



EATING DISORDERS & CONCURRENT PROGRAM

Terri Marques, MSW, RSW
Executive Director, BELLWOOD-EHN
Richa Sharma, MHA, CHE, RP (Qualifying)
Manager, Special Program Initiatives, BELLWOOD-EHN



OUR OBJECTIVES FOR TODAY:

01

INTRODUCTION

Provide an overview of the different types of Eating Disorders and associated symptoms and behaviours

02

EATING DISORDERS & ADDICTIONS

Discuss the interlinkage between Eating Disorders and Addictions

03

PERCIPITATING FACTORS

Discuss some of the precipitating and predisposing factors that can contribute to the onset and perpetuation of Eating Disorders

04

EATING DISORDERS & CONCURRENT PROGRAM AT BELLWOOD

Provide an overview of the new Eating Disorders & Concurrent program at Bellwood Health Services

Understanding Eating Disorders...

ANOREXIA NERVOSA

- The presence of an abnormally low body weight (e.g., 15% below expected for age & height)
- Intense fear of gaining weight or becoming fat, even though underweight
- Information process is focused with superior attention to detail
- Resistant to changing perspective despite there being new stimuli
- Rigid, inflexible, impaired set-shifting

BULIMIA NERVOSA

Recurrent episodes of binge eating which is characterized by both of the following:

- Eating, in a discreet period of time (i.e., 2 hrs.) a very large amount of food (1000 calories or more)
- Sense of lack of control
- Recurrent inappropriate compensatory behavior in order to prevent weight gain such as self-induced vomiting, misuse of laxatives, diuretics, enemas, medications, fasting, or excessive exercise
- Binge eating and inappropriate compensatory behaviours both occur on average at least once a week for three months
- Self-evaluation is unduly influenced by body weight and shape
- Disturbance does not occur exclusively during the course of AN

OSFED-Other Specified
Feeding & Eating Disorders

BED - Binge Eating Disorder

ARFID-Avoidant/Restrictive
Food Intake Disorder

Comorbidity & Mortality with ED...

ANOREXIA NERVOSA

- AN is the **third most common chronic illness** among adolescent girls
- Over half have a simultaneous psychiatric disorder such as, depression, anxiety, social phobia, substance use disorders
- Mortality rate between **5-20%**
- High suicide rate

BULIMIA NERVOSA

- Almost all report a co-occurring psychiatric disorder
- Mood Disorders are common
- Post Traumatic Stress Disorders (PTSD)
- Substance Abuse
- Social Phobia
- Impulse Control Disorders (Borderline Personality Disorders)
- Mortality rate reported to be as high as **4%**

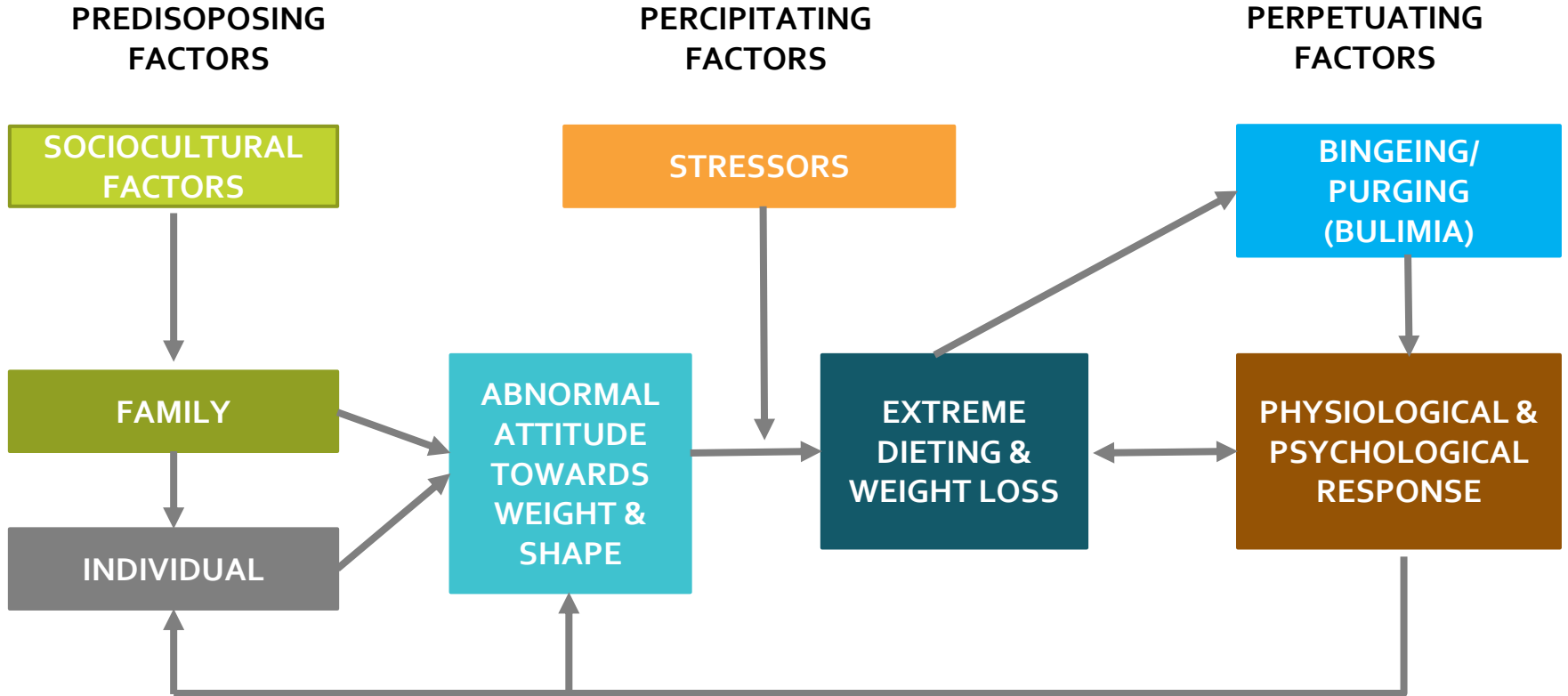


Modelling Support for Patients at Mealtime...



[Reference: Professor Janet Treasure-Maudsley UK](#)

The Multidetermined Nature of Eating Disorders Model...



Adapted from Garner & Garfinkel, Psychological Medicine, 1980, 10, 467-656

Predisposing Factors...

INDIVIDUAL

- Personality Features: Perfectionism, Obsessive & compulsiveness, early attachment difficulties such as separation anxiety, excessive compliance and low self-esteem
- Careers/professions such as modeling, dance, gymnastics, weight related sports
- Traumatic/difficult life events such as physical/sexual abuse, challenging changes/transitions such as family moves, changes in financial status, death/loss of a significant relationship (grandparent)

FAMILY

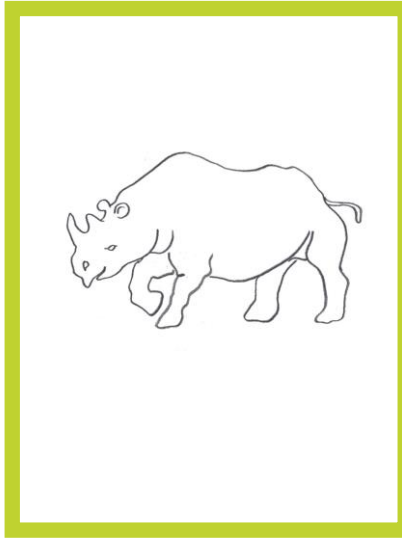
- Family history of depression, substance abuse, and obesity
- Value thinness and worry about their appearance and how they are viewed by others.
- Belief that control of food, weight and/or shape is connected to respect, sense of effectiveness, control, happiness, success and satisfying relationships
- Have strong attitudes about excellence and achievement
- Communication styles where there is lack of conflict resolution, difficulty expressing emotions (either under-expression or over-expression)
- Parenting styles that are rigid, chaotic, over-involved/under-involved



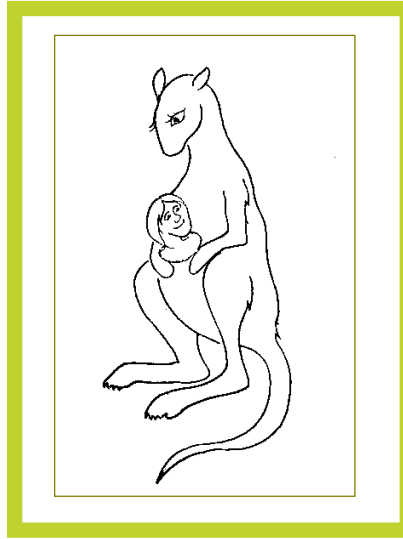
— —

THE FAMILY CONTEXT OF EATING DISORDERS





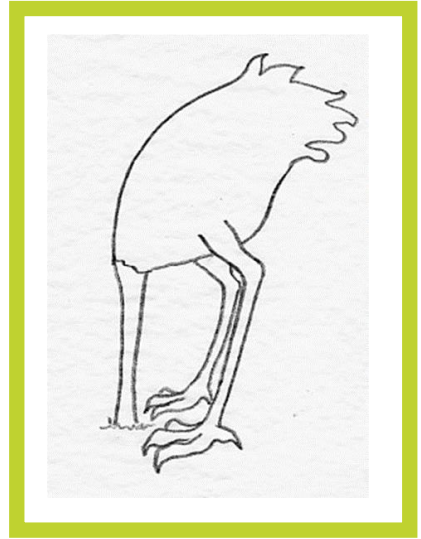
RHINOCEROUS
DIRECTING & ORDERING



KANGAROO
OVER-PROTECTION



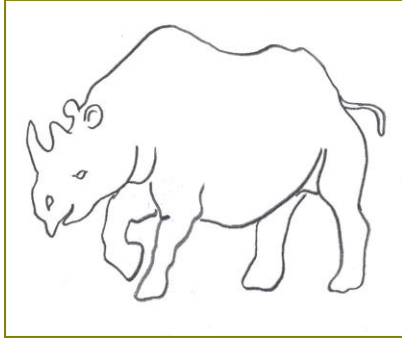
JELLY FISH
ANXIOUS



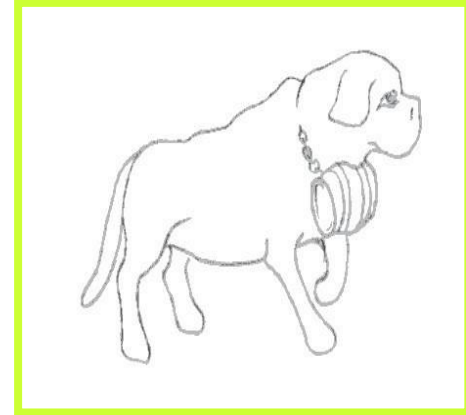
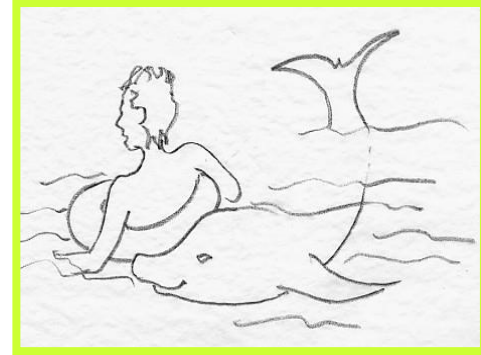
OSTRICH
AVOIDANT

FAMILIES ALONE DO NOT CAUSE EATING DISORDERS

Creating Change in Families...



**Calm
Caring
Compassionate
Consistent
Curious
Coaching**



Working with Families...



ENVIRONMENTAL CHANGE:

- Reduce over-protection
- Increase warmth and validation
- Decrease criticism
- Reduce accommodation to symptoms

The Sociocultural Context...



SOCIOCULTURAL CHANGE:

- Culture highly values thinness (Western Society)
- Thinness is equated with happiness, success, satisfying relationships



WE LIVE IN A
CULTURE THAT
VALUES
THINNESS, BUT
IN ITS
LIFESTYLE,
ENCOURAGES
OBESITY...



MANY OF THE
IMAGES WE
SEE ARE
DISTORTED...

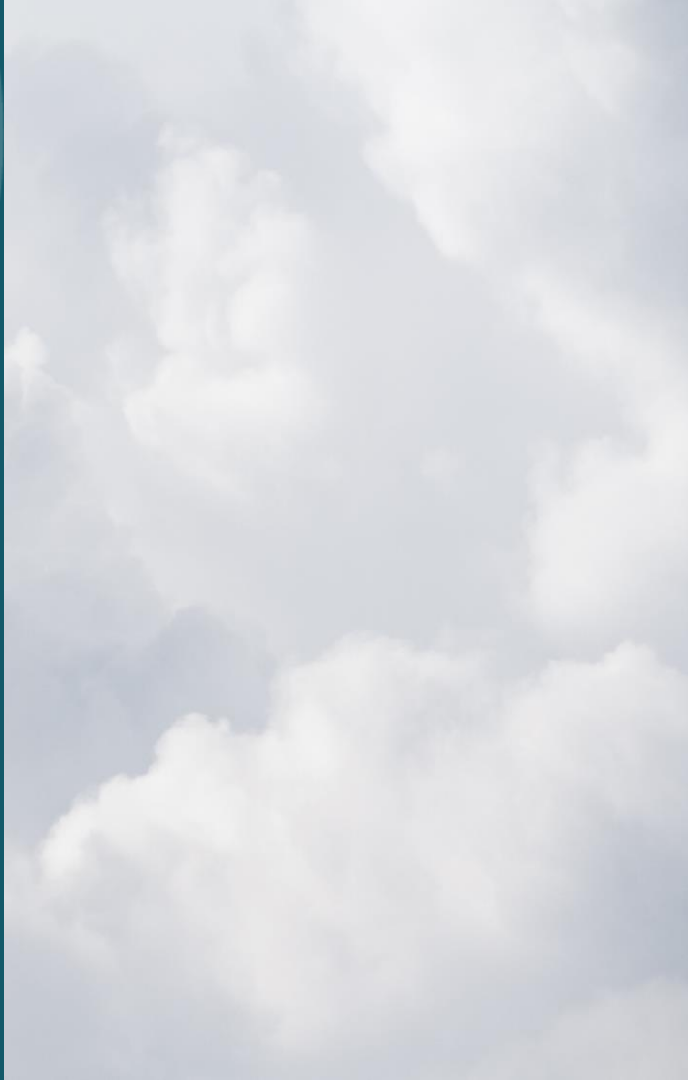


"My God! I've got last year's body!"

WE LIVE IN A
CULTURE THAT
VALUES
THINNESS, BUT
IN ITS
LIFESTYLE,
ENCOURAGES
OBESITY...



PRECIPITATING FACTORS

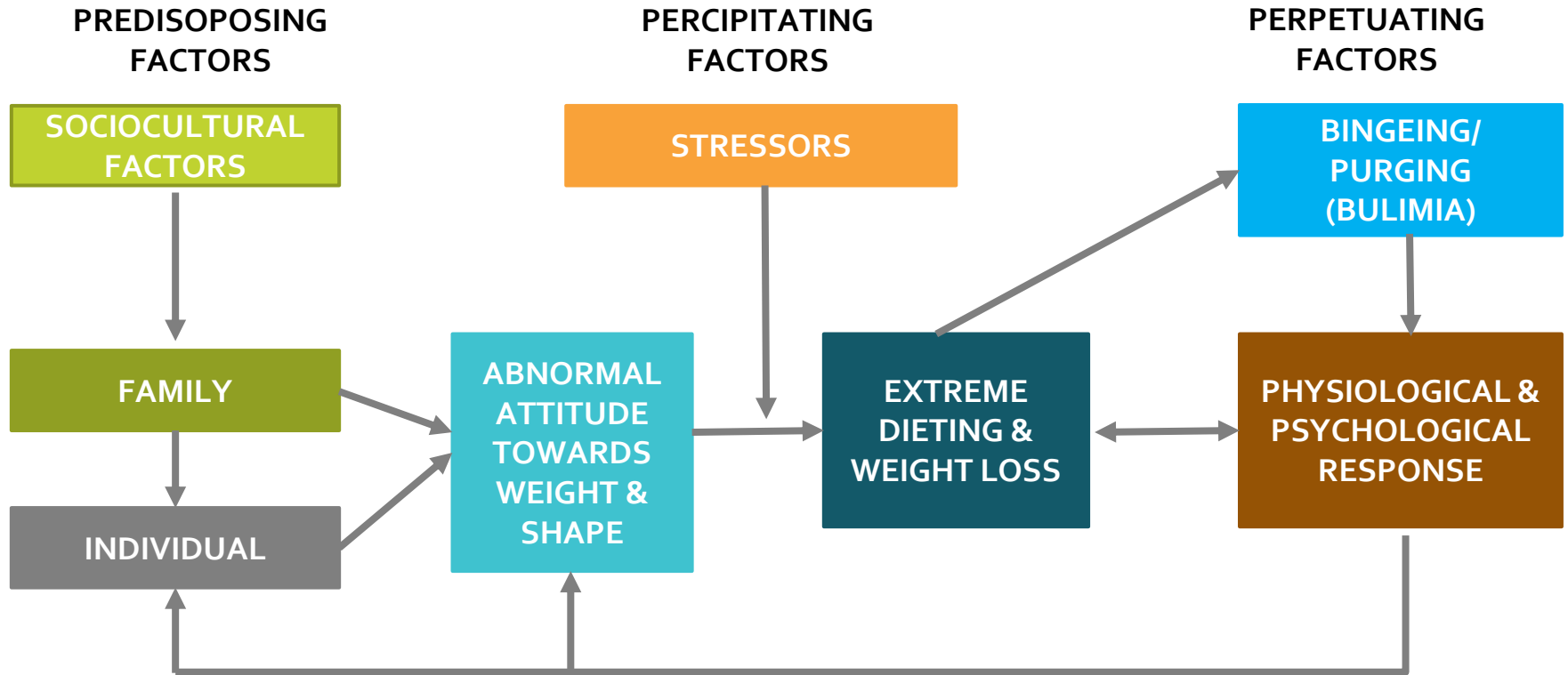


Perpetuating Factors...



- Dieting behaviours, especially, extreme dieting and weight loss can trigger physiological and psychological responses to the effects of starvation (bingeing)
- Distorted body image perceptions
- Continued exposure to cultural belief that thinness is essential for happiness, success, etc.

The Multidetermined Nature of Eating Disorders Model...



Adapted from Garner & Garfinkel, Psychological Medicine, 1980, 10, 467-656



— —

EATING DISORDERS & ADDICTIONS



Are Eating Disorders Addictions?

- If you have an eating disorder, you may engage in behaviours or have feelings that lead you to wonder if you are addicted to food
- Behaviour patterns observed with those with eating disorders are commonly identified in those with substance abuse.
- Common patterns include:
 - Preoccupation with the abused substance
 - Use of the substance to cope with stress and negative and uncomfortable feelings
 - Secrecy about the behaviour and maintenance of the behaviour despite harmful consequences
- Some have argued that individuals with eating disorders are “cross-addicted” to food and drugs and have suggested that an “addictive personality” may underline such cross addiction



Some General Difficulties with the Addiction Model in Eating Disorders...

- Despite a considerable amount of work in the area, it has been impossible to find a single type of personality that is an “addictive personality”
- Virtually none of the addiction treatment methods have a reasonable degree of documented effectiveness with eating disorders
- For women who make up 90% of those with eating disorders, addiction treatment alone has not reasonably addressed the socio-cultural context that impacts them
- The social context matters and is real.
- Addiction treatment alone has not adequately appreciated the impact dieting and starvation have on the physical and psychological sequelae
- The abstinence approach to addiction (stop using alcohol, drugs), is difficult to apply to eating disorders as one cannot abstain from food. It is necessary for survival.
- Avoiding alcohol may be the key to resolving addiction to alcohol, avoiding food will only increase the preoccupation with food & bingeing

Combining Addiction & Eating Disorders Treatment...

- Abstain from substances such as alcohol and drugs, dieting & starvation, bingeing & purging
- The key to recovering from an eating disorder is not food avoidance, but normalization of eating and restoration of natural weight
- For many with an eating disorder, it is reasonable to completely recover and move on with their lives



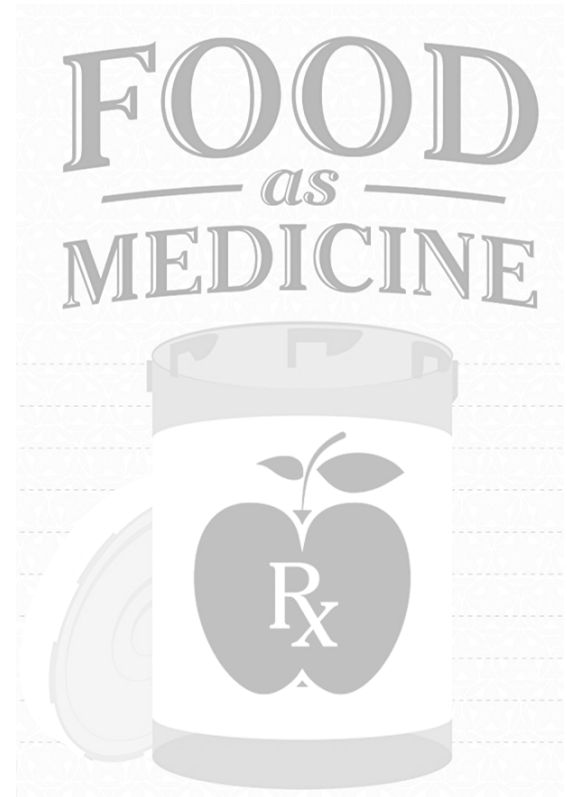
Treatment Approaches...

- Cognitive Behaviour Therapy (CBT) is the gold standard
- Dialectical Behaviour Therapy (DBT)
- Family Based Therapy (FBT) for younger patients
- Emotion Focused Therapy (EFT)



Principles of Treatment...


- Food is medicine
- Adopt a non-dieting and normalized approach to recovery
- Symptom cessation for both substances and eating behaviours (i.e. dieting)
- Address co-occurring psychiatric disorders
- Psychological focus on underlying factors while promoting normalized eating
- Adhere to trauma-informed care principles
- Therapeutic milieu: non-dieting culture for both staff and patients



Intensive Inpatient Residential Treatment...

- Longer treatment stays correlated with better outcome
- If full weight is restored in treatment=better clinical outcomes
- For those with low BMI's, inpatient/residential stays can be 3-4 months

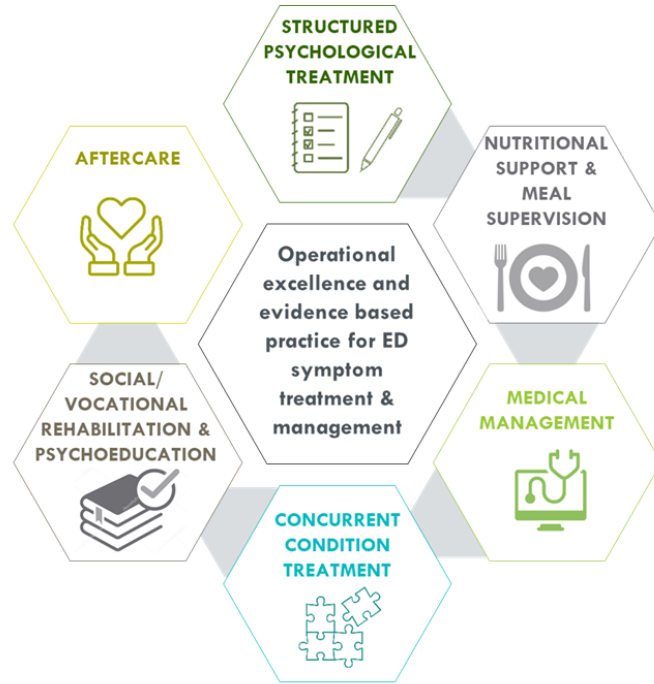




**EATING DISORDERS &
CONCURRENT PROGRAM
AT BELLWOOD**



Components Of Bellwood's Eating Disorders & Concurrent Program...



PROGRAM OBJECTIVES:

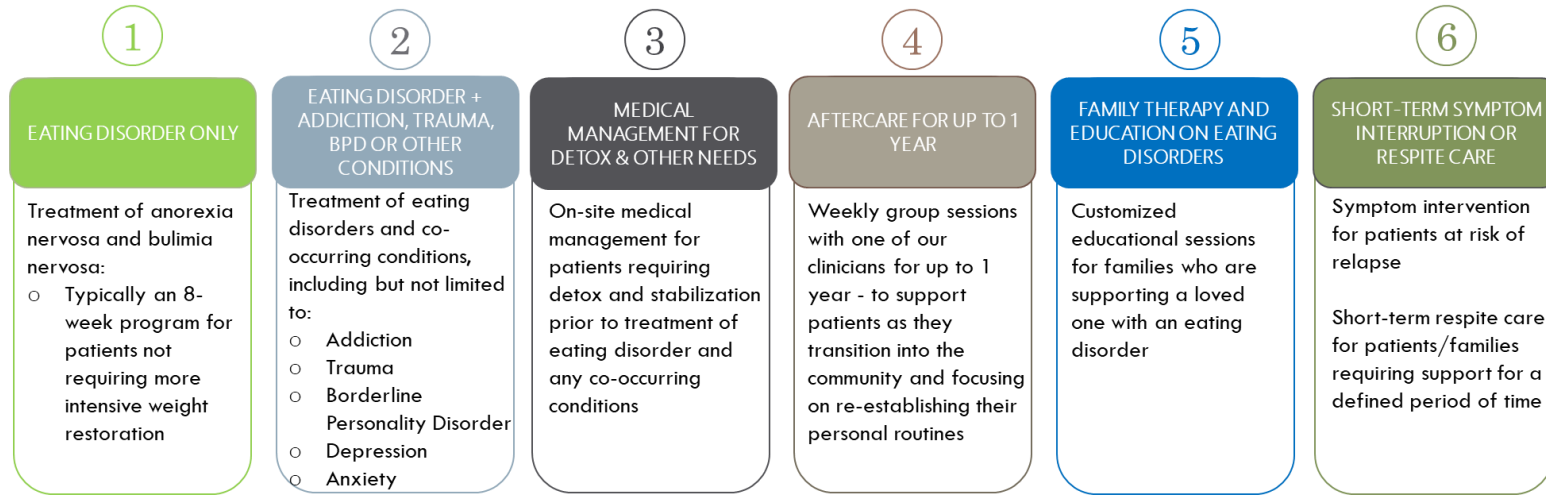
To provide evidence-based, best practice treatment to help our patients recover from their eating disorder (ED) and any concurrent disorders by aiding them in establishing or returning to a healthy and productive lifestyle through normalization of eating, weight restoration (if applicable), and reduction/elimination of ED symptoms.

Anorexia Nervosa

Bulimia Nervosa

Other Eating Disorders

Our Different Streams Of Programming Include...



← THE LENGTH OF ALL TREATMENT STREAMS IS DETERMINED & CUSTOMIZED BASED ON INDIVIDUAL PATIENT NEEDS →

Treatment with an interprofessional team of eating disorder experts:

- Psychiatrists
- Registered Dietitians
- Registered Psychotherapists
- Social workers
- Occupational therapists

Structured psychological treatment:

- Meal supervision
- Weekly individual therapy
- Daily group therapy
- Nutritional rehabilitation and psychoeducation
- Patient specific physical health and wellness activities

Use of evidence-based treatment methodologies:

- Pre-admission consultation with a psychiatrist
- Cognitive behavioral therapy
- Dialectical behavioral therapy
- Family therapy



QUESTIONS?
