Identifying and Assessing Eating Disorders in Children & Adolescents

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I would like to acknowledge the original custodians of this land and pay respects to the Elders both past, present and future for they hold the memories, the traditions, the culture and hopes of Aboriginal Australia

Eating disorders in Australia

National Eating Disorders Collaboration

Evidence | Experience | Expertise

FACT #1
Eating disorders are common. Approximately one million Australians are living with an eating disorder in any given year.

FACT #2
Eating disorders are serious, complex mental illnesses accompanied by physical and mental health complications which may be severe and life threatening. Eating disorders are characterised by disturbances in behaviours, thoughts and feelings towards body weight and shape, and/or food and eating.

FACT #3
Eating disorders are more prevalent among adolescents and young people, with the average onset for eating disorders between the ages of 12 and 25. However, any person, at any stage of their life, can experience an eating disorder.

FACT #4
The factors that contribute to the development of an eating disorder will differ from person to person and involve biological, psychological and sociocultural factors. Risk factors may include dieting, body dissatisfaction, relationship difficulties or a family history of eating disorders.

FACT #5
Among people diagnosed with an eating disorder, only around 23% access appropriate treatment. Challenges to seeking help may include stigma, ambivalence about recovery, cost of services, limited availability of services and difficulty recognising the severity of the eating disorder.

FACT #6
Eating disorders can co-occur with other mental health concerns such as depression and anxiety, and with medical conditions such as diabetes and digestive issues.

FACT #7
It is possible to recover from an eating disorder, even if a person has been living with the illness for many years. Early intervention and access to appropriate support and treatment can reduce the severity and duration of an eating disorder.

If you think that you or someone you know may be experiencing an eating disorder, it is important to seek help immediately.

To find help in your local area, go to **NEDC Support and Services**.

For information on eating disorders in Australia along with the references for these facts, go to **NEDC Eating Disorders in Australia booklet**.

What are Eating Disorders?

- Common
- Serious
- Scary for everyone involved
- Challenging to understand
- Difficult to treat
- Expensive and labour intensive for health services

Mortality

- Up to 20% after 20 years
- 5 times higher than the general population matched for age
- Death from “natural cause” is 4 x higher
- Death from unnatural causes is 11 x higher
- Death from suicide is 32 x higher than expected (and 20 x death rate from major depression)

Mirror Mirror on the Wall, Body Image Affects Us All

Diagnosed using DSM V

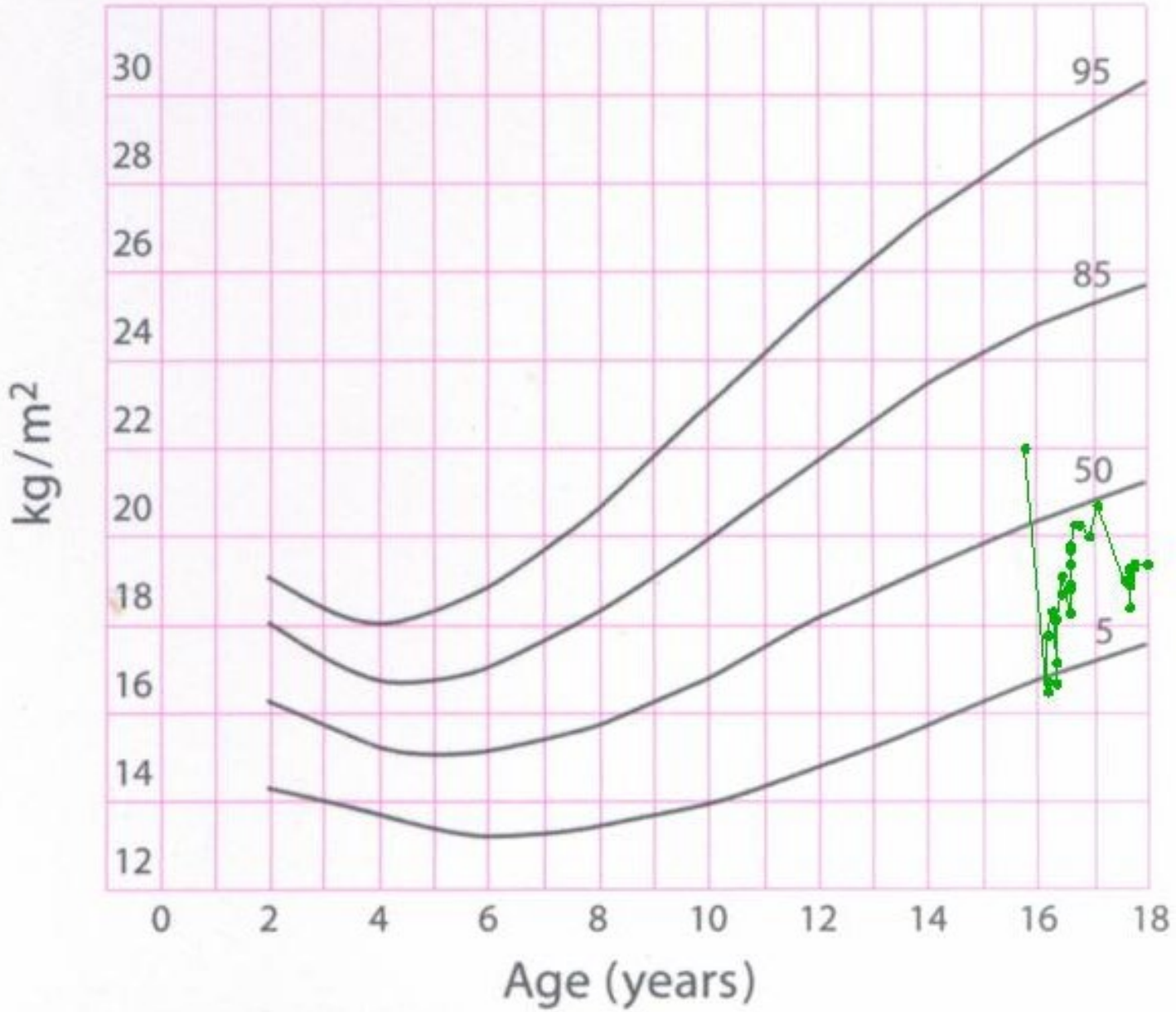
- DSM V
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Binge Eating Disorder
  - Avoidant Restrictive Food Intake Disorder
  - PICA
  - Rumination Disorder
  - OSFED & UFED

Anorexia Nervosa

- Persistent restriction of energy intake leading to significantly low body weight
- Either intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though at low body weight)
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

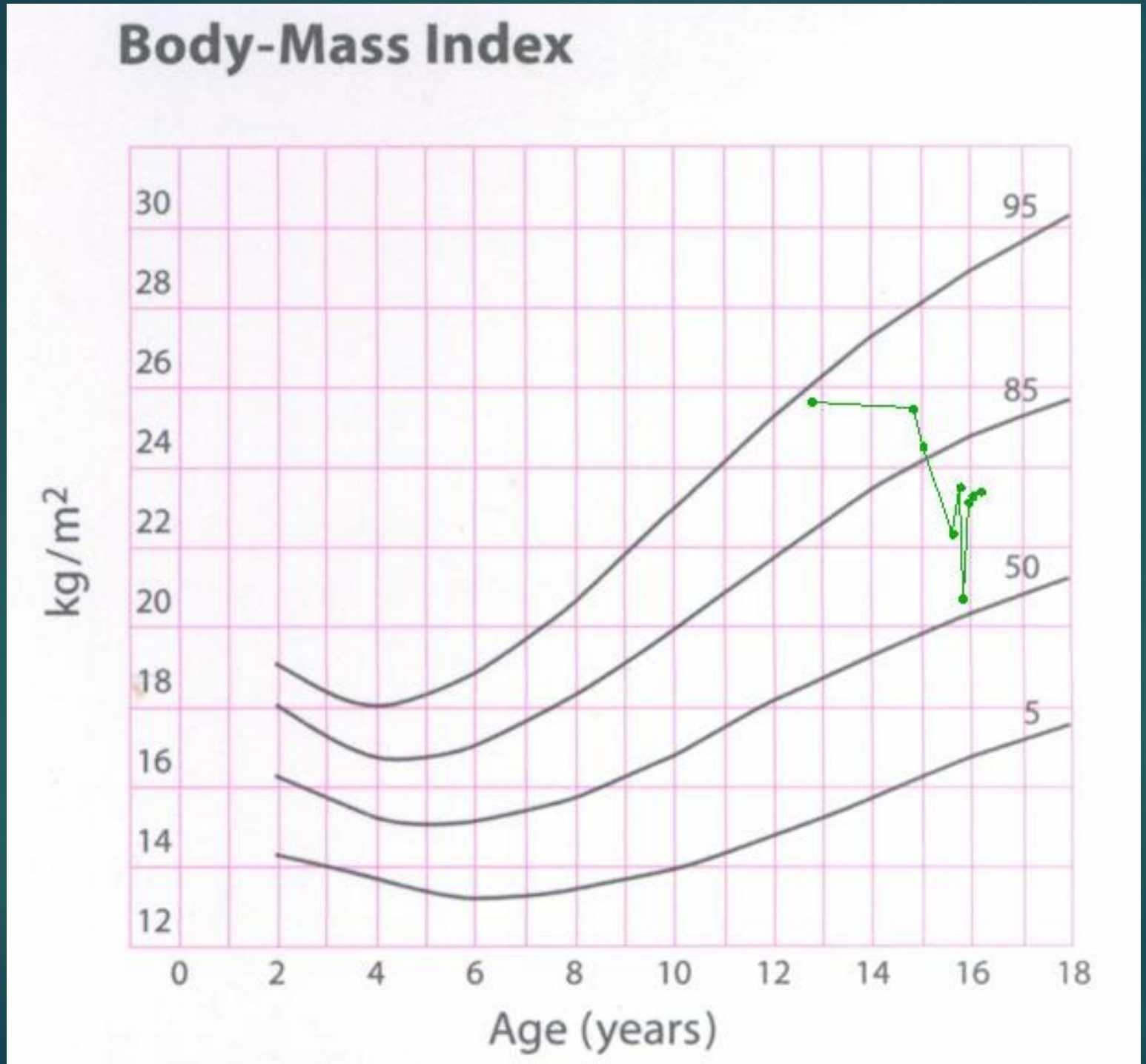
- Subtypes: 1. Restricting type 2. Binge eating/purging type

Body-Mass Index



Atypical Anorexia Nervosa (OSFED)

- Meets all of the criteria for anorexia nervosa, except that despite significant weight loss, the individual's weight is within or above the normal range.


Body-Mass Index
30
28
26
24
22
20
18
16
14
12
kg/m²
95
85
50
5
0
2
4
6
8
10
12
14
16
18
Age (years)

Bulimia Nervosa

- Recurrent episodes of binge eating.
  - Eating, in a discrete period of time an amount of food that is definitely larger than most people would eat during a similar period
  - A sense of lack of control over eating, during the episode
- Recurrent inappropriate compensatory behaviours, such as vomiting, misuse of medications, fasting, excessive exercise.
- The 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 shape and weight.

- This does not occur exclusively during episodes of Anorexia Nervosa.

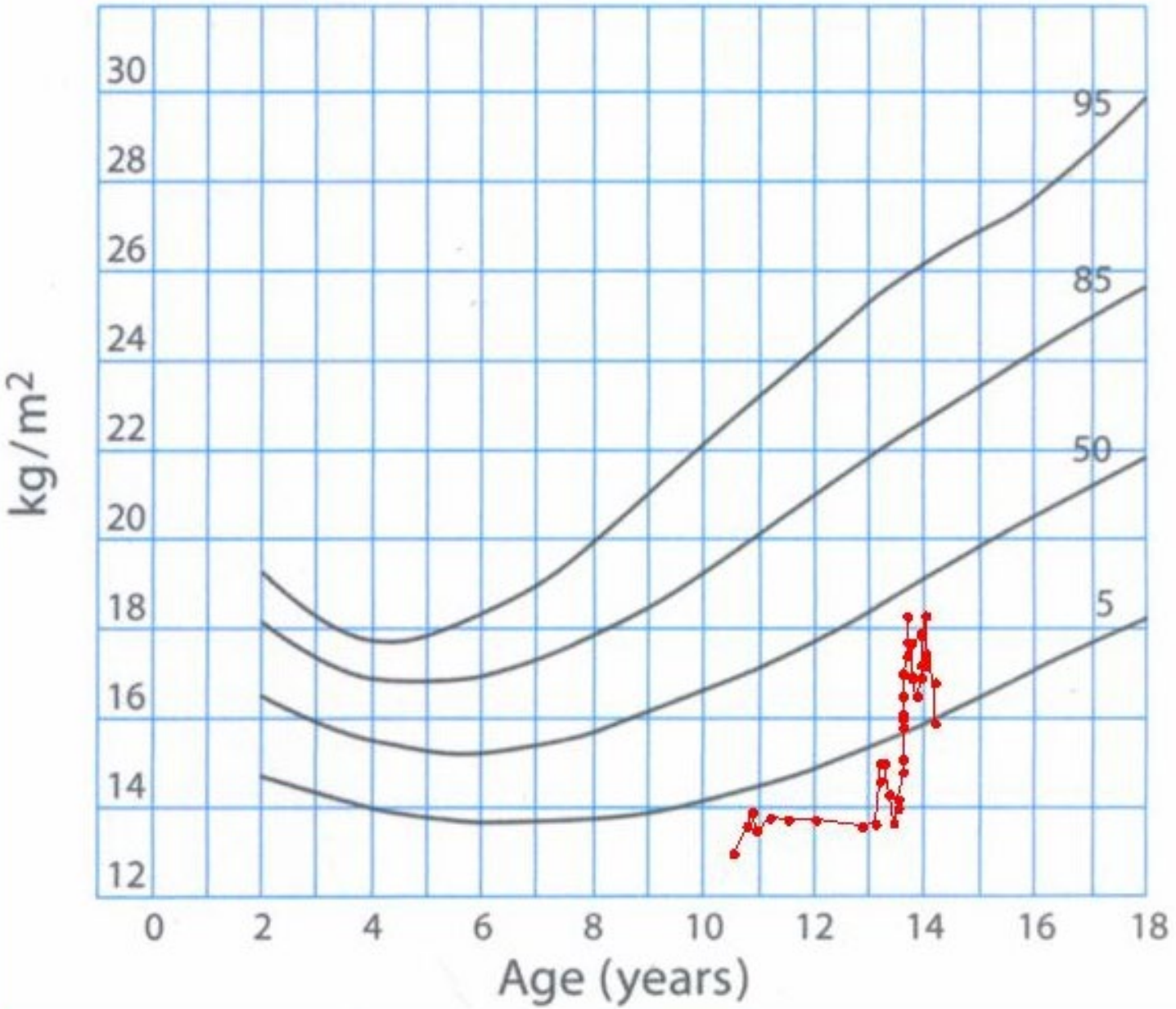
Binge Eating Disorder (BED)

- Recurrent episodes of bingeing
- The binge eating episodes are associated with 3+ of the following:
  - Eating more rapidly than normal
  - Eating until feeling uncomfortably full
  - Eating large amounts of food when not physically hungry
  - Eating alone because of feeling embarrassed by volume one is eating
  - Feeling disgusted with oneself, depressed or very guilty afterwards
- Marked distress regarding binge eating is present
- The binge eating occurs on average once a week for 3 months
- The binge eating is not associated with compensatory behaviours, and does not occur exclusively in the course of AN or BN

ARFID (Avoidant Restrictive Food Intake Disorder)

- An Eating or Feeding disturbance manifest by persistent failure to meet nutritional needs associated with at least one of the following:
  - Significant loss of weight (or failure to achieve expected weight gain)
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning
- The behavior is not better explained by lack of available food or by an associated culturally sanctioned practice.
- There is no evidence of a disturbance in the way one's body weight or shape is experienced.
- The eating disturbance is not attributed to a medical condition, or better explained by another mental health disorder.

Body-Mass Index



What am I interested in on history?

- Growth and weight history (please measure & chart)

- Medical symptoms
  - Cold and blue
  - Dizzy, fainting
  - Lethargic
  - Constipated
  - Amenorrhea
  - Low mood & anxiety

- Dietary Intake
  - What is actually eaten
  - Limitations, exclusions
  - Changes

- Behaviours
  - Exercise – quantify
  - Incidental activity
  - Work
  - Purging

SCOFF questionnaire

Eating Disorder Screening – for AN & BN

- S - Make yourself SICK when you feel uncomfortably full?
- C - Worry you have lost CONTROL over how much you eat?
- O - Recently lost more than One stone (~ 6 kg) within three months?
- F - Believe you are FAT when others say you are too thin?
- F - Would you say that FOOD dominates your life?

- Interpretation
  - Score one point for each question answered 'yes' above
  - Two or more points suggests eating disorder

- Efficacy
  - Sensitivity: 100%
  - Specificity: 87.5% (12.5% false positives)

- Reference: Morgan (1999) BMJ 319:1467

Main Decisions

- Is this person medically compromised?
  - If so send to hospital
- Is this person at risk of suicide?
  - If so send to hospital

Indicators suggesting Medical Compromise

- BP< 80/50mmHg children (BP < 90/60mmHg adults)
- Postural BP drop >20mmHg
- Hypothermia <35.5℃
- Bradycardia HR < 50 children (HR <40 adults)
- Significant Tachycardia, check for postural tachycardia >30pbm
- BMI < 5th percentile
- Rapid weight loss - > 1kg/week for more than 4-6 weeks
- Dehydration or severe fluid restriction
- Electrolyte imbalance especially - K and Cl
- Low blood sugar levels (<3.0 mmol/L)
- Cardiac conduction abnormalities (electrolyte related & prolonged QT)

Indicators for Psychiatry Risk

- Suicidal Ideation
- Severe Self Harm

- **Other reasons for admission**
- Failed Outpatient Treatment
- Family unable to manage young person
- Concerns about safety

Legislation to facilitate treatment

If a patient is at medical risk but does not consent to treatment, or their family does not consent to treatment, there are legal frameworks to assist ensuring urgent medical care is provided

- Duty of Care
- Child Care & Protection Act
- Mental Health Care Act
- Guardianship Act

Management Options

- Reassure, wait and see what happens – keep watching
- Refer to general paediatrician
- Refer to dietitian +/- psychologist
- Refer to CAMHS (via mental health referral line)
- Refer to Eating Disorder Medical Assessment Clinic (JHCH)
- Send to JHH Emergency Department

- If concerned call and discuss – Adolescent Physician or Fellow (routine hours) or on-call registrar or paediatrician

Medical Management

- Medical Refeeding (avoiding refeeding syndrome)
- Medical investigation – exclude other pathologies
- Psychiatric assessment/ management co-morbidities
- Containment of anxiety & distress
- Assistance with return to regular inclusive eating
- Normalisation of activities (as nutrition improves)

- Advocate for Family Based Treatment as first line in youth

Maudsley Family Based Treatment (FBT)

- FBT using the Maudsley Model is the evidenced based treatment preferred for children & adolescents AN, AAN, and ARFID
- It is outpatient based and continues for ~12months
- The parents are the prime resource for refeeding their child
- They are supported by a therapist very regularly
- Supported by paediatrician and psychiatrist as needed
- Good outcomes in 10-18yr olds within < 3yrs of illness onset

- 75% recovery at 5yrs with Maudsely Family Based Treatment

Outpatient Care

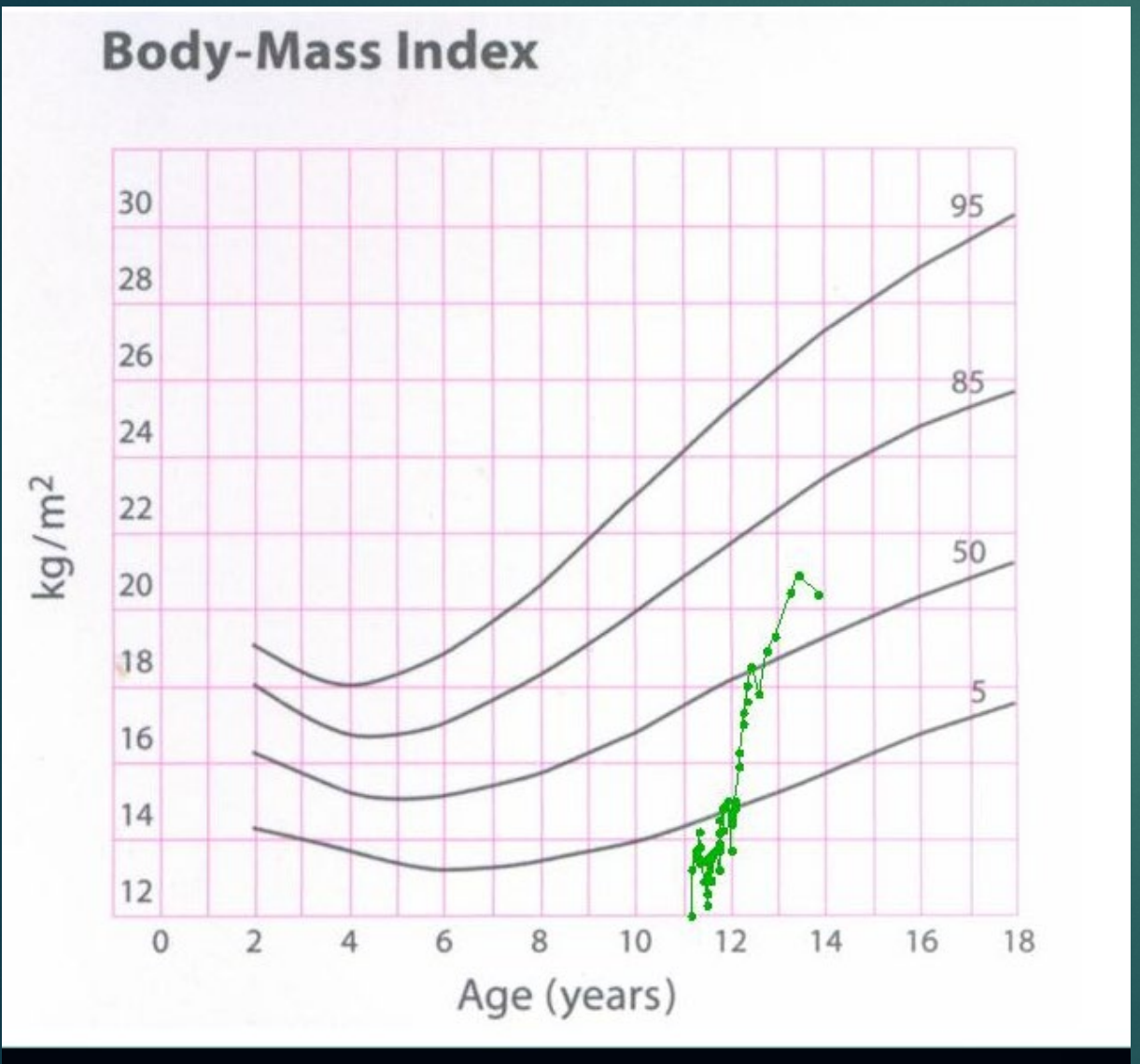
- Patients usually supported by a multidisciplinary team:

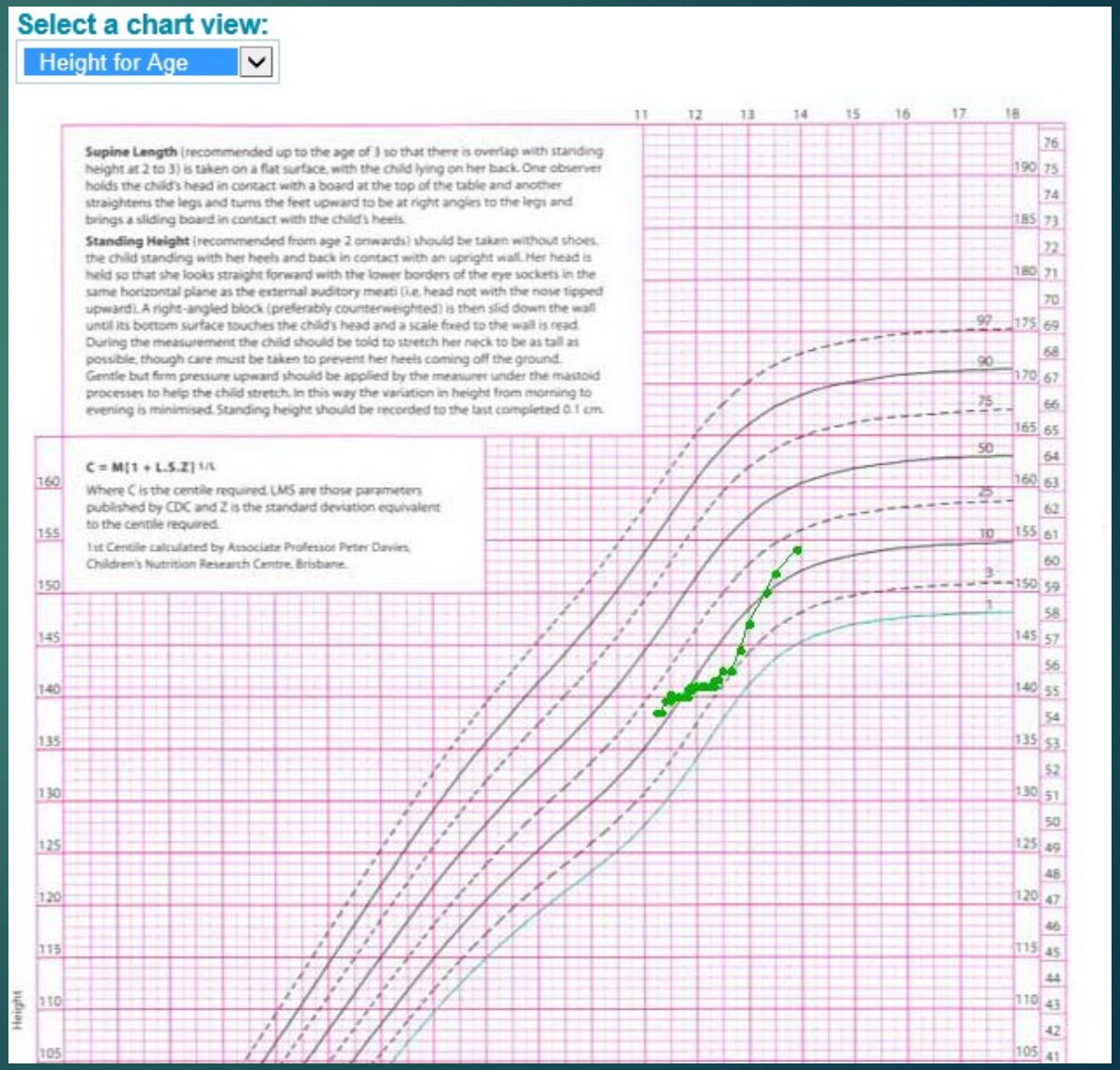
- CAMHS or private psychologists/dietitians weekly
- Paediatrics – every 1-3 months depending on acuity
- General Practitioners every 1-2 weeks initially
- General support services: Headspace, school counsellors

What is expected of GPs

- Regular review regarding medical stability and sharing of information
- This usually doesn't include weights - will be done by FBT team
- Monitoring pulse rate, BP, temp, blood tests, ECG (if needed) and checking in for psychiatric stability too
- Liaising with the extended treatment team – including CAMHS clinicians, dietitian, psychiatrist, paediatrician as needed.
- Helping avoid 'team splitting' by supporting a unified approach
- Including parents as the main therapeutic support for the young person

Recovery – what it might look like





Support Services

- Inside Out Institute www.insideoutinstitute.org.au
- National Eating Disorder Collaboration – NEDC
- CEED (Centre for Eating & Dieting Disorders), Victoria

- Online resources for families
  - Butterfly Foundation
  - Maudsley Parents, FEAST, Around the Dinner Table

Area Wide Service Supports

- **Community Health Pathways online**

- CAMHS Services and MH Helpline 1800 011511
- Paediatrician on-call – via switchboard
- Child & Adolescent Psychiatrist on-call – via switchboard

- Mel Hart – HNELHD Eating Disorder Service Lead, HNELHD

Dr Julie Adamson, Adolescent Physician

Julie.Adamson@health.nsw.gov.au

Phone: 49213670 (sec) or mobile via switchboard

Dr Mel Hart (PhD) – Lead, Clinical Support Team

New multi-disciplinary consultation and training service for HNELHD teams working with children with Eating Disorders.

Mobile: 0439 494108

Role of the Dietitian – our focus

- Dietetics have a significant role especially early in diagnosis while medical risk is high
- Tailor an individuals nutrition care aiming to correct nutritional deficiencies including caloric deficits and specific nutrients
- Help young people and their families understand the interaction between food, nutrition and well-being
- Promote optimal nutrition status specific to the individual
- Nutrition education to challenge inaccurate beliefs and food rules
- Tailored guidance for families around specific nutrition goals for the individual to maintain adequate growth, physical , psychological and intellectual development

Dietitian-our focus

- Support eating behaviours that assist treatment and recovery goals
- Work to improve physical health and improve cognitive functioning through adequate nutrition, to allow psychological therapies to proceed
- Nutrition intervention to manage/decrease physical effects of eating disorder e.g. constipation, dehydration, altered electrolytes
- Nutritional management of therapeutic diets whilst treating eating disorder e.g. Type 1 diabetes, food allergies , ADHD
- Weight neutral approach – functionality of body
- Body image work
- Enjoyment of food and the role of food in society

What We Don't Do

- Food police
- Sole treatment provider – must work with MDT for effective treatment
- Manage medical or psychological risk
- Weight loss – cannot effectively treat ED and aim for weight loss in any diagnosis. Risk of an eating disorder in young person who diets is 18x higher

Nutrition Red Flags

- Females, especially during biological and social transition periods (e.g., onset of puberty, change in relationship status, pregnancy and post partum , change in social role)
- Adolescent risk is highest between 13 and 17 years of age
- Competitive occupations, sports, performing arts and activities that emphasise body shape or weight requirements (e.g., modelling, gymnastics, horse riding, dancing, athletics, boxing, martial arts)
- LGBTQIA+ communities.
- Neurodiverse young people with restrictive eating patterns
- Type 1 diabetes , Food allergies e.g. coeliac disease , restrictive therapeutic diets – FODMAPS
- Vegetarian and veganism

Who we work with ?

- Depends on treatment modality
- FBT dietitian usually works more with the parents than the young person in early stages of treatment to enable parents to adequately refeed their young person, may work with young person in stage 3
- RAVES – will work with young person and family , useful for education of whole family in FBT model
- Closely with MDT using information from all team members including family, GP, psychologist , school particularly boarding, coaches-sporting clubs

'RAVES'

S. Jeffery, APD (2013)

Regularity	Foundation step in re-integrating food & eating into life
Adequacy	Sufficient food to meet your nutritional requirements, what ever they might be.
Variety	Further step in developing a positive relationship with food, form the foundation for eating socially & challenges rigid food beliefs
Eating **S**ocially	Integrating eating back into your social setting & connections
Spontaneity	Flexibility, ease of decision making about eating

Primary Goals of Dietetic intervention

- Weight restoration if underweight
- Adequate nutrition for growth & pubertal development (return of menses)
- Weight goals often need to be slightly higher than pre-illness weight particularly if illness has been over an extended period of time, to allow for expected growth and pubertal body shape changes
- Adequate nutrition for normal mentation – this is slowed when nutrition has been restricted for long periods of time; affect is often flat initially
- Decrease or cease compensatory behaviours e.g. purging, laxatives, resume exercise to normal amounts
- Minimise food rules
- Food variety and social aspects of food

Regular Structured Eating

- Re-embed regular meals in life
- Build a meal pattern
- Plan regular meal & snack times
- Pre-plan content of meals

- Restore physiological & social rhythms:
  - Appetite (anticipatory reward) – ingestion – satiation – satiety levels

- Eating times & food-free times

Physiological changes

- Adolescence is the only time after birth when the velocity of growth actually increases!
- Adolescents gain 20% of their adult height and 50% of their adult weight during this period
- Average growth boys 28-51cm and 34-54 kg
- Average growth girls 21.5-25cm and 30-50kg
- Most females gain no more than 5-7cm after menarche
- Skeleton stops growing around 18-19 years girls and 20-22 boys

Nutrients at Risk

- Energy
- Calcium
- Iron
- Zinc
- Vitamin D /fat soluble vitamins
- Macronutrients –carbohydrates, protein, fat
- Fluid

Aim to correct deficiencies with food but may need to use supplements in early stages of illness to increase levels

SERVE SIZES

Vegetables and legumes/beans

Serves per day	2–3 years	4–8 years	9–11 years	12–13 years	14–18 years
Boys	2½	4½	5	5½	5½
Girls	2½	4½	5	5	5

A standard serve of vegetables is about 75g (100–350kJ) or:

- ½ cup cooked green or orange vegetables (for example, broccoli, spinach, carrots or pumpkin)
- ½ cup cooked, dried or canned beans, peas or lentils*
- 1 cup green leafy or raw salad vegetables
- ½ cup sweet corn
- 1 medium potato or other starchy vegetables (sweet potato, taro or cassava)
- 1 medium tomato

*preferably with no added salt

Fruit

Serves per day	2–3 years	4–8 years	9–11 years	12–13 years	14–18 years
Boys	1	1½	2	2	2
Girls	1	1½	2	2	2

A standard serve of fruit is about 150g (350kJ) or:

- 1 medium apple, banana, orange or pear
- 2 small apricots, kiwi fruits or plums
- 1 cup diced or canned fruit (with no added sugar)

occasionally:

- 125ml (½ cup) fruit juice (with no added sugar)
- 30g dried fruit (for example, 4 dried apricot halves, 1½ tablespoons of sultanas)

Grain (cereal) foods, mostly wholegrain and/or high cereal fibre varieties

Serves per day	2–3 years	4–8 years	9–11 years	12–13 years	14–18 years
Boys	4	4	6	6	7
Girls	4	4	5	5	7

A standard serve (500kJ) is:

- 1 slice (40g) bread
- 1 (40g) roll or flat bread
- ½ cup (120g) cooked rice, pasta, noodles, barley, buckwheat, semolina, polenta, bulgur or quinoa
- ½ cup (120g) cooked porridge
- ¾ cup (30g) wheat cereal flakes
- ¼ cup (30g) muesli
- 1 (35g) crispbreads
- 1 (60g) crumpet
- 1 small (35g) English muffin or scone

Lean meats and poultry, fish, eggs, tofu, nuts and seeds, and legumes/beans

Serves per day	2–3 years	4–8 years	9–11 years	12–13 years	14–18 years
Boys	1	1½	2	2½	2½
Girls	1	1½	2	2½	2½

A standard serve (500–600kJ) is:

- 65g cooked lean meats such as beef, lamb, veal, pork, goat or kangaroo (about 80–100g raw)*
- 80g cooked lean poultry such as chicken or turkey (100g raw)
- 100g cooked fish fillet (about 115g raw weight) or one small can of fish
- 2 large eggs
- 1 cup (120g) cooked or canned legumes/beans such as lentils, chick peas or split peas (preferably with no added salt)
- 170g tofu
- 30g nuts, seeds, peanut or almond butter or tahini or other nut or seed paste (no added salt)

*weekly limit of 455g

Milk, yoghurt, cheese and/or alternatives, mostly reduced fat

Serves per day	2–3 years	4–8 years	9–11 years	12–13 years	14–18 years
Boys	1½	2	2½	3½	3½
Girls	1½	1½	3	3½	3½

A standard serve (500–600kJ) is:

- 1 cup (250ml) fresh, UHT long life, reconstituted powdered milk or buttermilk
- ½ cup (120ml) evaporated milk
- 2 slices (40g) or 4 x 3 x 2cm cube (40g) of hard cheese, such as cheddar
- ½ cup (120g) ricotta cheese
- ¾ cup (200g) yoghurt
- 1 cup (250ml) soy, rice or other cereal drink with at least 100mg of added calcium per 100ml

- To meet additional energy needs, extra serves from the Five Food Groups or unsaturated spreads and oils, or discretionary choices may be needed by children who are not overweight but are taller, more active or older in their age band.
- An allowance for unsaturated spreads and oils for cooking or nuts and seeds can be included in the following quantities: 4–5g per day for children 2–3 years of age, 7–10g per day for children 4–12 years of age, 11–15g per day for children 12–13 years of age and 14–20g per day for adolescents 14–18 years of age.
- For meal ideas and advice on how to apply the serve sizes go to:

www.eatforhealth.gov.au

How much food - more than you think!

Food rules

- Can't eat after 6pm
- No white foods
- No liquid calories
- Eat once a day
- Fruit only until dinner
- If eat more than fruit purge
- 1L water at each meal
- Only allowed to eat if weight less than yesterday
- Aim for 20 inch waist – measure three times a day

Weighing

- MDT needs to decide who weighs – not everyone in team should weigh as distressing and confusing as all scales vary!
- If psychologist or dietitian doing FBT they will weigh in session
- Must be good communication across teams so information is timely
- Needs to be consistent : same scales , light clothing or underwear, no shoes , empty pockets
- Parents need to be educated re manipulation of weight e.g. water loading , hiding items in clothing prior to appointments
- Decide whether blind weigh or open weighs most appropriate for each individual. In FBT & CBT-e open weigh is standard part of therapy.

Role of Psychology

- Comprehensive assessment with strong consideration of perpetuating psychological factors
  - Anxiety and obsessive compulsive traits
  - Avoidant and safety behaviours
  - Sense of self
  - Low self-esteem
  - Personality traits (perfectionism, neuroticism)
  - Locus of control
  - Reinforcing factors (attention from peers/family, social media use, school avoidance)
  - Psychosocial events & external drivers (trauma history, DV, access to food, family dynamics and mental health history)
- Individualised biopsychosocial formulation in collaboration with young person & their family.
- Treatment plan using evidence-based modality, considering individual context and needs.

Treatment for Children and Adolescents

- Inpatient Treatment (expert opinion)
  - Medical stabilisation & nutritional rehabilitation
  - Meal Support Therapy – supervised eating
  - Psychoeducation and management of distress
  - **Formal psychological treatment usually doesn't commence during an inpatient stay**.

- Outpatient Treatment (RCTs and good evidence of benefit)
  - Family Based Treatment (FBT Maudsely Model)
  - CBT-E/CBT-AR

  - Growing evidence & support for : MANTRA, SSCM, IPT, DBT, ACT – mainly in adults

Family Based Treatment (FBT) (Maudsley Model)

- First line treatment for children and adolescents under 19years of age that are medical stable and have a short duration of illness (<3yrs)
- Empirical evidence to support FBT for AN, BN, ARFID.
- 3 phases over 20 session (approximately).
  - Phase 1 – Weight Restoration (Sessions 1-10)
  - Phase 2 – Handing over control (Sessions 11-16)
  - Adolescent development issues (Sessions17-20)

FBT - Fundamental Assumptions

- **Neither the parents nor the young person are to blame for the illness**
- Clinicians take a non authoritarian stance
- Parents are responsible for weight restoration
- Externalisation of the illness. Separate the person from the illness – the eating disorder is the problem, not the person
- Focus on symptoms

- ***Contraindications***
  - ***No parental figures***
  - ***parents have own mental health/psychosocial issues and do not have capacity to control food and eating at home***
  - FBT can be effective with separated parents, but may bring extra challenges

Stage 1 – weekly sessions

- Goals
  - Help parents take control of the weight restoration process at home
  - Control over food is taken away from the eating disorder and given to the parents.
  - Creating an "intense scene" – parents are often too anxious or not anxious enough. The therapist will calibrate parental anxiety by engaging parents and escalating concern with support to work with them to make changes.
- **The Family Meal** – the whole family brings a meal to the session that both parents agree is enough food and challenging for the eating disorder. The therapist observes the meal until the eating disorder has taken control and then begins coaching. Assisting parents to encourage the child to keep eating and be consistent in messaging, problem solving rather than direction.
- "I know you are scared but I need you to eat it anyway".
- Food is Medicine!

Stage 1 cont.

- Following sessions aim to keep family focused on eating disorder, parents take charge of eating and mobilise the siblings to support the patient.
  - Food and meal time boundaries – no negotiating with the eating disorder
  - Young person is not in the area where food is being prepared.
  - Meals are to be the same for the rest of the family, eaten together at the table – not in their room
  - Rest time after meals, read a book, watch TV, no bathroom for 1 hour afterwards. Often highly anxious times and may require building on coping skills (e.g., distraction, self-soothing, imagery, mindfulness, pros and cons, TIPP, etc.).

Stage 2 – fortnightly sessions

- Maintain parental management of eating disorder symptoms until the child/adolescent shows evidence that she is able to eat well and gain weight independently
- Return food and weight control to adolescent as indicated by stage of development
- Explore the relationship between adolescent developmental issues & AN.
- Encourage normal adolescent activities.
- Weight to be at least 90% of healthy BMI before progression to Phase 2.

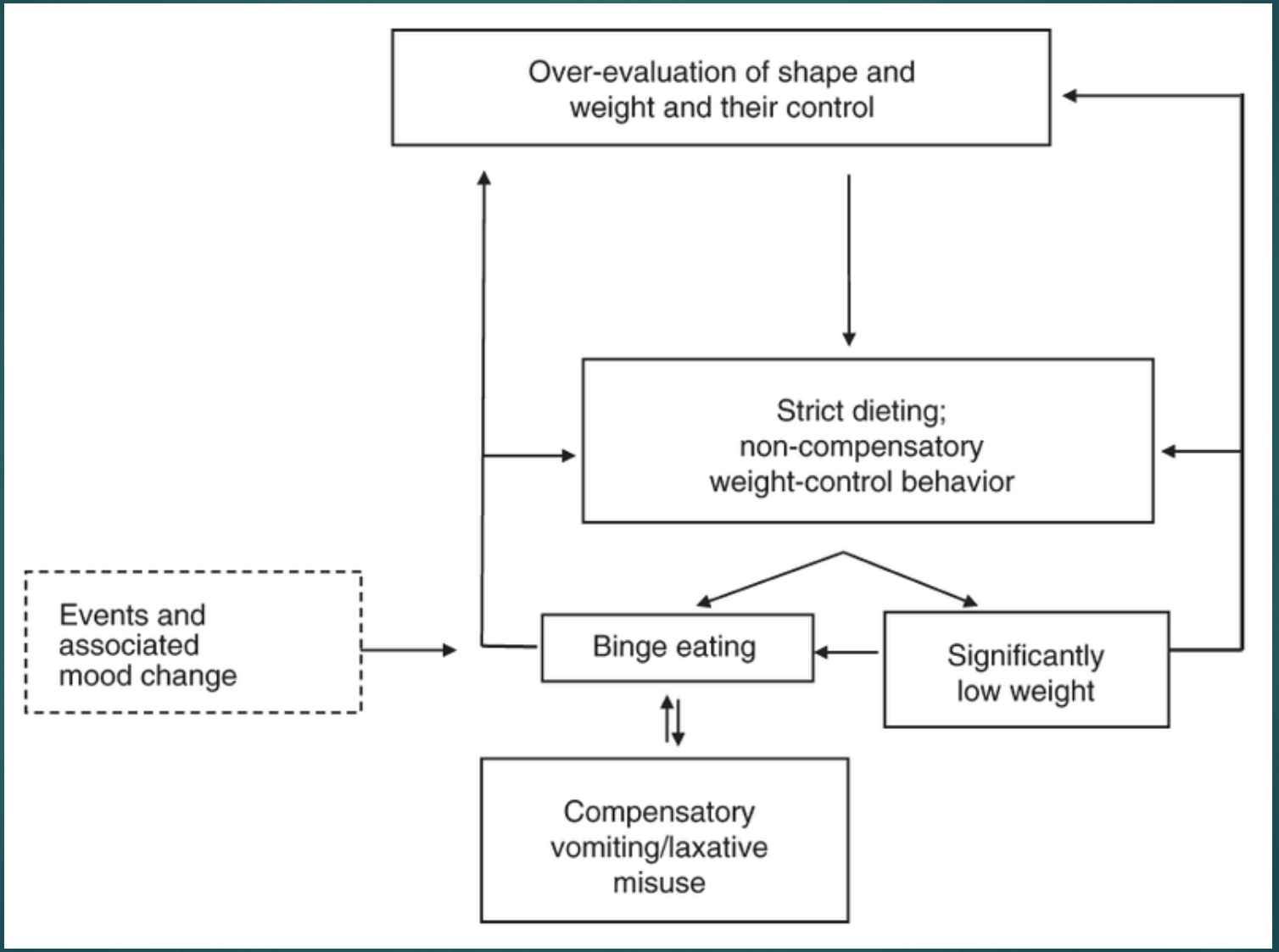
Stage 3 – monthly to 6 weekly

- Review adolescent issues with the family and model problem solving
- Terminate treatment
- Adolescent development reviewed
  - Puberty and body adjustment (ages 11-13)
  - Social identity and roles (ages 14-16)
  - Intimacy and leaving home (ages 17-18)
- Parents to reminisce about each stage of their own development to normalise the experience. Pick area to problem solve (e.g., sex, friends, rules, drugs).

CBT-E

- First line treatment for adults with Bulimia Nervosa, Binge Eating Disorder and mild/mod Anorexia Nervosa.
  - Evidence to support CBT-E for treating adolescents with eating disorders.
  - Empirical Support for CBT for ARFID (CBT-AR)
- Primarily an outpatient treatment – though can be adapted to inpatient and day patient
- 20-40 sessions
  - Interaction between overvalued ideas of weight and shape, associated thoughts, and strict dieting that results in disordered eating.
  - Prescription of regular normalised eating, graded exposure to feared foods, monitoring and challenging distorted thoughts about weight, food and the self.
  - Targeting Perfectionism, mood intolerance, low self-esteem and interpersonal problems

CBT-E Formulation for BN



Other considerations in treatment

- Limitations in research and "evidence based treatment".
  - Results rarely generalise to other populations
  - What about the % of participants that saw no improvement

- Considerations
  - Starvation syndrome and CBT-E
  - Complex family structures
  - "Resources" required for therapy – time, finances, emotional capacity,
  - Trauma informed work
  - Developmental age and maturity level.
  - Neurodevelopmental diagnoses and comorbid mental health concerns
  - Working with minorities
  - Previously trialled therapies

Challenges – highly emotional work

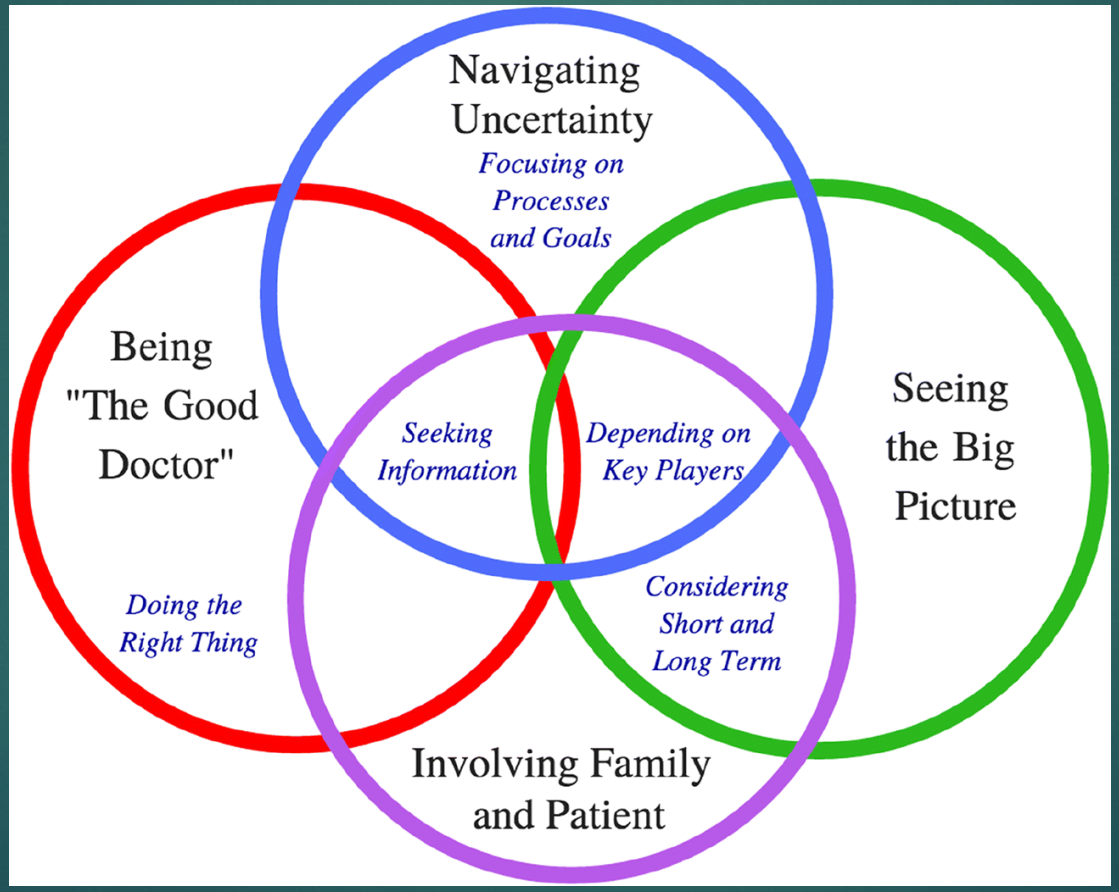
- Typically these young people often present as highly conscientious, agreeable, polite individuals. In reaction to the situation (i.e. needing to eat & gain weight) the eating disorder may cause them to have a strong emotional response:
  - High distress
  - Inconsolable crying
  - Anxiety/avoidance/withdrawal
  - Agitation and aggression
  - Suicidal thoughts and self-harming behaviours
  - Violence towards others
- This can generate emotional responses in clinicians including anxiety, distress, uncertainty, sense of inadequacy or failure, frustration, disgust, criticism, sadness.
  - Clinicians need to be aware of the **potential for countertransference** affecting their responses, boundaries, inappropriate sharing and becoming over involved

Challenges – highly emotional work

- **"Splitting"** – psychodynamic term that refers to a defence used by people to cope with overwhelming emotions by seeing someone as either good or bad, "idealised or devalued". Making it easier to manage emotions they are feeling which appear to be contradictory.
  - Can occur between any members of the treating team, with the family, or the young person.
  - It is not intentional – while it is hard to not take comments or actions personally, this is a psychological defence and not done knowingly.
  - Try to remain calm and think before responding. Show people that you do care, set healthy boundaries, always work with treating teams to remain on the same page.
  - Awareness is key, attend to clients needs, seek supervision or support.

Collaboration is Key!

Research with medical physicians who have treated eating disorder inpatients.
"Universally agreed that they could not treat a patient with an eating disorder alone"



Davidson, A.R., Braham, S., Dasey, L. & Reidlinger, D. P. (2019). Physicians' perspectives on the treatment of patients with eating disorders in the acute setting. *Journal of Eat Disorders, 7* (1), 1-9 https://doi.org/10.1186/s40337-018-0231-1

Collaboration is Key!

- MDT approach to Eating Disorders is vital
- GP and/or Paediatrician – medical monitoring to ensure medical stability.
- Therapist, psychologist or mental health clinician trained in evidence based treatment – working with the young person and family through treatment; coordinating care.
- Dietitian – Support the therapist and team, education, and nutritional decision making as needed.
- Psychiatrist – may be used to manage any comorbid mental health issues, psychiatric risks, psychotropic medications if needed
- Family members – should always be included in care of young people (unless indicated by family law court or child protection concerns).
- Other stakeholders may include – school/education, NDIS, DCJ, extended family members.

Looking after yourself as a health professional

- Multidisciplinary care coordination – stakeholder meetings
- Peer supervision, mentoring or debriefing as needed
- Distress tolerance skills
- Self-care