hypoglycaemia can lead to a coma)
- + reduced concentration, memory, abstract thinking, planning and problem solving ability.

### ***Physical problems related to purging methods (for example, vomiting, diuretics, and laxatives) can include***

- + dehydration
- + fluid retention
- + constipation and/or diarrhoea
- + blood chemistry disturbances, which may cause heart rhythm irregularities, impaired kidney function, muscle spasms and cramps, muscle weakness, and in extreme cases, heart failure.

### ***Other physical problems due to vomiting can include***

- + erosion of tooth enamel causing decay
- + chronically inflamed, sore throat
- + hoarse voice
- + bloodshot eyes
- + swelling of salivary glands
- + heartburn and abdominal pain
- + calluses over knuckles if hands are used to induce vomiting
- + stomach and oesophageal inflammation and/or tears, causing pain. this can also lead to vomiting up of blood
- + ruptured oesophagus
- + peptic ulceration.

### ***Other physical problems due to laxative or diuretic use can include***

- + weakness of the bowel muscle causing difficulty in having normal bowel movements if laxatives are suddenly ceased
- + in severe cases of laxative abuse, bowel disease can occur.

## How Common are Eating Disorders?

According to the Butterfly Foundation's 2012 report *Paying the Price. The economic and social impact of eating disorders in Australia*, there was an estimated 913 986 people in Australia with an eating disorder and the socio-economic cost was a staggering \$69.7 billion.

Approximately:

- + 3% of these have anorexia nervosa
- + 12% of these have bulimia nervosa
- + 47% of these have binge eating disorder
- + 38% had other eating disorders.

Accurate statistics are hard to gather as many people living with an eating disorder never seek treatment. It is estimated that only 23 per cent of people with an eating disorder will seek treatment.

The National Eating Disorder Collaboration estimates that 9% of the population will develop an eating disorder at some stage in their lives. Fifteen per cent of Australian women will experience an eating disorder requiring clinical intervention and 90 per cent of people with anorexia and bulimia are female.

**Large international studies estimate that:**

- + 0.5% of males and 1.5% of females have anorexia over their lifespan
- + 1% of males and 2% of females have bulimia over their lifespan
- + 3% of males and 4.5% of females have binge eating disorder over their lifespan.

Most people, including more than 70 per cent of adolescent females, report body dissatisfaction and/or a desire to lose weight.

Young people who diet to a severe level are 18 times more likely to develop an eating disorder.

85% of anorexia cases start between 13 and 20 years of age and most cases of bulimia start between 16 and 18 years of age.

About a third of people with bulimia had anorexia previously.

*Butterfly Foundation, (2012)*

*National Eating Disorders Collaboration, (2013)*



I don't WANT your help, I NEED your help.

*The eating disorder may push you away and hide me from you, but I need your support.*

*Love and support me until I'm me again.*

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# Seeking Help, Recovery and Recovery Strategies

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## Telling Someone

**If you believe you have an eating disorder, it may be useful to your recovery to seek support. Telling someone can be difficult, especially for the first time. You may feel scared, embarrassed, guilty or ashamed. Possibly, you may also feel afraid of the person's reaction. However, the only way to know how someone will react, is if we take the risk and tell them. It can be useful to remind yourself of the benefits of telling someone, such as getting support, not having to hide a secret anymore and getting well.**

Consider telling someone who you feel you can trust or are comfortable with such as a friend, a family doctor, a family member, your partner, your teacher, school nurse, a guidance officer, or a community worker. People will have varying reactions; some may be surprised, uncomfortable, confused, worried, or unsure of what to say. Some may have seen the signs and are glad you have told them.

If you have a negative experience telling someone, it is important that you don't let this stop you from telling someone else and getting the professional help and support you deserve.

### **Some suggestions that may be useful when telling someone:**

- + If you are concerned about telling someone such as your family, you may like to have a friend or someone else with you.
- + Phone an anonymous or confidential eating disorder service, such as the EDA. It can be useful to practise the words you may use, and also to see how it feels to admit your problem to someone else.
- + Set the time and place to tell someone when they are not stressed or preoccupied.
- + Write down what you would like to say, or give someone a letter.
- + Prepare yourself for their emotional reaction. Plan how you would like to respond to different reactions, such as if they don't accept what you are saying.
- + Remind yourself that you are only responsible for your own thoughts, feelings and actions, not other people's. You are not responsible for their pain, anger or guilt.
- + Give the person some information about where they can seek information about eating disorders, like the EDA.
- + Remind yourself of the importance of telling people. This process is often a valuable way to find out who will be your support network through your recovery.

## How to Approach Someone with an Eating Disorder

### Get information about eating disorders

Initially, if you suspect someone has an eating disorder, it is most helpful to seek out accurate information about the illness. This will usually confirm your suspicions, but also provide you with information that will support you in approaching the person.

### Make a time to discuss the eating disorder

The next step is to choose who would be the most appropriate person to make the approach, and what would be the most appropriate time. It is important that you approach your child or the person you are concerned for, in a loving way, directly expressing your concerns for their health and the fact that you are worried about them. You do not want to be accusing, or to allow the situation to turn into an argument. Initially, the point that you want to make is that you believe there is a problem; you think it may be an eating disorder; you are concerned for them; and you will do your best to support them in getting help.

There are usually two kinds of responses at this time. One is a positive response, the person is relieved that you have discovered the problem and would like your help. At this point, different types of treatment and therapy can be discussed, and this is likely to be most successful when the individual feels as though they have the most control over the process.

The other response, and usually the most common, is the denial of any problem, or defensiveness. The person can then become aggressive or more isolated. If this happens, it is important to remember that the person you care for may be feeling guilty and ashamed. They may fear that because you know their secret you won't like them anymore, or that you will be disappointed in them. Acknowledge any emotions or behaviours that arise with understanding, but do not be ruled by them. If the disorder is affecting their life, or that of your family, you have the right to be concerned and support them to seek treatment. Also, keep in mind that the person may even be relieved that you

While no one can walk the pathway to wellness for you, it is important to remind yourself that you do not have to walk this path alone. Support and understanding from those around us can be a powerful tool in recovery, especially because living with an eating disorder can be so isolating. Opening up and sharing the journey with those who care about you, will no doubt help you to break free from this isolation; the less isolated you feel, the less shame exists about the disorder. Ultimately, you will discover that the benefits you get from opening up to people who can provide you with the positive support that you deserve, far outweighs the loneliness, isolation and shame that are often experienced with an eating disorder.

Remember that whatever support you choose — family, friends, professionals, recovery groups, programs or other avenues — the connections you make should be empowering and helpful, and if they aren't, then tell someone else and make other connections. Seeking a supportive helpful network of family, friends and health professionals can be vital to recovery.

**In order to heal, you must eat every meal.**

**Being strong isn't being able to starve yourself. Being strong is being able to deal with your eating disordered thoughts, rather than the thoughts controlling you.**

**Eating adequate, regular nutritious meals is key to recovery.**

have expressed concerns, even if they are unable to tell you this. Don't be surprised if your child, or the adult with the eating disorder behaviours, denies the problem — it can be seen as part of the illness. It is best not to get into an argument about it at this point, and instead take some time out and set another time to raise the issue again. The first goal is to seek medical advice; there is no harm in receiving a medical opinion and it is quite normal for people to have regular check-ups with their doctors.

Common traps include trying to force the person to eat, cooking all their favourite foods, constantly watching them, and asking questions about their food intake and the like, without professional guidance. Meal support is very useful and is best done with professional guidance so that you and the person in your care can work together to return to regular, adequate nutrition. Another trap is to believe that because you can see the dangers of the eating disorder, the person with the eating disorder will, too. Unfortunately the reality is that the person themselves may need support to come to the point where they are prepared to accept that they have a problem and that they want to change it.

### **Going to a doctor, when to call an ambulance and hospitalisation**

If you suspect your child might have an eating disorder, take them to your family doctor or paediatrician right away. You've known your child since birth; the minute you have any concerns, trust your instincts. If the person you are concerned for is an adult, encourage them to see their doctor and perhaps offer to go with them. The EDA have a GP Information Kit available for your local doctor to download for free from our website: [www.eda.org.au](http://www.eda.org.au).

Some people with eating disorders may need to be hospitalised if they have become medically compromised. If admission to hospital is necessary, it should be to a unit that has experience and expertise in helping people with eating disorders. It is common for such a unit to be part of a psychiatric ward, where staff have specialist knowledge.

**If you believe someone is in serious medical danger, do not hesitate to seek outside help immediately. Call an ambulance if someone's pulse is less than 40 beats per minute (BPM) for adults or 50 BPM for children and adolescents and/or their temperature is less than 35.5C. Eating disorders pose a serious threat to life. Act as soon as possible.**

It is not realistic to expect a person to recover from anorexia nervosa while they remain underweight. However, achieving 'goal weight' is only the beginning step of recovery and is best done with the supervision of health professionals. Therapy directed at changing the individual's attitude towards themselves and their bodies, and improving their general coping skills, is also very important. This is best done after re-establishing the individual's nutritional status, which needs to be done to rectify chemical imbalances and other health problems caused from malnutrition. Individuals with bulimia nervosa are less likely to require hospitalisation, but those with disordered blood chemistry, whose eating pattern is chaotic, or who are depressed and suicidal may also need to be hospitalised.

Eating disorders are very complex problems and recovery can often be a lengthy process. Making change is difficult for most people as there are often very intense fears about what might be the result of change (for example, 'I will lose control completely and become grossly fat', 'I'll be a nobody', 'I won't have any other means of coping with life', 'This is the only thing I'm good at and it will be taken away from me'). The person needs to be regularly assured that recovery and a much happier and more satisfying life is possible.

## Recovery

**One of the best ways to find out what recovery means is by sourcing personal recovery stories. While recovery is different for everyone, there are some common themes.**

Recovery can be about the absence of problematic thoughts and behaviours. For example, not bingeing, purging, taking laxatives or obsessing about the calorie content of food. Recovery can also be about the presence of certain thoughts and behaviours. For example, being happy with one's body, being able to eat in the company of others or being able to exercise moderately. Recovery is not necessarily an end point. It can mean being able to manage eating disorder thoughts, rather than feeling the eating disorder thoughts control you. Recovery steps are often very private experiences for the individual that can lead to a wonderful sense of liberation.

The science of neuroplasticity has discovered that our thoughts can change the structure and function of our brains. Changes can be difficult because often what stands in the way is escaping from old ideas, patterns of behaviour and habits, which may have created neural pathways in the brain. Recovery can mean creating new neural networks and from physical, psychological, behavioural and social changes.

**Physical Recovery** from an eating disorder is important, and can include weight restoration, return of menstruation, stabilisation of electrolytes, identifying hunger and satiety signals, addressing gastro problems, among a range of other physical indicators of good health. Physical recovery is particularly important when someone is medically compromised and is often needed before psychological recovery can take place.

**Psychological Recovery** from an eating disorder can include a decrease in obsessions related to weight and food, being able to eat regularly, adequately and nutritionally from a variety of food groups without guilt, being able to manage eating disordered thoughts and learning self-acceptance or a positive body image.

**Behavioural recovery** can include no longer restricting meals, bingeing, purging, taking laxatives,

calorie counting or measuring weight. It often includes being able to eat all kinds of food without reservation or regret, eating out, eating what you want, when you want with no rigid structure or meal plan, not spending hours in front the mirror etc..

Eating disorders can often isolate individuals and **social recovery** can mean reconnecting with friends and family again and to be able to eat socially and spontaneously. For some it can literally mean the choice to live.

Some common statements from people who have recovered include:

- + "I no longer have a fear of food or the need to control it."
- + "I don't feel bad about what I eat."
- + "I can eat with my friends and family."
- + "I never even contemplate bingeing or purging."
- + "I don't have to use food as a coping mechanism."
- + "I don't overeat because of stress."
- + "I am satisfied with myself and my body."
- + "I'm not obsessed with food or calorie counting"
- + "I'm not obsessed with thoughts about excessive exercise"
- + "Other things preoccupy my mind, not food"
- + "I can respond positively to my eating disorder thoughts"
- + "I choose to eat my food mindfully"

Recovery can be about discovery and learning more about yourself, finding ways to cope and changing problematic behaviour to reach your potential. Recovery can mean that you fight hard to have access to life, citizenship, work and community and to feel you belong and are worthy. Recovery looks different for each individual because we are all unique. For some, life stressors can reignite eating disordered thoughts and behaviours and there has to be an effort put into re-engaging with recovery strategies. For others, there may be occasional eating disordered thoughts or urges that are easily managed when they arise. For many, recovery is living again, without disordered thoughts and behaviours.

*Anna M. Bardone-Cone & Christine R. Maldonado (2008)*

## Recovery Strategies

**Recovery is always possible regardless of your age, gender or length of illness. It often involves finding a supportive network that can help you with strategies for change. Change can take time as it can mean trying different strategies until you find the ones that work for you. Write your strategies down and put them in a visible place so you can access your list readily when you need. The important thing is not to give up. Help is available. You are worth it.**

### Health team and support network

Surrounding yourself with a supportive network of friends, family and others who have recovered, as well as a team of eating disorder health professionals, can be vital to recovery. It is important that you are honest about your thoughts, feelings and behaviours with your health team and support network, so finding a therapist you trust is important. The EDA encourages those dealing with eating disorders to be medically monitored by a doctor, to consult with a dietitian or nutritionist for nutritional advice, and to work on underlying issues with a support worker, counsellor, or therapist. Steps to recovery may include addressing the social factors, risk factors, difficult emotions and triggers that may have contributed to the development of the eating disorder and sometimes the cause is so complex that you begin recovery by addressing the most pressing problems. Recovery begins as soon as you reach out. Sometimes a diagnosis of an eating disorder is needed in order to access public health services and/or rebated health rates. The EDA can provide you with eating disorder information and support, a referral list of eating disorder health professionals in Queensland and connect you to others who have recovered. The sooner treatment is sought, the quicker your quality of life is returned, creating better outcomes for you and your family.

### Eating disorder information

Finding out about eating disorders and recovery experiences can be very useful to help understand what is likely to be going on for you and to provide you with strategies for your own recovery. There

are loads of books and information available about eating disorder recovery. The EDA has a specialist library, eating disorder resources and sells books that you and your family may find beneficial.

### Connect with others who have recovered

Connecting with people who have recovered can provide you with hope. You are not alone. You are valuable and there are many people who have recovered that care and are willing to share their experiences with you. The EDA has a peer support network advertised in their monthly newsletter.

### Don't give up, learn to express yourself

Recovery may take time and hard work, but it will be worth it! What's important is not to give up. Learn to develop the ability to be assertive, so that you can express yourself to those around you.

### Journaling

Writing a journal can be useful to recovery and assist in clarifying your thoughts, feelings, emotions and behaviours. A journal can help you to get to know yourself better, and to mark your recovery progress. What you write, draw or create in your journal can remain private, or you can choose parts to share with loved ones or your health professionals. You could try to write down all the ideas, thoughts, demands and behaviours of your eating disorder to see how it is negatively affecting your life. You can write about how you are now ready to find more positive ways to cope. You could also write all the things you would like to be able to do that you're the eating disorder took away. Draw your future. Paint your dream. Create a poem. No matter what you express, it is very therapeutic.

### Throwing away your scales

If you need to know your weight for recovery, get a health professional to gauge how you are doing. Responding to a number on a scale can bring with it negative feelings, anxiety or eating disordered thoughts that dictate how you respond to a number. Throw the scales away to help you see that you are worth more than a number on a scale. You are more than a measurement!

## Improving your nutrition

Certain nutrients can improve your chances of recovery from an eating disorder. For example, for some women who develop eating disorders, the ovaries become dormant and there is a high risk of infertility. Women are born with all their eggs for potential children and every attempt must be made to maintain nourishment of the eggs to restore fertility. Harvard researchers (*Jorge E. Chavarro, et al., 2007*) have found drinking a glass of whole milk, having a small dish of ice cream or full-fat yogurt every day significantly aids in the recovery from infertility. Low-fat products do not show this benefit, and in fact may have a negative affect. Your doctor and nutritionist can give advice on the best nutrition for your specific physical and psychological recovery. Hippocrates said, 'Let food be your medicine,' and nowhere is this more apparent than in the treatment of eating disorders.

## RAVES model of eating disorder nutritional recovery

The RAVES model of nutritional recovery includes:

**Regular** eating, **Adequate** eating, eating a **Variety** of food, **Eating socially** and **Spontaneously**.

Your support team can help you to regularly eat an adequate amount of nutritious food in the first instance. Over time you can broaden the scope of your food from "safe" choices to then be able to eat socially and spontaneously, as the effects of malnourishment and eating disordered thinking and behaviours subside. It is wonderful to see someone's personality return through good nutrition. Please see more about nutritional therapy in the Treatment Options section.

## Relaxation techniques

Relaxation techniques that help with stress, anxiety and depression are wonderful skills to assist with eating disorder recovery. Any techniques that can help people to become observers of their own mind and to become aware of their thoughts and their feelings, without having to act on them in problematic ways are useful lifelong skills. Learning how to give yourself the space to observe incessant eating disordered thoughts and let them pass, or be able to direct the focus of your mind, can be very empowering.

## Gratitude diary and positivity

Keeping a gratitude diary is a way to shift focus from a negative and deficient way of thinking to a more positive way of thinking. Having a positive mental focus can assist in positive behaviour change and so it helps to practice positive thinking. Writing down things that you are grateful for can help, such as "I'm glad the sky is blue today," "I am glad the bus came on time," or "I am enough". You can also incorporate positive sayings to help with changing specific behaviour. For example, you may decide that with every meal you say aloud "I'm glad I ate that" or "in order to heal I must eat every meal" or "eating slowly will help me get back in touch with my hunger and satisfaction cues". Practice flipping negative thinking into positive thinking. So when a thought comes that says you are getting fat when you need to weight restore, that negative thought can remind you to see yourself as engaging in weight restoration, blossoming, becoming a woman or taking the steps you need to get well. Writing down positive flips to eating disorder thoughts can help.

## Distractions

Sometimes using distractions can encourage change. For example, dealing with anxiety after a meal can include positive distractions like walking the dog, calling a friend, watching tv, engaging in some craft or focusing on your breath. Simple changes can help to break old habits and create new ways of being.

## Visioning yourself well

Having a projected vision of yourself as being well and a vision of what you would like to see for your future can be helpful.

## Having fun and connecting with others

Eating disorders often don't allow us to participate in activities that bring us joy or connect with others. Recovery is the time to reconnect to things that bring you joy and to your community. It might take a while to find something you really connect with, but you can have fun trying different things along the way. Write a list of activities you'd like to try, and tick them off as you do them. Reconnect with family and friends, or find community activities to



## Recovery from an eating disorder is possible

There is always hope for recovery from an eating disorder, and people who can offer support.

No one chooses an eating disorder but you can choose to recover.

**Don't give up! Choose life — choose recovery!**

engage in that foster a sense of belonging. Painting, bush-walking, having a massage, meditation, being surrounded by nature, joining a book or movie club, learning to play an instrument, learning to relax or simply appreciating the sun on your face again.

### Letting go of perfectionism

Being perfect is an impossible goal because no one is perfect. Recovery can be about letting go of the need to be perfect, and also letting go of the idea that you're a failure if you are not perfect. Instead of all-or-nothing, black-and-white rigid thinking, there are shades of grey or what some refer to as rainbow thinking. Rainbow thinking can mean having numerous options instead of only two and

having access to all our feelings. It means believing that good enough is good enough.

For example, if you have rigid thinking about food, like bread is a 'bad' food and salad is a 'good' food, you may attempt to eat a lot of salad and no bread (You can substitute bread and salad for any food considered "good" and "bad"). Feeling deprived, you may eventually find yourself binge eating on a whole loaf of bread. Stuffed and ashamed, you vow never to eat bread again until you give in to self-imposed restriction and deprivation, and binge again. And so the cycle continues. Instead, you could have one sandwich, you deserve to have one sandwich, and one sandwich will not make you fat. Having a sandwich instead of no bread at all

or a whole loaf of bread, is an example of rainbow thinking. If you apply this flexibility in many areas of your life getting used to being perfectly imperfect, the journey can become much easier and more enjoyable.

### Externalising the eating disorder

Separating or externalising the eating disorder from your true identity is a helpful and powerful strategy. Externalising the eating disorder can help you understand that you are not the problem. It can be useful to see the dominating eating disordered thoughts and behaviours as the problems that need to be addressed. The process of externalisation removes blame and empowers you to make change. The message behind externalisation is: 'The person is not the problem, the eating disorder is the problem.'

It is useful for families to create a common term for the eating disorder to assist with recovery. Referring to the eating disorder as *The Illness*, *Anna*, *Ed*, *Mia*, *Negative Thoughts*, the *Negative Self* or another name, can give families a way of communicating about the eating disordered thoughts and behaviour. At the same time encouraging positive thoughts, those of the healthy self or the true self, can help with recovery.

Externalising can be a difficult concept to understand, but it is very helpful in maintaining boundaries, keeping people safe and open to change. The use of externalising can help to acknowledge positive thoughts and build up non-eating disordered behaviours. As a first step in this process you might find it useful to compare and contrast the eating disordered and non-eating disordered thoughts and behaviours and how they impact in different areas of your life. It can sometimes be hard to consider the possibility of having thoughts and feeling being separate to your eating disorder, especially if you have been with an eating disorder for a significant amount

of time, but it is possible to loosen or shift the influence that you're eating disordered thoughts and behaviours have on you. Externalising the eating disorder thoughts and behaviours and acknowledging helpful thoughts and behaviours can be the start of understanding the issues you need to focus on for recovery and to reclaim your life that has been overshadowed by the eating disorder.

### Non-harming Strategies

Self-harm and eating disorders can be seen as ways to cope, block out or release intense feelings or emotions like grief, anger, shame, worthlessness, loneliness or as an expression of self-punishment or self-hatred. Some use self-harm as a punishment for not sticking to the strict rules created around eating, or to provide relief from those constraints. The relationship between self harm and eating disorders is complex and finding other non-harming coping strategies to deal with difficult feelings, emotions and life stressors can be key to breaking free from the harming cycle. (Self Harm UK)

### Managing Difficult Emotions

Learning to identify, feel and manage difficult emotions is so important and how you do this will look different for each person. Talking with others who have recovered often reveals some commonalities. For example, for those who need to restore weight, learning to come to terms with feeling full and intense anxiety requires developing and practicing strategies to manage these feelings.

### Eating Regularly and Slowly

Eat regularly and slowly to connect with your body's own hunger and satiety cues. It takes about 20 minutes for your food to fully digest and to send messages that you are satisfied. Your body will tell you when you are hungry, when you are satisfied or full, if you learn to listen. Pausing throughout your meal to become more mindful of your body's cues can be useful. Eating when really hungry means we tend to eat more quickly, not taste our food and eat more than we need, because our satisfaction cues haven't had a chance to respond to the digested food.

Food tastes better when we are hungry, not starving; the more we eat, the less tasty food becomes. Eating until full can also make us feel uncomfortable and not feel so good about ourselves. Eat slowly and enjoy every mouthful. How much you should eat depends on your body's energy needs, which is different from one person to the next. Eating slowly is a positive behaviour change to help you eat when hungry, not starving and stop when satisfied, not full. Regular eating also helps with gauging hunger cues. People with anorexia nervosa may need to eat more quickly and feel temporarily uncomfortable after eating as part of their recovery.

### Positive body image and holistic health

Shifting thoughts from self-hatred to self-love, can go a long way to contributing to a holistic health for all people. Valuing of all human beings regardless of gender, culture, size and shape, promotes positive body image and body diversity. Behaviours fostered by low self-esteem often do not lead to positive health outcomes and the cycle of poor health can continue. Positive health changes are more successful when initiated from positive self-esteem. Anybody can take steps towards improving their health and these steps will be different for different people. Weight is one measure of health among many, not **'the'** measure of health. For holistic health, some people may need to get more sleep, others may need to do more exercise, or work on their mental health. For others, reducing their blood pressure, taking more vitamin B, learning how to deal with anxiety or learning self-acceptance will be the key. Holistic health messages need to be for everyone. When people want to take steps towards improving their health, we need a cultural shift from 'I need to go on a diet' to 'I need to drink water, regularly eat a variety of nutritious foods adequate for my body's energy needs, do regular exercise for my body type, get good sleep and foster positive thinking'. Drinking lots of water, healthy adequate eating, addressing mental health concerns, promoting self-love and the idea that everybody is valuable are all part of an holistic approach to health.

### Recovery Strategies for Carers

People who develop eating disorders are often labelled 'anorexic', 'bulimic' or 'binge eater' rather than someone who is suffering from an eating disorder. By labelling someone as their eating disorder we are ignoring the fact that they are individuals with their own personalities, values, beliefs, ideas, experiences, and that there is always a part of every person that wants to make healthy choices. The healthy self and positive thoughts are often silenced when eating-disordered thinking and behaviour dominates.

Useful questions and phrases to consider when helping a person separate from their eating disorder include:

- + You have to eat this meal as planned by your dietitian to get well. I know that must be hard for you, but those negative thoughts will pass.
- + What did the eating disorder say to trick you into skipping lunch?
- + How did 'Anna' make you do that?
- + It sounds like the eating disorder is taking a lot away from you.
- + How are the eating disorder's values different to your own values?
- + What does ED tell you about yourself?
- + When is ED most likely to take advantage of you?
- + If you had to look after a child and were responsible for giving them dinner and they refused to eat, what would you do?
- + Is that you or the eating disorder speaking?

Such questioning is designed to help the individual gain distance from the eating disorder problem. To be able to distinguish between what they think, feel and believe about what the eating disorder part of them is saying and what the 'healthy self' thinks, feels and believes.

Supporting someone with a mental illness can be a process of negotiation. Support offered should include a space for listening, information exchange, encouragement and validation for someone's experience and decisions. It is a process where you walk side-by-side with someone on their journey, where you explore problems in an environment that allows self-healing or recovery to occur. Create an environment that fosters motivation to change.

## Understanding the Stages of Change in the Recovery Process

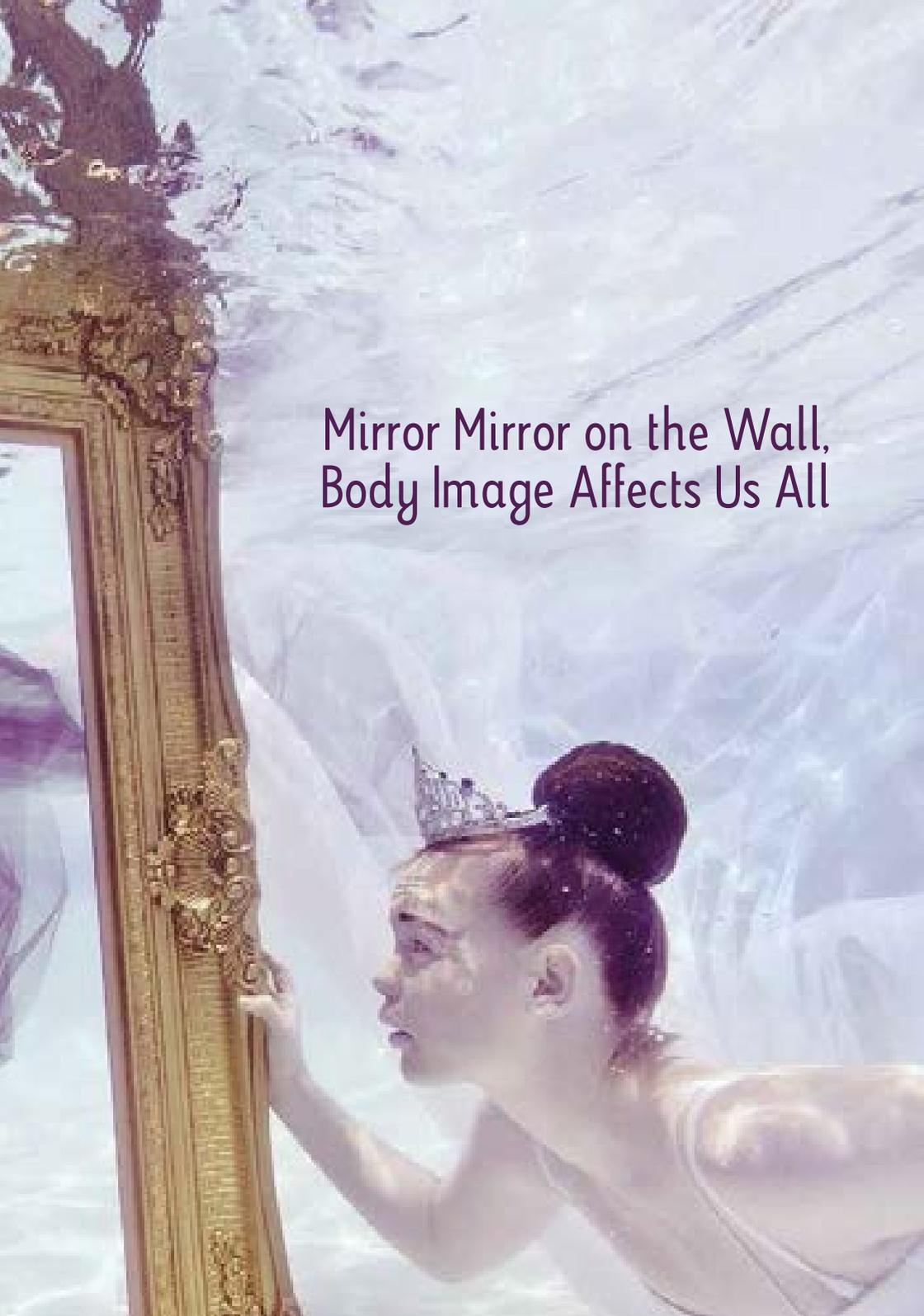
STAGES OF CHANGE	PERSON WHO HAS DEVELOPED AN EATING DISORDER	CARER
<p><b>Pre-Contemplation Stage</b></p>	<p>The person does not believe they have a problem.</p> <p>Refusal to discuss the issue and deny needing help.</p>	<p>Others can see eating disorder behaviours exhibited like restrictive eating, bingeing, vomiting, over exercising or pre-occupation with weight and appearance.</p> <p>Trust your instincts.</p> <p>Carers should educate themselves about eating disorders and share this information with their loved one, highlighting the harmful effects of the disorder on their health and the positive aspects of change.</p> <p>Understand the signs and symptoms of an eating disorder and avoid rationalizing eating disordered behaviours.</p> <p>Openly share your thoughts and concerns with your loved one and take them to a doctor as soon as possible.</p>
<p><b>Contemplation Stage</b></p>	<p>Person is willing to admit they have a problem and open to receiving help.</p> <p>Find a treatment team (GP, Dietitian and therapist).</p> <p>Fear of change maybe strong.</p> <p>Therapist can assist in helping the person to discover the function of their eating disorder, why it is in their lives and how it no longer serves them.</p> <p>Start to list the pro's and cons of the eating disorder, to see clearly in what ways it has helped and in what ways it has hindered you.</p> <p>As you find other ways to cope, you will see that they way it hinders you far out weighs the way it helps you.</p> <p>Write down the things you identify as negative eating disorder thoughts and behaviours and those thoughts and behaviours that come from self care.</p>	<p>Take you child to see an eating disorder specialists.</p> <p>If your loved one is an adult, encourage them to seek specialist help.</p> <p>Try not to "fix" the problem yourself.</p> <p>Educate yourself more about eating disorders.</p> <p>Encourage your loved one to write down the pro's and cons of the eating disorder and to distinguish between negative eating disordered thoughts and behaviours and healthy self caring thoughts and behaviours.</p> <p>Be a good listener.</p> <p>Seek support for yourself from eating disorder services or support groups for family and friends.</p>

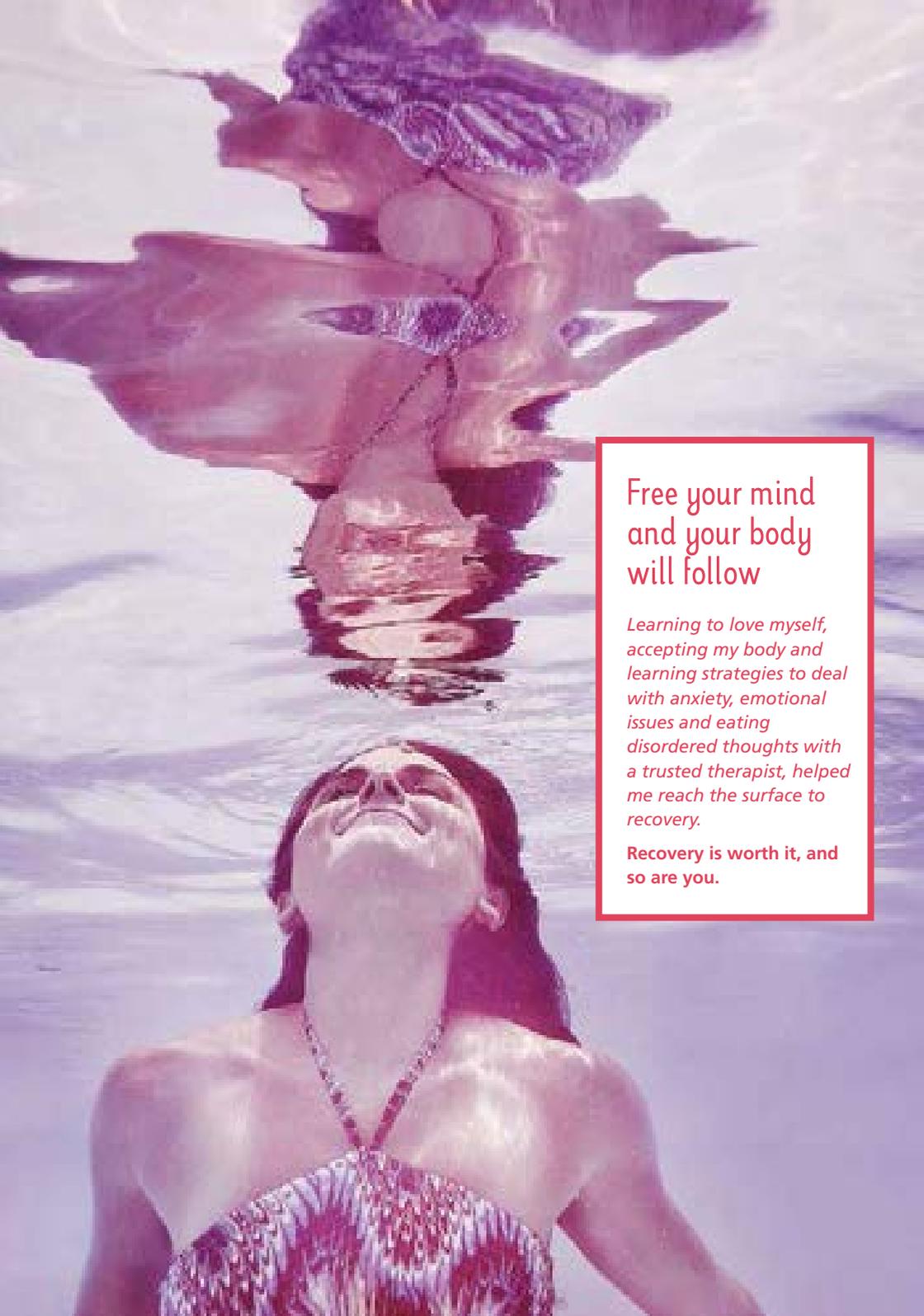
*Some stages of change information sourced from Sarah R. Brotsky, (2009)*

STAGES OF CHANGE	PERSON WHO HAS DEVELOPED AN EATING DISORDER	CARER
<p><b>Preparation Stage</b></p>	<p>Ready to change but not sure how to do it.</p> <p>A plan of action is developed with a treatment team (GP, Dietitian and therapist) and carers.</p> <p>Finding people or services to call in times of crisis.</p> <p>Time is spent finding strategies and coping skills to deal with negative eating disorder thoughts, emotions and behaviours.</p> <p>Potential barriers to change are identified.</p>	<p>Identify your role in the recovery process.</p> <p>Explore your own beliefs about food, weight and appearance.</p> <p>Ask your loved one and the treatment team how you can be involved in the recovery process and what you can do to be most supportive.</p>
<p><b>Action Stage</b></p>	<p>Person begins to implement their strategies, try new ideas and new behaviours and to face fears in order for change to occur.</p> <p>Trusting treatment team and support network.</p>	<p>Follow treatment team's recommendations. Know what strategies they are trying to implement and support them to do that.</p> <p>Remove triggers from your environment like scales.</p> <p>Be warm and caring with you rloved one, yet determined with rules, guidelines and boundaries in dealing with the eating disorder. For example if you have the important role of meal support, you have to be able to be firm and follow the treatment plan at the same time as acknowledging the difficult work in changing behaviour. "You have to eat this meal, I know that will be hard for you, but this is what you have to do to get well and I'm here to support you to get well". Reinforce positive change without focusing on weight, shape or appearance.</p>
<p><b>Maintenance Stage</b></p>	<p>This stage is actively practicing new behaviours and new ways of thinking, using self care and coping skills. When the person has found strategies that work and has sustained change for 6 months or longer they can find new areas of interest and begin to live life in more meaningful ways. It sometimes involves revisiting potential triggers in order to prevent relapse.</p>	<p>Keep being supportive.</p>



Mirror Mirror on the Wall,  
Body Image Affects Us All





**Free your mind  
and your body  
will follow**

*Learning to love myself, accepting my body and learning strategies to deal with anxiety, emotional issues and eating disordered thoughts with a trusted therapist, helped me reach the surface to recovery.*

**Recovery is worth it, and so are you.**

## Treatment Options

### Getting help and Choosing the Right Health Practitioner

**It is important to find the right eating disorder health professionals to help you in recovery. The EDA can assist you in the process of seeking help and choosing the practitioner who is right for you. We have a list of eating disorder health professionals in Queensland, including general practitioners, psychologists, counsellors, dietitians, eating disorder services, well-being coaches, psychiatrists, social workers, and so on. We also provide a monthly newsletter advertising support groups, and peer and carer opportunities throughout Queensland. What we have tabled here are things that may help you in finding your health professional team.**

#### ***Questions that may be useful to ask a practitioner:***

- + Do you think you can help me?
- + What do you know about eating disorders and what is your particular philosophy on them?
- + What type(s) of treatment do you use and in what ways will they help me?
- + What alternatives do you have if this recommended treatment doesn't work out?
- + Are you up to date with the latest research and treatments on eating disorders?
- + How much experience do you have in treating eating disorders?
- + Have you treated someone with the particular eating disorder that I have before?
- + How long and how frequently do you suggest we meet? What happens if I have a setback during treatment?
- + What are your fees and are they negotiable? Can I contact you after hours if I need to?
- + How do you protect client confidentiality? Who, besides you, will have access to my files?

#### ***Questions you may like to ask yourself, and to make note of when choosing a therapist or other health practitioner:***

- + Do I feel safe and comfortable with this person? Do I feel that my ideas and concerns are listened to and respected?
- + Do we agree on the nature of the eating disorder? Do the practitioner's goals of treatment match my own goals?
- + Do they have the right qualities to be my practitioner, such as being friendly, honest, supportive, non-judgemental?
- + Is this person willing to answer my questions?
- + Is this practitioner prepared to include my family in the treatment process (if that is important)?
- + Has this person got something to offer me, and do I feel supported and encouraged?
- + Am I willing to work with this person? Do they support my own agency (my own decision making) in my own recovery?
- + Does the practitioner give me the resources I need to make my own decisions about my recovery?

Professional support is an opportunity to have personal awakenings.

- + Be honest. If your therapeutic relationship is not built on trust then you do not have a solid foundation to work from.
- + Let your health practitioner know if their support or therapy is not working for you, or if they are not giving you what you want.
- + Try to take control and be in charge in the session, so that you get to discuss what you want to. State what you need.
- + Honour your progress in recovery. If things get hard, it's OK, it is worth it. Don't give up.
- + Expect setbacks, they are a normal part of recovery. Take them as another opportunity to learn about yourself.
- + Instead of fearing the 'what if' flip those thoughts to 'when this happens, I choose to ...'
- + Your eating disorder is as powerful as you allow it to be. It can work for you as a significant warning signal that your body, mind, or spirit needs some tender love, care and attention.
- + Don't expect your health professionals to do your hard work for you.

Recovery is possible for everyone. Treat yourself and your health professionals with respect.

## Your Rights when Seeking Help

**The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.**

### Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1. Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
2. The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.
3. Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

## WHAT CAN I EXPECT FROM THE AUSTRALIAN HEALTH SYSTEM?

	MY RIGHTS	WHAT THIS MEANS
<b>Access</b>	I have a right to health care.	I can access services to address my healthcare needs.
<b>Safety</b>	I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
<b>Respect</b>	I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
<b>Communication</b>	I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
<b>Participation</b>	I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
<b>Privacy</b>	I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
<b>Comment</b>	I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Rights information sourced from [www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/](http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/)

Ask each health professional you seek to see their client rights information.

### Questions or complaints?

Any concerns about the professional conduct of your health practitioner can be raised with them or their management. You can also call the appropriate regulating body with any questions or concerns.

Queenslanders can expect a more accountable health complaints system following the passing of the Health Ombudsman Bill in Parliament in August 2013. The Health Ombudsman will be appointed to oversee the health complaints management system in Queensland and manage serious allegations against health practitioners. To access the Health Ombudsmen, phone Queensland Health Services on (07) 3234 0111.

For a short time you can still contact the Health Quality and Complaints Commission (HQCC)

Telephone (07) 3120 5999

Free call 1800 077 308 (outside Brisbane)

Email [info@hqcc.qld.gov.au](mailto:info@hqcc.qld.gov.au)

For a psychiatrist, contact the Royal Australian and New Zealand College of Psychiatrists on (07) 3852 2977.

For a psychologist, contact the Australian Health Practitioner Regulation Agency on 1300 419 495.

For a counsellor, contact the Australian Counselling Association on (07) 3356 4255 or 1300 784 333

## Different Types of Treatment and Therapy

**Below is summary of the different roles of health professionals and health systems. Different professionals can assist individuals in different ways.**

You need to assemble your personal support team, which usually includes a GP, a dietitian, and a counsellor or therapist, who ideally communicate with each other in order to provide well-rounded support, and so that procedures like weighing are only done by one person.

### **Hospital system**

If medically compromised, people with eating disorders may need to spend time in hospital. Here are some of the ways that hospital services work:

#### ***In-patient care in hospital***

The main aim of in-patient hospital care is to provide medical care and pharmacotherapy (medication). In the case of eating disorders, the goal is weight restoration, and/or breaking the binge–purge cycle, and improving psychological health.

#### ***In-patient clinics***

In-patient clinics provide a structured and contained environment in which the person with an eating disorder has access to clinical support 24 hours a day. This involves structured programs and usually therapy as well. It is most effective when followed up with an out-patient program.

#### ***Out-patient care***

Out-patient care does not require the individual to be hospitalised.

#### ***Day hospital care***

People for whom out-patient treatment is inadequate may benefit from the increased structure provided by a day hospital program. These programs provide structured eating situations and active treatment interventions while allowing the individual to live at home, and in some cases, to continue attending work or school.

### **Children's Hospital system**

#### ***Mater Child and Youth Mental Health Service (CYMHS)***

Mater (CYMHS) together with the Mater Children's Hospital provides a range of services for children and young people who are experiencing eating disorders depending on the level and type of treatment required. Within our hospital based services you may need to access the Emergency Department, paediatric medical wards and sometimes the CYMHS inpatient unit. If your child or adolescent is well enough to be treated as an outpatient you will be seen at one of a community clinics. Mater CYMHS offers a number of treatment options including the Maudsley Model of Family Based Treatment for Anorexia Nervosa in our community clinics at no cost to families. Our capacity to provide Maudsley Family Based Treatment is limited due to the specialist training required to deliver the model. See our website to find which community clinic you should visit as each suburb is allocated to a different clinic at [www.kidsinmind.org.au](http://www.kidsinmind.org.au). If you require urgent advice contact the Mater Children's Hospital Emergency Department on (07) 3163 8111 or alternatively bring your child to the hospital for an assessment.

#### ***Family Based Eating Disorder Team Clinic***

We are a specialist team which provides family based treatment for children and young people under 18 who have a restrictive eating disorder such as Anorexia Nervosa (AN). We have a once a week clinic at the North West Community Health Centre, Keperra, on Wednesdays. The multidisciplinary team consists of trained health practitioners who work in pairs with the family, and a Consultant Psychiatrist who reviews cases every 6 weeks. The family GP who provides ongoing medical monitoring during treatment is an important addition to the treating team and is a key professional in the young person's recovery.

We provide out-patient family based treatment for families with a young person with a diagnosis of a restrictive eating disorder (e.g. Anorexia Nervosa). During treatment at the FBT Eating Disorders Team Clinic it is a requirement that the child is seen weekly by the GP for at least the first 6 weeks. It is recommended that these appointments be booked as soon as possible and in a block.

Initially the therapists will undertake a family assessment with the purpose of gaining a greater understanding of the context in which the young person lives and to help the family understand the illness their child is experiencing. It is at this point that commitment to the program will be discussed and any potential challenges to treatment are raised. For example, It is generally recommended that the parents and the child have a 2 week break from work/school commitments at the beginning of treatment.

FBT Eating Disorder Team Clinic: 07 3335 8888  
Nundah: 07 3146 2594 Pine Rivers: 07 3817 6380

### ***Child and Family Therapy Unit (CFTU)***

CFTU is a specialist tertiary referral unit primarily serving Central and Northern areas of Queensland.

CFTU's facilities include:

- + a 10 bed inpatient acute care facility for children and young people up to and including 13 years of age
- + a family admission suite
- + a specialist inpatient mental health assessment, treatment and assistance with discharge follow up planning
- + acute and elective (planned) admissions
- + an on discharge follow up services are provided by local services/agencies such as Community Child and Youth Mental Health Clinics.
- + a Royal Childrens Hospital Consultation Liaison Service (C-L)

The service provides highly specialist mental health/psychiatry assessment, treatment and referral support to patients and teams in the Royal Children's Hospital. Both ambulatory specialist clinics and inpatient units are able to access this service. Some specialist areas have regular liaison from the C-L Service to the treatment team meetings. Referrals are made from within RCH to CFTU C-L Service.

### ***Referral***

Referrals are made by CYMHS Community Clinics, Paediatricians, Child Psychiatrists and other agencies throughout Queensland. Referral agencies are supported to remain actively involved during inpatient admission and continue their role as a major service provider following discharge (unless other appropriate referral is made)

Child and Family Therapy Unit Intake Officers  
07 3636 7878 for referral to Inpatient services and consultation liaison services

See section on Family-based Treatment (FBT) for Children and Adolescents with Eating Disorders by Gold COAST CHYMS for more detail about FBT therapy.



The eating disorder almost took my life

*The eating disorder put my life on hold, like my potential was in suspension. However, there are always rays of hope and help available.*

**Most people recover from an eating disorder, regardless of their age or the severity and length of illness.**

## Medical Issues

### Medical practitioners

A qualified medical practitioner holds a medical degree. Medical practitioners are concerned with people's physical health. They may offer a medical examination, medical advice, education and referrals to specialist medical practitioners or therapists. They are also able to prescribe drug treatments such as antidepressants.

### Medical check-ups

There are many physical complications that can result from an eating disorder. Left unattended, they can lead to serious health problems or death. It is important that physical health is monitored,

preferably by a medical practitioner with experience in the area of eating disorders. The body works hard to keep blood stable and some people who are very unwell may receive blood tests that do not indicate a problem. A medical examination should involve several tests, followed by treatment of any medical problems such as loss of period, heartburn, disturbances in heart rhythm, low bone density, and so on. Check-ups from your GP need to be ongoing.

Treatment of medical conditions are too complex to table in this booklet, however we would like to highlight some important information regarding laxative abuse and dental health.

Eating disorders can pose extremely complex medical conditions, exacerbated by the profound effects of malnutrition within the brain. For example, if serotonin levels are inadequate, sleep will be disrupted, often compounding psychological problems. Serotonin is the chemical that makes people feel good. Melatonin is the hormone required for sleep and is formed from serotonin. Serotonin synthesis requires the amino acid tryptophan. Excellent sources include turkey, peas and warm milk. Carbohydrate is required for tryptophan to pass across the barrier that protects the brain, explaining why many people become depressed on low carbohydrate diets. It also explains the cravings for carbohydrates that can lead to binges, because the brain needs tryptophan and believes that eating carbohydrates will allow more tryptophan to be transported into the brain where it is required. The next step in serotonin synthesis requires iron (red meat, eggs), calcium (dairy), folic acid (leafy green vegetables) and vitamin C (fruit, including tomatoes and capsicum), zinc (oysters, pumpkin seeds, nuts) and vitamin B6 (grapes, bananas) in order to form serotonin. To make matters even more complicated, if the body is low in B vitamins (which are required for energy production) the serotonin is stolen to form niacin (vitamin B3).

B vitamins are water soluble, so they need to be replaced every day. Wheat germ, seafood and almonds are good sources. Vitamins A, D, E and K are fat soluble. If one is not eating adequate amounts of fat, these vitamins don't get absorbed, so it can be seen that fat is very important to healthy eating. Contrary to popular belief, cholesterol is actually an extremely important nutrient required for production of all hormones in the body. It is vital in forming cell membranes, facilitating the transfer of impulses from the brain to muscles, and is required for vitamin D synthesis, which is important for strengthening bones and the prevention of osteoporosis.

You can see that if someone is to cut out fats and carbohydrates and not eat a variety of foods, the physical and psychological effects can be profound. One can improve one's chances of recovery from an eating disorder by simply improving the intake of a number of important nutrients. Successful treatment of eating disorders includes close medical monitoring to be able to understand what the body needs to recover from an eating disorder.

**Dr Leanne Barron**

## Medical Complications of Laxative Misuse

The medical complications of laxative misuse depend on several factors, including the type of laxatives used, the amount used, and how long they have been used. Some of the more common complications of laxative misuse follow:

**Constipation:** This may lead people to increase the dosage of the amount of the laxative, which in turn only worsens the constipation problem.

**Dehydration:** Laxatives cause fluid loss through the intestines. Dehydration then impairs body functioning.

**Electrolyte abnormalities:** Electrolytes such as potassium, sodium and chloride are important to life functions. With chronic diarrhoea, electrolytes are drawn out of the body through the faeces. This leads to an electrolyte imbalance in the body.

**Oedema:** Laxatives cause fluid loss. Dramatic changes or fluctuations in fluid balance confuse the body's self-regulating protective mechanisms by retaining fluid. As a result, prolonged laxative misuse frequently leads to fluid retention or oedema.

**Bleeding:** People who misuse laxatives, especially the stimulant-type laxatives, can develop blood in their stools. Chronic blood loss associated with laxative misuse can lead to anaemia.

**Impaired bowel function:** People who misuse stimulant-type laxatives can develop permanent impairment of bowel function.

### How to stop misusing laxatives

Reduce your intake of laxatives gradually, under your doctor or dietician's supervision.

### What to expect from laxative withdrawal

There is no way to predict exactly how stopping laxatives will affect you. For example, the amount of length of time laxatives have been used is not an indicator of how severe the withdrawal symptoms will be. The best way to lessen the unpleasant effects of laxative withdrawal is to prepare yourself for these effects and to develop an action plan for coping in case the unpleasant side effects do occur.

Common side effects of laxative withdrawal are:

- + Constipation
- + Fluid retention
- + Feeling bloated
- + Temporary weight gain

Just reading this list, you can see that laxative withdrawal is especially difficult for people with eating disorders. You already are highly reactive to "feeling fat" and the symptoms of laxative withdrawal only worsen this feeling. To help you get through the process of laxative withdrawal, it is essential to remember that any weight gain associated with laxative withdrawal is only temporary. Symptoms of laxative withdrawal do not lead to permanent weight gain. People have these symptoms ranging from a couple of days to several months.

## Dental Health and Eating Disorders

In the long term, frequent vomiting, malnutrition and excessive sugar intake, can cause dental problems for people with eating disorders. These dental problems can often be permanent, so seeking professional advice is important. If you have concerns about your dental health or someone else's, it is best recommended to discuss this with a dentist.

There are common signs and symptoms of dental problems associated with eating disorders, however some of these may only be identifiable by your dentist.

- + Tooth erosion and tooth loss
- + Chemical erosion of the tooth enamel (increased acidity due to vomiting)
- + Thermal hypersensitivity (which is when your teeth are sensitive to hot and cold)
- + Enlargement of the salivary glands
- + Dryness of the mouth and decreased salivary flow
- + Redness of throat and soft palate
- + Reddened, dry lips, fissures at angle to lips

Tooth loss and dental damage is quite complex and treatment really does need to be tailored to the individual. It goes without saying that regular dental checkups will help to identify problems early before irreversible changes occur.

If you are suffering from an eating disorder, here are some tips on what you can do to reduce any damage to your teeth:

1. Rinse immediately after vomiting
2. Daily brushing with fluoride-containing toothpaste and in some cases using a stannous fluoride.
3. Flossing daily
4. Restoration of teeth with composite resins or crowns
5. Regular dental check-ups

### Finding a dentist

It is important that you find a dentist that you are comfortable with so that you can make them aware why your teeth are the way they are. This saves having to invent stories to account for the deterioration or fragile state of your teeth. You may even like to find a dentist that has some experience in working with people with eating disorders.

### Some other helpful hints

- + Rinse mouth out thoroughly with water and then wait several hours before having anything acidic, such as fizzy drinks and fruit. By doing this and holding back from scrubbing your teeth, it will enable the saliva to have a neutralising effect on the stomach acid, which seeps in the surface enamel after vomiting.
- + Hold back from brushing your teeth and instead rinse your mouth with water or a mouth wash as mentioned above. Those with Bulimia often make the mistake of scrubbing their teeth straight after being sick. Brushing teeth can damage the surface crystals on the enamel layer of the teeth.
- + If you feel compelled to brush your teeth after being sick, avoid using toothpaste, particularly smokers toothpaste. Instead use a tooth brush dipped in water.
- + By eating a piece of cheese or drinking milk can minimise the detrimental effects of acidity on dental enamel. However, if eating these foods is likely to cause you to panic binge, then just settle for rinsing your mouth with water.

*Eating Disorders Foundation of Victoria, 2000*

## Nutritional Rehabilitation and Normalising Eating

**Unless the body is nourished adequately, eating disorder thoughts will persist and the risk of relapse remains high. The aim of nutritional rehabilitation is to restore weight, reduce binge eating and break the binge–purge cycle. Included in this is the correction of any chemical and psychological imbalances caused by malnutrition. Following on, the aim is to normalise healthy eating patterns, which includes working with individuals to help them recognise when they are hungry, satisfied, full, and so on.**

### The role of a dietitian

A dietitian is a health professional qualified in nutrition and dietetics, and has completed a minimum of four years of university study. Dietitians are an important member of the treating team, and can provide nutritional information about a wide range of topics. Dietitians can also assist with the establishment of an eating plan to help support recovery and an improved understanding of the food-body relationship.

The main aim of treatment is to re-establish eating for good nutrition and enjoyment rather than using food restriction and weight loss to cope. Learning how to eat normally again is not the sole solution to treating people with eating disorders; however, it is an important part. The dietitian can provide accurate information about nutrition and weight control to help dispel many food myths held by people. By guiding food choices and behaviours, the dietitian can assist with the return to more normal and relaxed eating patterns.

### The four main goals of dietary management are:

1. To attain normal nutritional status in adults and normal growth in adolescents, and to maintain this over time. For adults, the objective is steady weight gain, or weight maintenance at a weight where the patient is physically healthy and can eat to maintain that weight. For adolescents, the objective is steady weight gain or weight stability so the patient is physically healthy and continues to grow at a normal rate. Height and weight charts are used to recommend the appropriate age-related weight for height.
2. To establish normal eating behaviours, the aims are to:
  - a. include 3 main meals and 2-3 snacks
  - b. have a varied diet with flexibility in food choices. It is also recommended that no food groups be excluded.
  - c. cease binge eating and other abnormal eating behaviours
  - d. learn to eat adequately and comfortably in the company of others and in a wide range of social situations
3. To establish a positive relationship with food, nutrition education may be required to correct misinformation about food and weight and to help patients acquire a basic understanding of their energy and nutritional requirements.
4. To establish a normal response to hunger cues and to satiety cues, some people will need to learn the acceptance of normal bodily sensations.

### Guidelines for normal eating

Below are some guidelines to assist in being able to eat a wide variety of foods in adequate amounts and in a relaxed and flexible manner.

- + avoid weighing yourself
- + plan to eat three meals and two to three snacks a day
- + it is important to go no longer than three to four hours without eating
- + plan the next meal or snack (when and what it will be)
- + aim to eat balanced main meals with a combination of protein foods (such as meat, fish, poultry, cheese, eggs, pulses, nuts), starch (potato, rice, pasta, pastry, bread) and vegetables and fruit
- + choose to serve yourself meals that you would be happy to serve to others (with respect to the type and quantity of food)

- + choose foods you like because you like the taste
- + don't choose foods because of their caloric intake
- + don't allow your eating to dictate where you will go, or to interfere with school, work or family
- + before you start eating a meal or snack, plan what you are going to do after eating
- + when possible, sit down and eat in a relaxed atmosphere
- + enjoying eating out socially and eating in a similar manner to others
- + sometimes eat more of the foods you like and occasionally overeat, for example, Christmas
- + Eating food in a way that you would feel comfortable eating in front of others.
- + use appropriate cutlery and utensils
- + don't divide foods into good and bad
- + don't let food dictate your mood
- + remember in the early stages, not being hungry doesn't mean your body doesn't need food – you need to eat regular meals and snacks for a few weeks or months before your body will send out normal signals.

## Out-patient nutritional management

A person may be seen by a private dietitian, a community dietitian or a hospital-based out-patient dietitian. Any eating disorder can be treated in the out-patient setting. It is important to remember that a dietitian should be part of a treating team and not the sole practitioner for a patient with an eating disorder.

The dietitian will go through several stages for assessment and treatment:

### 1. **Assessment**

A complete nutritional assessment is made. Initially, a food and behaviour diary may need to be kept to help the dietitian and the individual gain insight into the individual's routines and behaviours.

### 2. **Establish goals of treatment**

The aim is to normalise eating. This may or may not involve establishing a goal weight. For people with bulimia nervosa and binge eating disorder, the focus is on normalising eating rather than on weight. Once eating is normalised, weight management can then take place if needed. For people with anorexia nervosa, establishing a plan for weight gain is needed along with normalisation of eating.

### 3. **Work out ways to achieve goals**

The guidelines to normalise eating as outlined above will be worked through. A meal plan may be worked out to establish regular and normal eating patterns. There will be discussion on ways to help avoid any negative eating disorder behaviours, for example, stopping bingeing or purging by using distraction techniques.

### 4. **Regular review**

The individual is usually weighed weekly or fortnightly by a health professional — this may be the dietitian. The patient will see the dietitian regularly to work through any new eating related issues that arise. The dietitian will offer continued support to achieve the goals that have been outlined.

### 5. **Nutrition education**

The dietitian will educate the individual on various nutrition topics to empower the person to correct their dysfunctional eating patterns. Topics often include: the physical and psychological consequences of excessive dieting and malnutrition; the nutrient content of foods; the requirements for increasing weight; the dynamics of energy input; activity and weight control; nutritional requirements for good health and weight maintenance; dangers of purging behaviours; practical advice about cooking and shopping; the relationship between starvation and bingeing.

### 6. **Relapse prevention**

The dietitian will discuss ways to help prepare for future difficulties and ways of coping with these.

## Therapy and Support

**Therapy can be provided by a range of health professionals. When seeking therapy, many people ask about what the differences are between counsellors, social workers, psychologists and psychiatrists.**

The professional difference is in their qualifications, but the model or style(s) of therapy they employ depends on many factors, such as their interests, personal characteristics, specialist-training, and so on. Two practitioners may have the same qualifications (for example, two psychologists) but employ different therapeutic techniques. Because different therapists work in different ways, it is important that people choose someone they feel comfortable working with. Sometimes this can take time, and a person may see several counsellors, psychologists or psychiatrists before they feel comfortable.

### Psychiatrist

A psychiatrist is a qualified medical doctor who has obtained additional qualifications to become a specialist in the diagnosis, treatment and prevention of mental illness and emotional problems. Psychiatrists are able to view illnesses in an integrated way by taking into consideration the related aspects of body and mind. Their focus is on interactions between medical conditions and psychosocial disorders. They are able to prescribe, and monitor the effects of medication and drug treatments, such as antidepressants. Psychiatrists are registered with the Medical Board of Australia, and they may also be a member of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). A referral from a general practitioner, or other medical practitioner, is required.

### Psychologist

Psychologists must have completed a general degree in Psychology, postgraduate studies (usually specialising in a particular area) and two years of supervised practice to be accredited by the Australian Psychological Association. A psychologist

has specialist skills in seeing how the physiological and cognitive processes underlie behaviour. Psychologists use a client-focused non-judgemental, empathetic approach to assist clients in making decisions regarding their life. Psychologists use a range of approaches and can provide counselling for a varied client group. Ideally, a psychologist should be working alongside a medical practitioner to ensure the physical components of the eating disorder can be monitored.

### Social worker

A Social Worker is a qualified professional who works directly with the individual and their environment, incorporating their living situation, relationships, financial resources, employment, and health for assessment and psychological intervention. Social workers must have completed an Australian Association of Social Work (AASW) accredited Bachelor of Social Work degree or Master of Social Work (qualifying) for entry into the profession of social work, and to meet the minimum eligibility requirements for AASW membership. An accredited mental health Social Worker is qualified to provide focused psychological strategies with a range of approaches and can provide counselling to individuals, couples and families as well as family therapy, group therapy, and facilitation of self help and support groups. An Accredited Mental Health Social Workers (AMHSW) has a specific breadth of experience in assessing and working effectively with people experiencing mental health problems including: eating disorders, depression and other mood disorders anxiety disorders, psychosis, relationship problems, adjustment issues, family conflicts, personality disorders, suicidal thoughts, life crises, and trauma. Accredited Mental Health Social Workers are eligible to hold a Medicare Provider Number and access referrals and rebates under several government funded programs including the Better Access to Mental Health Care program.



It's never too early or too late to get help.

*I'm a truck driver and have been struggling with binge eating for 8 years.*

*I reached out for support, so can you.*

### Counsellor

To do their job, counsellors may obtain one of many different qualifications. General courses in counselling techniques, or welfare studies, and so on, can range from three months to four years. Although there is a national body of counsellors (the Australian Counselling Association), a person can work as a counsellor without being a member of this body, and without having any specific qualifications. People with varied backgrounds can work as a counsellor. During the initial contact, it is a good idea to ask questions about a counsellor's qualifications and experience in working with eating disorders.

### Mental health services

Mental health services are free services offered through Queensland Health. Mental health services are usually provided by a multi-disciplinary team, consisting of psychologists, social workers, case managers and nursing staff. All mental health services will have access to a psychiatrist or registrar. In some cases, the team will also include occupational therapists and dietitians.

Before listing different health disciplines and what they mean, it is important to outline the therapies that have the best evidence base of success with eating disorder recovery.

# Family-based Treatment (FBT) for Children and Adolescents with Eating Disorders

By Kim Hurst

Family Based Treatment (FBT) is an outpatient treatment for children and adolescents up to the age of 19 with an eating disorder who are residing at home with their family. FBT is currently the most promising treatment for adolescents with anorexia and is also suitable for bulimia nervosa. FBT is sometimes called the Maudsley model as it was developed at the Maudsley Hospital in the 1980's. Before explaining FBT, it is important to remember that this family based therapy is not appropriate for all families and/or individuals and other therapies including Adolescent Focused Therapy has also shown success with eating disorder recovery.

## The treatment model

FBT is an intensive outpatient treatment approach that puts parents in the centre of their child's treatment. Treatment focuses on: (1) weight restoration, (b) restoring control of eating to patient, and (3) returning to normal adolescent development. This is achieved in three phases across 20 treatment sessions over a 12-month period. The main difference between FBT and traditional treatments is that parents are empowered and seen as a key resource in assisting their child to recover. FBT believes that the child is not to blame for the challenging eating disorder behaviours, but rather that these symptoms are mostly outside of the adolescent's control (externalising the illness).

### Phase 1: Refeeding

Weekly Sessions (approx 1-11 sessions)

The focal point of this phase of treatment is on weight restoration and a return to normal eating. This is achieved by focusing on the dangers of severe malnutrition associated with anorexia and coaching the parents to work together around the issue of the child's food refusal in a firm but warm and consistent way. Siblings have an equally important role of providing support and encouragement to their sister/brother during this

difficult period. The young person needs to achieve at least 90% EBW (Expected Body Weight) and be demonstrating less anxiety and resistances around food and eating to transition into the next phase of treatment.

### Phase 2: Transition control of eating back to the adolescent

Fortnightly sessions (approx 5 sessions)

Once a sufferer is physically well and able to maintain a healthy weight, treatment shifts to Phase Two. The focus is on encouraging the parents to help their child take more control over eating once again. This is achieved through carefully negotiated trial periods during which the young person is responsible for her or his eating. As steady weight gain continues and the young person is eating without needing to be persuaded by parents, an exploration into the relationship between adolescent developmental issues and anorexia begins and is the focus of the next phase of treatment.

### Phase 3: Adolescent issues and termination.

Monthly Sessions (approx 4 sessions)

Phase 3 of treatment shifts to a focus on the impact anorexia has had on the young person and to the establishment of a healthy adolescent identity that is free from anorexia. At this point, the young person has achieved stable weight, and the self-starvation has abated. The fundamental assumption of Phase 3 is that the anorexia has interrupted regular adolescent development; the therapist's task is to facilitate a return to this stage of growth.

## Does the treatment program work?

While the physical and emotional consequences of anorexia can be devastating, the good news is that it's a treatable condition. With the right treatment team, people with anorexia can and do get better. They can regain their health, learn to eat normally again, and develop healthier attitudes about food and their bodies.



People in health and body image occupations are at risk of developing eating disorders. Children can develop eating disorders too.

*Childhood is a time of growth and any weight loss, preoccupation with body image and dietary restriction may suggest an underlying problem.*

*Parents know their children best, and any concerns about eating disorder behaviours need to be addressed in the first instance by a GP or pediatrician, experienced in treating eating disorders. Referrals can then be made to an appropriate treating team, incorporating support and guidance for the child and family.*

### **Who will be involved in the treatment?**

The Maudsley approach considers the family as a resource and essential in successful treatment for AN. AN not only affects the sufferer but all members of the family.

#### **Parents**

It is essential that both parents attend treatment sessions. If parents are separated, there is still an expectation that both would be involved. A sole parent may choose to bring a friend or relative to support and encourage them during treatment.

#### **Siblings**

Siblings also play a very important part in treatment. Their role is to provide support and encouragement

to their sister/brother by engaging in activities and shared time together.

#### **Professionals**

A Psychologist and/or a Social Worker will conduct the therapy sessions. In addition it may be required for the sufferer to be reviewed by a Child & Adolescent Psychiatrist, this would be discussed with the family. Physical observations will be regularly assessed by the medical staff at the community clinic.

The Maudsley approach considers the family as a resource that is essential in the successful treatment for AN. AN not only affects the sufferer but all members of the family.

## Adult Recovery Therapies

### Psychological therapy

The basis of psychological treatment is the formation of a trusting relationship with the therapist, and addressing the issues that are pertinent to the person, such as the thoughts, feelings and behaviours that lead to the development and maintenance of the eating disorder. This may include issues with anxiety, depression, poor self-esteem and self-confidence, difficulties with interpersonal relationships, and empowering the person to realise their own resources to overcome their difficulties.

Some particular models of psychological therapy that may be used in the treatment of eating disorders include:

#### ***Cognitive behavioural therapy or CBT***

One of the evidenced-based treatments for people with bulimia nervosa and binge eating disorder is cognitive behavioural therapy or CBT.

Cognitive behavioural therapy looks at changing the thought processes and, consequently, the behaviours underlying the eating disorder. It aims to reduce binge eating and purging behaviours and to improve attitudes related to body weight and shape, and self-esteem problems. This involves: minimising food restriction and increasing the variety of foods eaten; more effective problem solving; and examining unhelpful attitudes, beliefs and styles of thinking. Healthy, but not excessive, exercise patterns may also be encouraged.

CBT has become a popular form of treatment for people experiencing eating disorders. Based on the premise that thoughts and feelings are interdependent, CBT encourages people to re-examine and challenge existing thought and behaviour patterns. Challenging distorted or unhelpful ways of thinking can allow healthier behaviours to emerge.

In relation to eating disorders, CBT aims to change the way the person thinks about food and themselves. It aims to identify the characteristic thoughts that reinforce disordered eating behaviour and encourage more positive ways of thinking.

Some thought patterns that CBT may challenge include black-and-white thinking, magnification (of importance of events, and so on) and errors in attribution (misunderstanding of the relationship between cause and effect).

Basic elements of CBT as used with people with eating issues:

- + commitment for change and goals
- + self-monitoring
- + weekly weigh
- + education, for example, starvation syndrome and binge–purge cycle
- + analysis of behaviour to determine what leads to the behaviour and keeps it going
- + targeting body checking and body avoidance behaviours
- + incorporate avoided foods
- + increasing skills needed to reduce behaviour
- + adopting more balanced, realistic thinking.

#### ***Interpersonal psychotherapy***

Interpersonal psychotherapy aims to identify and modify current interpersonal problems. This means identifying and improving underlying difficulties for which eating disorders constitute a solution, albeit an unhealthy one. Interpersonal psychotherapy then aims to improve the person's insight into these issues and looks at motivating for change. IPT has been used successfully in the treatment of eating disorders, particularly bulimia and binge eating problems. IPT focuses on interpersonal difficulties in the person's life that are considered to be the basis of the eating disorder. Generally, therapy involves three phases including the identification of interpersonal difficulties, the development of a contract to work on several specific issues, and the assessment of changes. The therapy is usually medium-term in length (16 to 20 weeks).

In the initial stage, the therapist will generally explore the history of eating problems, interpersonal relationships prior to and after the development of an eating disorder, significant life events and self-esteem and depression issues.

Major problem areas are identified and typically fall into four categories: grief, role disputes with other people, role transitions and interpersonal skills. A therapeutic contract is developed between the client and the therapist based on the major problem areas in the person's life.

### **Family therapy**

Family therapy focuses on teaching families how to vent emotions, set limits, resolve arguments and solve problems more effectively. It also aims to increase the parents' understanding of the difficulties of the child who has an eating disorder, and helps the parent to not measure success or failure in terms of weight, food and self-control.

Family therapy usually involves the people who are living with, or are very close to, the person with the eating disorder. This may involve parents, siblings and spouses. The family, as a unit, is encouraged to develop ways to cope with issues that may be causing concern, including the eating disorder. The success of this treatment is dependent on the family being willing to participate and make changes to their behaviours. Family therapy can also offer education to other family members about the eating disorder and how to better support the person they care about. Overall the family is encouraged to develop healthy ways to deal with the eating disorder.

Family therapy also acknowledges that every family has issues that are difficult to deal with. As a part of a person's recovery from an eating disorder, it can be useful to address problems in the family context such as conflict or tension, communication issues, difficulty in expressing feelings, substance abuse, physical or sexual abuse, etc.

### **Feminist therapy**

Feminist therapy addresses role conflicts, identity confusion, sexual abuse and other forms of victimisation in the development, maintenance and treatment of eating disorders. It also emphasises the importance of women's interpersonal relationships. It centres the therapy around what the person identifies as the problems in their

life, and helps them see their experience in the context of women's position in society. There is good evidence to show that feminist therapy and feminist therapeutic group work is successful in treating eating disorders.

### **Creative feminist approach**

This approach believes eating issues:

- + are the solutions women have found to deal with underlying conflict in their lives
- + are gender, social and political issues that say something about the position of women in society
- + have massive implications for women's health, but are not medical in origin
- + should be approached from an understanding that is informed by the gendered nature of the issues.

The goals of feminist therapy and counselling for eating issues are to:

- + create a safe space where women can recognise and validate what it is they are attempting to communicate through their body and eating behaviour
- + work on and resolve the underlying issues that give rise to a woman's eating behaviour while at the same time exploring alternative strategies for coping
- + work with women to develop more explicit and beneficial ways to communicate their needs
- + enable women to know themselves more fully, to realise their potential and develop a sense of themselves as being autonomous and effective within a relationship.

### **Narrative therapy**

The word 'narrative' refers to the emphasis that is placed upon the stories of people's lives and the differences that can be made through particular tellings and retellings of these stories. When working with someone with an eating disorder, the therapist will assist the person to recognise the 'voice' of their eating disorder and the manipulative messages it is giving them. Then the person can

learn how to challenge and dispute those messages in order to reclaim their own voice and be the way they themselves want to be. The person affected by the eating issue learns to view the eating disorder as external, therefore something they can fight against. This external view helps the person to begin to separate themselves from the eating disorder.

### **Acceptance commitment therapy (ACT)**

ACT's overall therapeutic goal is to help clients increase their psychological flexibility. ACT uses mindfulness skills to assist people to interact with their inside experiences of thoughts and feelings so one can take control of their actions which align their values. ACT does not attempt to change the content of the mind, such as undesirable thoughts and difficult emotions. Instead the goal is to help people see these thoughts as thoughts and allow feelings to come and go. Research has demonstrated that ACT is highly effective with disorders that are driven by experiential avoidance: a compelling urge to avoid or control difficult internal states such as unpleasant or painful thoughts, emotions, or sensations.

### **Mindfulness-based therapy**

Mindfulness based therapies have in common an emphasis on the practice of mindful meditation, mindful eating, yoga and a range of other techniques, aimed at increasing awareness. Unlike CBT, the aim of mindfulness is 'noticing' 'allowing' and 'letting go' of thoughts and feelings rather than learning to challenge them. Mindfulness based therapies include Acceptance and Commitment Therapy (ACT), Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), Dialectical Behaviour Therapy (DBT) and Mindfulness Based Eating Awareness Therapy (MB-EAT). These approaches are considered evidence based for various mental health problems yet research is ongoing and required in the area of eating disorders.

### **Drug therapy**

Drug therapy may be used to treat hormonal or chemical imbalances. In the treatment of eating disorders, antidepressants belonging to

the serotonin specific reuptake inhibitor group (SSRI), such as Zoloft, Prozac, Aropax and Paxil, are commonly prescribed.

Research suggests that antidepressants such as Prozac are useful in suppressing the binge-purge cycle, particularly for people with bulimia. They may be useful in stabilising weight recovery for people experiencing anorexia nervosa. However, like all medications, not all antidepressants work for everyone, because people will respond differently. Some people experience side effects in varying degrees of severity, such as anxiety, nausea, loss of or increase in appetite, nervousness, insomnia, sexual dysfunction, headaches, rashes, abnormal dreams, and blood pressure changes.

The effectiveness of drug therapy increases when combined with other forms of therapy such as cognitive behavioural therapy.

### **Group therapy or support groups**

Group therapy and support groups can have similar goals to cognitive behavioural therapy and interpersonal psychotherapy, depending on the approach taken. Information, support and help are provided for individuals to more effectively deal with the shame surrounding their eating disorder. Groups can also provide additional support and feedback from people in the same, or similar circumstances. This can be a valuable adjunct to most forms of therapy. The main purpose of group therapy is to explore issues around their eating disorder in a supportive network of people who have similar issues. Groups may address many issues, from alternative coping strategies, underlying issues, ways to change behaviours, triggers to personal needs, and long-term goals. Groups are generally closed in attendance for a specific period of time (for example, eight weeks). Support groups differ from therapy groups in that they are intended to offer mutual support, increased understanding and information. Where a therapy group is generally closed in attendance and runs for a specified period, support groups are generally open in attendance (people can attend as often as they wish) and meet on a regular basis (for example, fortnightly). Generally, support groups are not run by professionals, but by people who have either personal or indirect experience with the issue.



## Know your mind and your body will follow

*Mindfulness skills helped me understand my mind and get in touch with the life I want to live and the person I want to be.*

### **Guided self-help**

Self-help texts are most commonly based on the cognitive behavioural approach and the techniques included aim to provide strategies for improving eating patterns, reducing binge and purging patterns, reducing weight and shape concerns, and improving the general psychological outlook for people with bulimia nervosa and binge eating disorder.

### **Psychosocial treatments**

The aim of psychosocial treatments is to enhance motivation for changing behaviour, look at strategies and techniques to increase self-esteem and assertiveness, and to better manage anxiety. It also aims to help improve interpersonal and social functioning skills, and to treat other psychological issues related to the eating disorder.

### **Alternative therapies**

Alternative therapies such as naturopathy, acupuncture, massage, meditation, yoga, or

homoeopathy can be helpful for some people in dealing with the effects of an eating disorder. Alternative therapies can be useful for some people as an adjunct to psychological, nutritional and medical treatments. For example, meditation can help reduce anxiety levels, or massage can help us to reconnect with our bodies. Each approach is different; however, alternative therapies are generally concerned with treating the person as a whole, including their mental and physical health.

### **Hypnosis**

Traditional hypnotherapy typically involves a sleep-like state or altered state of consciousness usually induced by a therapist. It is based on the premise that during this altered state of consciousness a person is more responsive to suggestions and has greater access to influential functions usually outside their conscious control; however, more recent theories of hypnosis may include role playing, storytelling and interpersonal influence between the therapist and the client.

## Relaxation therapies

Relaxation therapies are any method, process, procedure, or activity that helps a person to relax; to attain a state of increased calmness; or otherwise reduce levels of anxiety, stress or anger. Relaxation techniques are often employed as one element of a wider stress management program and can decrease muscle tension, lower the blood pressure, and slow heart and breathing rates among other health benefits. Meditation, yoga, qigong, taiji, and other techniques that include deep breathing, tend to calm people who are overwhelmed by stress, and help people gain control of their mental health by learning to focus their attention. The rhythmic exercise improves the mental and physical health of those who are depressed.

## Health at Every Size

Launched in the late 1980s, Health at Every Size is a treatment philosophy rather than a commercial program. It encompasses not only food-related decisions, but a wide range of lifestyle choices as well. The aim is to empower people to claim their natural body size and enjoy the full spectrum of life through counselling that looks at what fosters good health and what doesn't. Health at Every Size takes the focus off weight, since research shows that diets often fail and that yo-yo dieting can lead to additional weight gain and health problems. It also acknowledges that weight is an unhealthy preoccupation for many people across the weight spectrum. It is not against people losing weight, but rather against the focus of health being on the pursuit of weight loss. Health at Every Size practitioners help people learn to enjoy eating again, instead of seeing it through a lens of deprivation and moralising about food — putting themselves and the food into rigid categories of 'good' and 'bad'. People are supported to listen to internal cues of hunger and fullness — something many have lost through years of dieting, bingeing and trying to follow external messages about weight and beauty. Practitioners also encourage women to appreciate the natural diversity of body sizes and shapes and to reclaim physical activity as joyful and appropriate for their kind of body. There is good evidence that this treatment improves the holistic health of people with eating disorders.

## Eating Disorder Diagnosis, ATAPS and Better Access Schemes

Many people know when they have eating issues, regardless of an official diagnosis; however, a diagnosis can be useful to make sense of what is happening and enables individuals to access specialist care through the Better Access and the ATAPS System.

The **Access to Allied Psychological Services** (ATAPS) programme is a component of the Better Outcomes in Mental Health Care Initiative (BOiMHC), funded by the Department of Health and Ageing and coordinated and managed locally by Medicare Locals.

ATAPS provides access to effective low-cost treatment for people with mild to moderate mental disorders who will respond well to focused psychological strategies. The program provides time-limited evidence-based psychological treatment at no cost or at a low cost to the patient, through a GP referral to an allied mental health professional who can provide short-term focused psychological strategies.

ATAPS is a targeted program designed to increase the capacity of Medicare Locals in giving priority to hard-to-reach groups that continue to miss out on Medicare subsidised services under Better Access. These groups include people who are less able to pay fees, who are from culturally and linguistically diverse communities, who are homeless or at risk of homelessness, and those in rural and remote locations.

Psychologists, appropriately trained nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers are eligible to provide Allied Health services under the ATAPS programme.

The **Better Access** initiative provides access to Medicare rebateable psychological services from a psychiatrist, a psychologist, or a suitably qualified social worker or occupational therapist for the treatment of mental health illnesses through a referral from a GP. Based

on an assessment, a GP completes a mental health treatment plan for the patient. The patient can then access up to 10 individual and 10 group sessions each calendar year. The Medicare items that support GPs to complete mental health treatment plans for their patients provide the framework for early intervention, assessment and management of mental illness. The Medicare item used by a GP is dependent on the time spent with the patient in preparing the plan and whether or not the GP has completed a mental health skills training endorsed by the General Practice Mental Health Skills Collaboration (GPMHSC).

### ***How does ATAPS differ from Better Access?***

ATAPS and Better Access are complementary programs. They cannot and must not be used to offset or top up services under either program. It is the role of the GP to diagnose those who have a mental illness and complete a mental health treatment plan. The decision to then refer a patient to either ATAPS or Better Access should then be made based on whether the GP feels that the patient has the ability to contribute to the cost of these services. If the patient is able to cover the co-payment, then a referral to Better Access is more appropriate. If the patient cannot afford to cover part of the payment then a referral to ATAPS is more suitable.

### ***How do I find out more information about ATAPS in my local area?***

The Medicare Locals in your region manages the funds for the provision of allied health services under the ATAPS program. GPs are reimbursed through the Medicare Benefits Scheme for the preparation of the mental health treatment plan dependent on mental health skills training status and the time spent working with the patient to develop the plan. For more information about how ATAPS is managed in your local region, contact the mental health program staff from your Medicare Local directly. The profiles of each Medicare Local, including contact information, can be found at: [www.yourhealth.gov.au](http://www.yourhealth.gov.au)

### ***Recent changes to Better Access including Medicare items and rebates***

A number of changes were made to the Better Access program that came into effect from November 1, 2011. These changes included the reduction of psychological services sessions for patients from 12 individual sessions to 10 sessions in a calendar year. The item numbers for GPs to prepare mental health treatment plans also changed at that time to reflect a time-based system. More detailed information on Better Access, including a range of fact sheets and details of the Medicare item rebates, can be found on the Department of Health and Ageing website at: [www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba](http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba)

### ***National Disability Insurance Scheme (NDIS)***

People who develop chronic, severe and enduring eating disorders may also be eligible for treatment funding through the NDIS scheme. This scheme will be introduced in Queensland in 2014.

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## How Are Family and Friends Affected?

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**Eating disorders not only affect the individual, they also significantly affect family and friends. It can be very disturbing to find out that a loved one has an eating disorder. Often this discovery is not made until the behaviours are well entrenched, because of the desire to hide the eating disorder. Family members and friends may feel very afraid and be frustrated or reviled by the activities of the person with the eating disorder. Attempts to help the person are often met with denial of the problem and sometimes a stubborn resistance. This can result in feelings of helplessness, confusion, anxiety and anger on the part of the family and friends. Often the stress of living with a person with an eating disorder can create conflict and divisions within the household.**

Family and friends may start examining their own behaviour and consequently may feel guilty, perhaps for not recognising the person's distress and problems earlier, for not being there, for maybe helping to contribute to the problem, and so on. While these are natural reactions, it tends not to be very constructive or helpful to focus on these feelings. No one is to blame for the development of an eating disorder. It is important for family and friends to be supportive and encouraging to the person who has the eating disorder.

Due to the frustration of the situation, sometimes family members and friends may make comments about the behaviours of the eating disorder in front of the person and others in a hope to try to embarrass them out of their behaviour (for example, 'I don't know why you are even bothering to eat

that, we all know you are just going to throw it up anyway'). This can have dire consequences for the individual, because they feel as though they are being degraded as a person. Family members and friends need to remember that despite their loved one's problem with food and with their eating disorder, deep down, they are same person they always were — normal, worthwhile, and deserving of attention and respect. It is important to be there when they need someone to talk too, and it is good to communicate feelings — yours as well as theirs.

Weight is likely to be a very touchy subject and comments about it are likely to be misinterpreted, as are other comments relating to appearance, such as, 'You're looking well' (which can be misinterpreted as you are looking fat), or, 'You look terrible' (which can be misinterpreted as you are looking fat or ugly). Instead, try to make positive comments about things other than appearance. Remember, you do not need to take on the role of a therapist — your role as mother, father, brother, sister, or friend is important on its own. Once the person with the eating disorder is receiving professional care, you need to be patient. Changes do not occur overnight. It is also important to realise that there may be times when the individual may slip back into their unhealthy eating patterns. This may just be a setback, and it is at these times that unconditional support is crucial.

The attention and care given to the individual with an eating disorder should not result in other family members missing out on their share of attention, as this may lead to more family conflict. Similarly, be careful not to put so much attention and energy



into caring for the person with an eating disorder that your own life, health and well-being suffer. This would not only be detrimental to you but may also serve to make the individual feel even guiltier. A better outcome for all involved is more likely to be achieved when independence, autonomy and initiative is encouraged.

It is important is to engage in recovery as soon as possible by supporting someone in a nurturing way to eat good nutrition, adequately and regularly. This often involves creating calm environments before eating, and remaining with the person afterwards to help them to change harmful compensatory behaviours like vomiting and over exercise.

Caring for someone in recovery from an eating disorder can involve meal support and emotional support, and this can take its toll when at least six meals a day have to be supervised. It is important for carers to get support for themselves, as well. Seeking help and support for yourself is not only important for your own physical and mental health, but it also models and reinforces good self-care for the person you are looking after. A lot of members find it helpful to talk to those who have gone through, or are going through, similar problems. There are various carer support groups and networks you can connect with to get support locally, nationally and internationally. Do not be afraid to seek counselling or therapy for yourself if you are feeling as though you cannot cope. The EDA can help you to connect with other carers and eating disorder health professionals.

**Warning: The number on scales will affect your mood**

**You, your health and beauty are more than a number on a scale.**



## Carers can be vital to someone's recovery

A carer can be a friend, a partner, a relative, a parent, a teacher, a treatment team, even an adult child.

You are not alone as a carer. There are people to help you support your loved one in their recovery.

Get information on eating disorders and the effects of starvation.

Attend carer groups or online forums to connect with others who have helped someone recover from an eating disorder.

Take care of yourself and find your own supports.

Take time out when you need to.

**Don't give up, your loved one's freedom from an eating disorder will be worth the effort.**

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## What Can Family and Friends Do?

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**The support of a spouse, parent, sibling, or friend is one of the most valuable tools a person with an eating disorder can have. If someone close to you has an eating disorder, you can face it together in many different ways. Carers can research treatment options, read appropriate books, attend lectures, talk to experts, and lend a supportive ear, but only the individual can experience recovery.**

Keep in mind that an eating disorder may be a way to feel in control of one's life. Sometimes, what is intended to be helpful and considerate can be interpreted as being controlling by the person with the disorder. Communicate that you are available to help. You are there to support and encourage them in their struggle to get well.

An eating disorder can be a protective device used to handle pain. If it was easy to give up, the person would have done so already. Someone who uses food as a coping mechanism needs understanding and compassion. The reality of an eating disorder may shock you, but separate the individual from their eating disorder. They deserve love and appreciation for who they are, regardless of the eating disorder, and compassion for the pain that has driven them to a mental health illness.

At the same time, do not be manipulated or lied to. Do not 'enable' the disorder by looking the other way, or by pretending that the problem is not serious. If you stock the refrigerator with food only to have it flushed down the toilet, be honest and assertive about your rights and needs. Having an

eating disorder is not justification for treating loved ones poorly. As a carer you can be supportive, but also have your own boundaries about being treated fairly.

Trying not to turn meals into battles is difficult because food is both not the issue and it is the issue. The person needs to eat regularly to get well, but the eating-disorder part of them, or the illness, may not want this. Support is a delicate balance of nurturing the healthy self to make good choices and understanding the difficulties posed by the eating disorder.

Parents of individuals with an eating disorder, especially, need to be aware of their limitations in helping their children; it may be appropriate for parents to seek out professional advice or a support group for help with their own feelings.

Parents may need to re-evaluate their values, their ways of communicating, the family's rules about food, their ways of handling feelings, the roles of parents, and the family's decision-making process. Guilt, anger, frustration, denial, and cynicism are all likely sentiments. As hard as this all sounds, family therapy has proved to be one of the most successful methods of overcoming eating disorders. With better communications, increased self-knowledge and mutual acceptance of what has happened in the past, parents and children can focus on the important task of recovery in the present.

## Advice for Carers

- + The very first thing a carer can do to support someone in recovery is to ask them how they would like you to support them.
- + Gather and read as much information about eating disorders and treatment as you can. This will increase your understanding and may help to reduce feelings of anxiety and helplessness.
- + Encourage the person with the eating disorder to seek help from a health professional with experience in working with people with eating disorders, keeping in mind that no single approach to recovery works for everyone. Remember that your loved one has the problem, and it is up to them to do the work with someone they feel a supportive connection with.
- + If you are a carer of a child with an eating disorder, having a health professional empower you to offer meal support is recommended. It is important that all family members be involved in the treatment.
- + Make a pact of complete honesty.
- + Be patient, sympathetic, non-judgemental and a good listener.
- + Let your loved one know that you care and have their best interests at heart.
- + Accept that recovery is a process and does not happen quickly.
- + Help your loved one to be patient.
- + In your communications, discuss non-food-related issues such as other pursuits, vocational interests, relationships, and so on. Do not make negative or positive comments on appearance or weight. Instead, compliment the individual on their personality, character, achievements, etc.
- + Realise that the 'dieting' behaviours (for example, starving and vomiting) can be symptoms of other underlying issues and conflicts. Try to develop honest, open communication with the individual and encourage them to express their feelings, while maintaining a non-judgemental attitude. Do not try to guess what they want. Encourage your loved one to express their needs.
- + Try to differentiate between the eating disorder and its subsequent behaviours, and your loved one. Please see the section on externalising. Some people find it useful to give the eating disorder a name, and attribute the eating disordered behaviours to that identity. This way you can set boundaries for the eating disorder and at the same time provide empathy for the individual. For example, "I know you will find it hard to eat more because the eating disorder doesn't want you to, but I will be here to support you to do it."
- + Show acceptance of yourself and the person with the eating disorder, despite their behaviours.
- + Build their self-esteem by reinforcing healthy choices and behaviours instead of criticising destructive ones.
- + Allow the individual with the eating disorder to take responsibility for their own actions (for example, buying and paying for their own binge foods).
- + Even though the person with an eating disorder may withdraw from you, and isolate themselves, try to let them know that you do really care. Be sincere, and let them know that you are interested in them as a person regardless of their eating disorder.
- + Realise that as a consequence of the eating disorder, the individual may be more irritable, and may exhibit mood swings. This is often due to the malnourished physical state. When your loved one's behaviour affects you negatively, express yourself without placing guilt or blame on them. Try not to take their actions personally as they are dealing with the effects of an illness. Use 'I' messages, explaining your feelings and concerns. You may need to disengage to take care of yourself sometimes, be honest and let them know why you need to do so
- + Have compassion. Your loved one may be overwhelmed as they get in touch with the

painful issues underlying the behaviour. Your loved one will need your support at these times more than ever. Ask what, if anything, you can do to help. Encourage them to find healthier ways to deal with pain.

- + Do not make derogatory remarks or impose guilt, for example, 'Our family was happy until you became anorexic'.
- + Remember to make time for yourself, other family members, and friends. Take time out to rest. This is good role modelling for looking after oneself. Do not allow the eating disorder to take over your life or the lives of the rest of the family members.
- + Accept your limitations in being able to fix the problems associated with the eating disorder.
- + Realise that you do not need professional training or a tertiary degree to support someone recover from an eating disorder. Your support and unconditional love are what matters most.
- + Do get support for yourself by attending support groups catering for relatives and friends.
- + Recognise that it is tough to be a relative or a friend of a person with an eating disorder.
- + Above all else, hang in there! There will be days when you feel like giving up. You are not alone. Remember that recovery takes time but that there will be periods of growth as well as setbacks.

**Remember: You didn't cause it**

Recovery from an eating disorder, although slow and difficult, is possible! Relatives and friends can play an important role in forming a network of loving, nurturing and healthy relationships that can be a lifeline to the person with an eating disorder.

## Carer Allowance

### As a carer of someone with an eating disorder, you may be eligible for a Carer Allowance.

Centrelink use either the Adult or Child Disability Assessment Tool to determine a person's eligibility for a Carer Allowance. The Adult Disability assessment tool is used for individuals over 16 years of age. The adult assessment involves a clinical component and a care requirement component. The clinical component includes questions regarding the sufferer's physical, cognitive and psychological status. There is a minimum qualifying score. The assessment of care requirement includes questions regarding the type of assistance provided, such as dressing, feeding, emotional outbursts, etc. One of the questions asked, is whether the sufferer can eat unassisted. If you as a carer, have to sit with the sufferer in order for them to eat or if you have to provide emotional support in order for them to eat, it is important for you to state that they cannot eat unassisted. The child assessment is more complicated and involves more questions than the adult assessment. The clinical component of this is assessed against the Childhood Development Milestone Tool to determine whether the behaviour is normal for that stage of development. This assessment also involves a care-load summary.

Centrelink staff should be asking applicants questions such as:

- + What impact is this having on the family unit?
- + How long is recovery expected to take (as determined by your GP)?
- + Does the sufferer live with you?

Try and make a claim for carer allowance as soon as you can because if you make a successful claim months or years later, they will not back-date the payment. If you are rejected for your claim, keep appealing. Caring for someone with an eating disorder is very important and you deserve an allowance for this important work.

A woman with long dark hair, wearing a purple and white patterned dress, is floating in clear blue water. She is looking upwards with her arms outstretched, and her reflection is visible on the water's surface. The scene is bright and serene, with sunlight filtering through the water.

## Know your mind, love your body

*Recovery helped me  
discover who I really am.  
It was a way to reconnect  
with my true self.*

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## Recovery Stories

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**We know that recovery stories can provide hope to others. We thank the contributors here for their stories. More personal stories can be found on the EDA website [www.eda.org.au](http://www.eda.org.au) and in our peer-driven monthly newsletter.**

### I choose to reclaim my life ...

By Julie

I choose to reclaim my life,  
And help it heal and mend,  
And to believe in my heart that was broken  
That one day, the hurting will end.

I choose to care for myself now,  
To nurture and nourish my soul,  
My mind, my spirit, my body,  
So one day I might feel whole.

I've damaged myself, I know this,  
So easily, I could have just died.  
Yet I am learning to say, it's not my fault,  
For it was the way I coped, and survived.

The journey is hard, there are struggles,  
But there's love and there's hope on the way,  
And joy that helps me keep going,  
Like a rainbow that came yesterday.

And the kindness of a friend, or a stranger,  
The help of people who care,  
Who understand why, I am like this,  
And that has caused, all this, to be there.

Anorexia and depression  
Sometimes, there is self-harm,  
Fear, anxiety, self-hatred

Yet I can also find peace, and find calm.

For I am learning to live in the present,  
Though the past can still be so near,  
And memories of childhood,  
That brought deep pain and fear.

But I choose to live my life now,  
I'm starting to find who's me,  
And one day my wings that were broken,  
Will be healed, and will fly, and be free.

### Anorexia Recovery: Finding My Way

By Tenille

Anorexia stole seven years of my life. I can never get that time back, but I can, and will, make sure that the present and future is wonderful enough to make up for the time I lost. Recovery was harder than I ever believed or thought it should have been, but it turned out better than anything I could ever have imagined. I am free now. I was really lucky that my Mum did a lot of research into anorexia while I was very sick and living away from home in Melbourne. She attended a number of seminars on eating disorders and also contacted the EDA where she and Dad did a support program for parents.

It was here that Mum saw a dietitian who specialised in eating disorders speak. She really liked what he had to say and his approach to treating his patients. I saw him for three years and his manner of treating me really suited. He created a meal plan for me and Mum made sure that I ate everything that was on it. This was good (although it definitely didn't feel good at the time) because

it took the control away from not only me but my parents as well. I couldn't argue that Mum was trying to feed me too much because she was just following my meal plan.

In saying this, eating was not easy for a very long time, for the first six to seven months we had arguments and tears at every meal. My dietitian also helped me with strategies to deal with the feelings I was experiencing, and he gave Mum a lot of strength to keep going and fighting for me when I was not strong enough to fight for myself. I always felt that he listened to what I was saying and understood what I was going through, I didn't always agree with what he was making me do but he could always justify what he was doing and would always listen to and acknowledge my concerns. I also saw a counsellor for the first year and a half who helped a lot with my feelings of worthlessness and dealing with my anger and frustration towards most of the things in my life. She helped me to realise that I wasn't the bad person I believed I was and reminded me that things were changing and improving as I was getting better.

I saw a psychiatrist for a while but I didn't feel that he understood what I was going through, nor that he ever really listened to what I was saying. My dietitian recommended a GP who had a special interest in eating disorders so I ended up seeing her instead. She was very understanding and was familiar with the medical complications associated with anorexia.

My dietitian liaised with my GP and counsellor to make sure they were all consistent in their approach to treating me and to ensure that any current issues I was having trouble with or he was concerned about were being addressed.

Mum and the team around me had gotten me to a place where I was safe and much happier than previously. I was faced with the choice to stay there, be safe but not really happy or take a chance and fight for recovery. I decided to take a chance. It was difficult but I did it and I set myself free. I know that I can deal with my feelings in a much healthier way now and that I will never go back to where I was.

I am so lucky that I have such beautiful parents who were willing to do anything and everything to help me recover. They learnt so much about the illness and were strong enough to help me through the darkest time of my life. She never gave up on me, even when I had given up on myself. It is only now that I can see the pain that I unintentionally inflicted on my family. We can now talk openly about what happened and I have learnt that my anorexia caused my family and friends a lot of pain that I did not realise at the time. When I was sick I felt like I was the only one in pain, I had no idea of the worry, hurt and frustration that the people watching me were experiencing. It is not until you come out the other side that you realise how much your illness has affected the lives of friends and family. It is not just your own life being torn to pieces.

Everyone has the ability and should be given the opportunity to recover. Reach out to those around you; you may be surprised by what they can teach you and how they can help you. Often those around me knew what I needed long before I had any idea. Trust that those around you love you and want the best for you. This is one of the hardest things when you hate yourself and can't see any reason for anyone else to love you. The people around you want to set you free and can see or remember the 'real' you behind the eating disorder. It is the most difficult thing you will ever do but you have to do it. Give treatment a really good go and you will never go back. Set yourself free.

A friend suffering with anorexia helped me through a lot of tough times. She was always there, always understood, and always knew what to say when I had a bad day. We still talk a lot and I am learning that just being there for someone can help enormously.

My life now is so unlike what it was when I was ill. I now have a full-time job which I love, I am almost finished my Science degree, am back doing gymnastics and have started up circus classes. Things I can do now would have been impossible in the midst of anorexia. I was lost but I have found my way and I will never be lost again. I now

know when, where and how to find help when I need it. I am surrounded by beautiful people, as I have always been. The difference is that now I can recognise this and I can appreciate them and the things they do for me. They have helped me grow and set me free. I am forever grateful.

## Where I Came From: My Journey of Recovery From Bulimia

If you talked to me three years ago about where I think that I would be in my recovery, I don't think that I would have seen what I have become today. I think, back then, I would've hoped and thought that I would definitely be over my eating disorder demons and that they wouldn't be a single part of my life, but I hardly think that I would have known the sort of person that I could've become, and that I am today, because of my eating disorder.

To understand how far I have come, I need to start from the beginning. I know this sounds like all those cliché life stories where they stay 'I'll start from the beginning', but when I say 'I need to start from the beginning' I really mean I'll start from the source, the cause, of my fight with bulimia. It started in 2006 when I had troubles with friends from school, a fight which wasn't even my own battle. I ended up with only a few friends, but didn't feel like I really fitted in anywhere. It became so bad that I often just faked sick and stayed home from school to avoid the problem. In the end I turned to food, it always tasted so good so I would keep eating until I felt ill and couldn't eat anymore, so I would throw it all up and start all over again. It made me feel good. I could eat whatever I wanted and still have a way of getting rid of it and not putting on weight, sometimes even losing weight.

Of course the entire binge and purge cycle was done in complete secrecy — I would often eat in my room and then go to bathroom where I would pretend to shower and listen to music, when in reality I was throwing up for a minimum of 15 minutes. For a long time I never thought anyone knew. That was until my Mum took me into her room one day and confronted me. She said she

had heard me throwing up on multiple occasions, and had also found food packets hidden in my room. I remember sitting there in silence, unsure of what to say, I started to feel like my mother had been spying, it made me angry. She then pulled out a few brochures she had ordered from the Eating Disorders Association, and asked me to read over them. She said she was concerned that I had a problem and wanted me to seek help. This just made me even more angry and frustrated. I yelled at her, telling her to stay out of my business. I didn't think I had a problem, and plus how it could be a problem if it was making me feel better about myself! I didn't think there was any reason for concern. I refused to seek help, saying if I wanted help I would do it on my own. I could stop this anytime. But I couldn't stop it, and it continued to get worse.

On many occasions I started to find myself purging after regular meals, and on more regular occasions. It started to become something that happened four or five times a week rather than two or three. And then I started over exercising to the point where I would go for runs which would last for one or two hours then proceed to the gym.

I started to feel changes in my moods, in how I related to people, in my involvement in family life. If I felt something was interfering with my binge purge cycle, I cancelled. I started becoming reclusive. Towards the end of 2007 I started to realise that my bulimia really was something to be concerned about so I contemplated seeking help. I weighed up the pros and cons of seeking help. I decided on going to weekly sessions with a psychologist, but I still wasn't completely prepared to give up this eating disorder which I had devoted almost an entire year to.

Even though I started to feel my self-esteem levels increasing because the number of times I was bingeing and purging had decreased, I was still over exercising and I felt I was under a huge amount of pressure to 'get better'. I really was doing it not for myself but for my parents, and I wanted them to be proud of me, and I wanted them not to worry anymore — I hated seeing them worry. It was very

distressing and confusing seeing how upset they got because of this thing I was doing to myself — back then I thought 'I'm doing this to me, not to them, WHY are they so worried?!'

After four years of therapy I now understand. These wonderful people gave me life, they have seen grow up from a tiny baby into a beautiful, strong young lady, of course it's distressing. Bulimia is a form of self-harm. I was hurting myself. What parent wouldn't be upset about this! It hurt them to see me hurting myself. After going through the contemplative stage of change, I grew determined to get better.

I had learnt so much about the costs and harmful effects of bulimia. If I continued the way I was going, I could do great damage to myself — not just emotionally but physically. Not only this, but I felt depressed all the time. There was not a week, sometimes even a day that went by that I wouldn't cry, or that I wouldn't sit in my room hating myself for what I was doing to myself. I would call my mother up at work, crying to her about what I had done, about what I was doing. I felt completely out of control. I had to kick this thing before I lost myself more than I had already. I wasn't the person I knew I used to be. I wasn't the fun loving, happy, joking, and life loving girl that I used to be. I really had lost myself, but not so much so that I couldn't remember who that girl was. I wanted to be her again. So desperately so that I finally threw everything that I had into getting better. The cost of continuing with living with bulimia outweighed the benefits. I had to get better.

I started to take action, I knew change was required. I had been going to see a psychologist for three years, things had gone back forth. I would sometimes be able to go for two or three weeks without bingeing and purging, but other weeks it would happen between three and five times. I was on an emotional rollercoaster for several years. Not only could I feel emotional effects, but I had started feeling physical effects. Parts of my body would ache; I would go through spells of dizziness, and on one or two occasions I saw blood in what I had thrown up. It was getting serious — more serious than before. I made a real conscious effort in

putting steps into place to help implement change.

This was around the time when my psychologist suggested cognitive behaviour therapy in mid-2010. My progress gradually kept going forward rather than back and forward. I felt immense changes in myself. Although I often felt overwhelmed by it all, I knew it was for the best. I got to a point where I could consciously stop myself mid-way through the binge-purge cycle, I would think to myself, 'What the hell am I doing!? This needs to stop!' and I would just cut it out and continue on with my day as if it had not happened.

Yes, I still had days where I would be over exercising, but it wasn't to the extent it would be, and I would often feel guilt and anger about what I had done, but I knew that to get better I just had to keep trying, and go on with my life in as normal as possible way. During this difficult time, I received immense support from family and friends — I had gradually built up the strength to confide in some friends, which I have found to be a vital step in my recovery, as I could talk to people who cared about me and would support me no matter what. They gave me the extra drive I needed to get better; they gave me love, support and confidence when I was struggling with this huge change in my life, a change which I was struggling with for a few years.

Getting better was something that took great time and effort, it took almost everything that I had, to get better, and at times it still does. It wasn't till an overseas holiday with my boyfriend that I was really able to put normal eating habits into practise. I know that something like this isn't always possible for people, but it thrust me into normal eating behaviours — I was basically forced into eating normally. It felt strange for a while, like something was missing, like I should be bingeing and purging, but I didn't miss it. I didn't feel any urges to resort back to those behaviours.

I was and still am enjoying life without an eating disorder. I feel like an enormous weight has been lifted off my shoulders, I feel like I am enjoying life the way I used to, and I feel that through my journey of recovery I have become a stronger, more driven person. Even though it has been about five months since my last binge and purge, I sometimes

fear the danger of relapsing. I am scared that one day I might fall back into that scary world; it is something that I hope I will never have to go back through.

Of course there are the triggers of stress and anxiety, and procrastinating with study or other such things, but I have in place coping strategies — things I hope that I will never have to use. But if I do relapse I know that it's all a normal part of the progression out of this eating disorder, and I know that I reach out for support if I need to.

## A Parent's Perspective

By Gail Bowden

It was seven years ago that I first realised Kristie had an eating disorder. She physically collapsed and we took her to see our family doctor. Unfortunately, he knew very little about eating disorders, and sent us away recommending that she eat a chicken sandwich. After this time we knew that something was seriously wrong, and not getting better, so my husband and I took further action and had her admitted to an eating disorders clinic. I remember looking at her at this point and feeling an overwhelming sense of shock. After her admission to hospital I was really scared. To look at her, she looked so sick and so weak. It was sad to think that such a beautiful young woman with such potential had gone so far inward.

It was at this point where the issue of my daughter having an eating disorder really hit home fast. We didn't understand where it had come from or how it had manifested itself. Looking back, I can now see all the tell-tale signs that were so evident. I remember being quite concerned when she started to lose weight rapidly, and I told her so. At this point my understanding of eating disorders was that it was about young girls going on funny diets. My daughter was in denial of course, and told me that I was imagining things. She told me that the diet she was on was completely harmless. This made me think that I was truly imagining things. But I also realised that when she was losing about 2 kilos a week over a period of six months, that I needed to do something.

Her stay in hospital didn't magically make her eating disorder go away either. We had some 'issues', and I really felt as though somehow I had let her down by putting her in hospital. But I also knew that that was the best place for her at that time, and I needed to leave her there.

The eating disorder had a huge impact on the family, as well. My son, who wasn't living at home at the time of Kristie's diagnosis, didn't really understand the situation. He was really angry. He thought that she was just being silly and needed to grow up. Over time though, he became more empathic. We all felt a range of emotions: anger, sadness, fear, helplessness, and so the list goes on. It was always in the back of my mind that she might die from this, and that thought was paralysing.

While the hospital supported Kristie, I found that there was no one there for us to talk to really. They didn't seem to involve the parents very much at all. About a year after her admission to the clinic, I found out about a parent support group and went along. The Eating Disorders Association's support group was the most solitary helpful thing for me. Finding other parents, listening to them. I felt as though someone understood me and that I wasn't on my own with this. This also in turn made it easier for me to understand and accept the issues relating to the eating disorder. And that there was no quick fix cure. If there was anything I could go back and do differently, it would be to get more support at this time. We learned that the eating disorder doesn't just affect one person; it affects the whole family unit. It would have been good to speak to a professional person who could answer the questions we had about eating disorders. We were so confused and frightened and this could have helped to put our minds at ease a little more.

When Kristie came out of hospital, I was sure that she would have been fixed. I thought fixing an eating disorder was like fixing a broken leg. I was wrong. I think I would have been more prepared at home if I had known that there was no quick fix, and this is where the support group was very helpful.

Today I believe that Kristie is pretty much in recovery. There are moments in the past where I think she

may have lapsed into her eating disorder behaviour, but I think it is something that may always be with her. She is a lot stronger mentally and much healthier physically. She has learned so much about herself. This was a major learning experience for her, and she has grown to be a better person.

I think the key in all of this for us was to be there to support Kristie. We always did what we could to let her know that we loved her, even though we didn't like her behaviour and the self-destruction that went along with it. There were times I felt like screaming because I didn't feel as though I was coping, but it was important to keep giving her that unconditional love. I would never leave her without giving her a kiss and hug and telling her that we would always be there if she needed us. Kristie always knew that, and she even says that now.

## A Mother's Story

By Elizabeth — mother of two aged 11 and 12 at onset.

### *The start of our story*

A shrieking wail erupted from deep within me as two bold print statements bounced back at me from the web page: 'Can last an average of five to seven years', and 'Death can occur in one quarter of untreated cases'. My spinning head and numbed senses barely had time to grip the recent diagnosis. These words stabbed at my very soul more than the diagnosis itself.

This cannot surely be — not my children; not this family. There must be a mistake. Someone please lift my aching heart off the bare floorboards.

My children faded before my eyes. My eyes were shaded by the reality of what was, and was to be. They attacked each other physically in frustration, in starvation. I shouted, I yelled in frustration. I was starved of knowledge: how to cope, how to comprehend.

Their emotions were too overwhelming and they were too young to comprehend. My emotions were too overwhelming and I was too drained to comprehend.

They felt helpless to the monster overtaking their minds. I felt helpless and to the monster overtaking my mind. They were shunned. I was shunned.

They hid their food. I hid my helplessness.

They ran, jumped, ran, skipped, ran, danced. I ran around in circles trying to make sense of it all.

They hated me for taking them to strangers who interrogated them. I hated the fact I took them to strangers who interrogated, and belittled, me.

They lost faith in those they were sent to in my desperate bid to help. I lost faith in those I paid dearly to help them, help me, help us.

They exerted their bodies to the point of exhaustion. I hauled my aching body to bed and cried to the point of exhaustion. They hid in their bedrooms; they hid from the world. I hid my shame, and hid from those who whispered and glared. They lost most of their friends, and I lost most of mine. Family members rarely called.

They lost trust in my ability to help. I lost trust in their ability to help themselves. They were too afraid to let go and could not see the barrier to their lives. I was afraid they would lose their mind, their body and inner soul.

Then something changed, in them, in me!

### **THE CHANGE IN OUR STORY!**

I stopped shouting. I stopped yelling. I praised them when I could and should. I told them over and over how much I loved them. I told them over and over how much I cared. I told them when I was concerned and why. I told them I was here for them and that this disease was not going to beat me or beat them!

I kept an even and sincere tone. They began to smile. I began to smile. They began, slowly, to laugh. I began to laugh as we all started to reengage back in life.

They took very small steps forward. I took one large backward step away from it all. I started to take better charge of my life. They started to take better charge of their lives. I gritted my teeth, sucking in my impatience.

I am bursting with pride for both my daughters. I can accept their qualities ... and mine. We are learning the bitter reality of life. We are learning about ourselves. The journey continues along the jagged, rocky pathway, but we are better prepared. Recovery is a process, a journey, and we have learnt to accept that!!

Why us? Why anyone? It is a cruel monster indeed that lurks and exerts its powers on the wonderful, the amazing, the beautiful and the dearly loved.

This disease is now not welcome in our house even though sometimes there is a knock at the door. We all know not to let it in. Sometimes they may ask to have a peek, and I protectively allow them, but we are adamant that the door will never be open to it, no matter how many times it knocks. I danced with rapturous joy when we finally sensed the turning tide toward healing, toward recovery, toward contentment. Our relationship has strengthened as a consequence of anorexia, and although I don't advocate for that, they are stronger for it, I am stronger for it!!

I never gave up. They never gave up, even though at times we all wanted to give up. This disease is powerful and strong, but a mother's love is even stronger and more powerful than that and that kept me going!!!

## **A voice from someone who has lived with many eating disorders**

**By Karla Cameron**

Hi. I'm Karla. I have the privilege of being the voice for the thousands of people with eating disorders in Queensland. I hope I can deliver for them. Most people with eating disorders don't really have a voice. There are so many things they can't bring themselves to say because of the nature of the disorder. It keeps us silent. It keeps us in isolation. But at the same time, we desperately want you to know more about us even though we are unable to express ourselves.

I grew up in a violent and abusive situation. From all the years of hostility and fighting, I learned that if I was always the 'good girl', kept quiet, and did

what I was told without question, I could stay out of trouble. But the price I paid was not having my own needs acknowledged.

My brother and I were often force fed when we wouldn't eat our vegetables. Food was used as a punishment and a reward in my house. I would often get into trouble for taking the food off my brothers' plates after they had finished eating. My mother would say 'Don't be such a pig Karla, girls don't need to eat as much as boys'. And I was much bigger than both my brothers.

A class experiment at 10 years old showed that I was the heaviest girl in my class at 50 kilos. I was crying to my mother that night about how I didn't want to be the fattest girl in the class. All she could say was, 'Well, you are a pig with food'. Then she reminded me that I could never be skinny like the other girls because I was a 'big girl' with a 'solid frame' and 'heavy bone structure'.

None of that sounded very good to me. I thought girls were meant to be feminine and petite. My female relatives would compliment my mother on maintaining her 'girlish figure' even after all those children, then turn around and pass comment on my body, not letting me forget that I was a 'big girl' with a 'big build' and a 'big butt'. My body had let me down again, I felt.

At 15, I got my first full-time job. I also started to binge eat. In a short space of time, I gained weight. Again the comments started coming — from home, from my boyfriend, from people at work. This time, I got angry with myself for being so out of control. I reasoned that no one else in my family had a problem with food, why did I? I started my first diet. I was so sick of the old me, I wanted a brand new me. I wanted everything the diet promised. I was going to 'show them all' that I could do it.

I was so good at dieting. In eight months, I lost weight and I didn't know how to stop. I became completely obsessed. Dieting and exercising were my new grown-up lifestyle and they took up every ounce of my energy to maintain. In the end, I was falling asleep at work and I started fainting regularly on the bus to work, which really scared me.

The day I broke my diet, was the day I became bulimic. I stayed there for the next five years. (At least with bulimia nervosa you get to eat!) After bingeing there is a very strong compulsion to 'get rid of it'. I chose to vomit. It was always disgusting. After throwing up, I had immense feelings of shame and guilt. I knew that most people didn't do this, and if they knew what I was doing, they would like me less than I liked myself. After bingeing and purging, the only thing left to do is start dieting again. And so the cycle continued for me; self-loathing in full swing.

After bulimia nervosa, I moved straight onto binge eating disorder and stayed there for seven years. By not vomiting the binged food back up now, I had another problem of getting fatter. This became my new weapon to beat myself up with. My thought process here was 'If I'm not happy, it's because I'm now x kilos overweight. If I can just lose this weight then I won't have any more problems'.

Whatever the question in my life at the time, the answer was always a diet. For me binge eating was my way of stuffing down my anger or suppressing my feelings with food.

There were many times over this period of 13 years of disordered eating when I felt like I was watching myself from the outside. I knew what I was doing to myself was really destructive and 'not good' but I felt powerless to stop. I wanted someone to notice that I was suffering and help me get off the merry go round. I knew I didn't want to spend the rest of my life living like this — and for what? Other people's approval? I needed help but I was so practised at not using my voice that I didn't know how to ask.

Over the years I tried to get help. I was greeted with some really bad experiences by professionals who didn't understand eating disorders, or me for that matter. I even had a psychiatrist say to me — 'Listen, you don't really have a problem do you?' It took so much to work up the courage to go and see him, and to have him turn around and tell me that was devastating. I never wanted to go back again.

For me, recovery never meant hospitalisation, treatment programs, or support groups. What actually worked was creative visualisation and spiritual healing. I created a vision in my mind of the person I really wanted to be — happy, confident, enjoying a social life, and not having food dictate everything. The more thought I put into that vision, the more it would work for me. Every time I started to feel uncomfortable emotions (which would normally precipitate a binge) I would call on this image to get me through. I then worked on spiritual healing, which for me involved learning to meditate and working on your soul and spirituality. Meditation is an art I now practise every day. This allowed me to start trusting myself again, and gave me the courage to unlock the doors I had closed my whole life. I was able to rid myself of the fear-based beliefs, which were now useless to me.

I started to see a psychiatrist every couple of months who helped me get over some long standing body image issues, and a few deeply rooted issues centred around low self-esteem and negative thought processes. I would not consider myself recovered. There are thoughts that come back to plague my mind and torment me from time to time. I have however learned to deal more effectively with them. I know for me though, this was only possible because I was 100 per cent ready to learn how to overcome this, and ready and willing to put these new behaviours in place.



## What does your “selfie” reflect about you?

Self-image is often dependant on interactions with others.

We need to support each other and recognise the role we can play in not only improving our own self-esteem but also that of our friends and family. We can challenge negative comments, watch our language and what we say about ourselves and others through social media.

If we want to feel good, we need to develop a good relationship with ourselves.

Your appearance says something about you, but it shouldn't define you.

**Promote positive body image.**

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# Eating Disorder Community Services in Queensland

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## **Eating Disorders Association Queensland wide**

*Information, Support, Groups, Referrals and Peer Support networks for people living with eating disorders, their carers & Health Professionals*

Telephone (07) 3394 3661  
12 Chatsworth Road,  
Greenslopes. Q. 4120.

## **ISIS – The Eating Issues Centre Inc**

*Self-referral for people with eating issues over the age of 16*

Telephone (07) 3844 6055  
1/109 Gladstone Road,  
Highgate Hill, Qld 4101.

## **Adults Hospital Services**

### **Public**

**Brisbane Inpatient and Outpatient Services**  
**EDOS – Eating Disorders Outreach Service (Need GP referral) 18yrs +**

Telephone: (07) 3114 0809

**Gold Coast Inpatient and Outpatient Services**  
**Eating Disorders Adult Service (Need GP referral) 18yrs +**

Ashmore: (07) 5667 2000

Palm Beach: (07) 5525 5661

### **Private Clinics**

**New Farm Clinic**  
**Inpatient and Outpatient Services**

*Private Clinic for people 14yrs +*

22 Sargeant St, New Farm 4005

Telephone: (07) 3254 9100

**University Clinic**  
**QUT Eating Disorder Clinic**

Telephone: (07) 3138 9777

## **Children and Young People Under 18**

**Child & Youth Mental Health Services**

Mater CYMHS: (07) 3163 1917 or  
[www.kidsinmind.org.au](http://www.kidsinmind.org.au)

Gold Coast CYMHS:  
(07) 56356392

FBT Eating Disorder Team Clinic  
North West CYMHS:  
(07) 3335 8888

Nundah CYMHS : (07) 3146 2594

Yeronga CYMHS: (07) 3848 8011

Inala CYMHS: (07) 3372 5577

Greenslopes CYMHS:  
(07) 3397 9077

To find your closest CYMHS call:  
(07) 3310 9444

Child and Family Therapy  
Unit Intake Officers  
07 3636 7878

## Other Youth Organisations

### Headspace

*Assists young people 12–25yrs who experience a mental health and/or drug and alcohol problem, including eating disorders.*

*Self or family referral. For kids with mild to moderate eating disorders*

[www.headspace.org.au](http://www.headspace.org.au)

Call headspace National Office to find your nearest headspace office: (03) 9027 0100 or for online support  
[www.eheadspace.org.au](http://www.eheadspace.org.au)

## National Services

### Butterfly Foundation (Sydney)

1800 ED HOPE, 1800 33 4673  
[www.thebutterflyfoundation.org.au](http://www.thebutterflyfoundation.org.au)

### National Eating Disorder Collaboration

[www.nedc.com.au](http://www.nedc.com.au)

### Eating Disorder Victoria

### Eating Disorders HELPLINE

1300 550 236 Toll free

[www.eatingdisorders.org.au](http://www.eatingdisorders.org.au)

## Useful Websites

### Online support :

[admin@eda.org.au](mailto:admin@eda.org.au)

[www.isis.org.au](http://www.isis.org.au)

[www.self.net.au](http://www.self.net.au)

[www.marinotherapycentre.com](http://www.marinotherapycentre.com)

[www.ifnotdieting.com.au](http://www.ifnotdieting.com.au)

[www.bodymatters.com.au](http://www.bodymatters.com.au)

support

[@thebutterflyfoundation.org.au](https://www.thebutterflyfoundation.org.au)

[www.eatingdisorders.org.au](http://www.eatingdisorders.org.au)

[www.b-eat.co.uk](http://www.b-eat.co.uk)

[www.mentorconnect-ed.org](http://www.mentorconnect-ed.org)

### Family/Carer Support

[www.maudsleyparents.org](http://www.maudsleyparents.org)

[www.feast-ed.org](http://www.feast-ed.org)

[www.aroundthedinnertable.org](http://www.aroundthedinnertable.org)

[www.eatingwithyouranorexic.com](http://www.eatingwithyouranorexic.com)

[www.e-mental-health.eu/anorexia/website/](http://www.e-mental-health.eu/anorexia/website/)

[www.bodymatters.com.au](http://www.bodymatters.com.au)

***For referrals to other services and a range of private health professionals please contact the EDA on 07 3394 3661***

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### **Centre for research and intervention into suicide**

[http://www.crise.ca/fr/cdd\\_nouv\\_14tca.asp](http://www.crise.ca/fr/cdd_nouv_14tca.asp)

### **Healthcare Rights**

[www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/](http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/)

### **Self Harm UK**

[www.selfharm.co.uk/get/facts/self-harm-and-eating-disorders](http://www.selfharm.co.uk/get/facts/self-harm-and-eating-disorders)



Health is not what your  
body looks like, it's what  
your body and mind can do.

Telephone  
07 3394 3661



**EDA**  
EATING DISORDERS  
ASSOCIATION INC.

Opening the doors to recovery!



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Eating disorders are complex medical and psychological conditions. The causes of eating disorders are as diverse as the people who get them. They can affect people of any size, age, gender, class and culture.

**Eating disorders don't discriminate. One size does not fit all.**

www.eda.org.au