CHIEF PSYCHIATRIST
of Western Australia

OFFICE of the CHIEF PSYCHIATRIST Community of Practice

Eating Disorders - What is risk in co-occurring needs and complexity?

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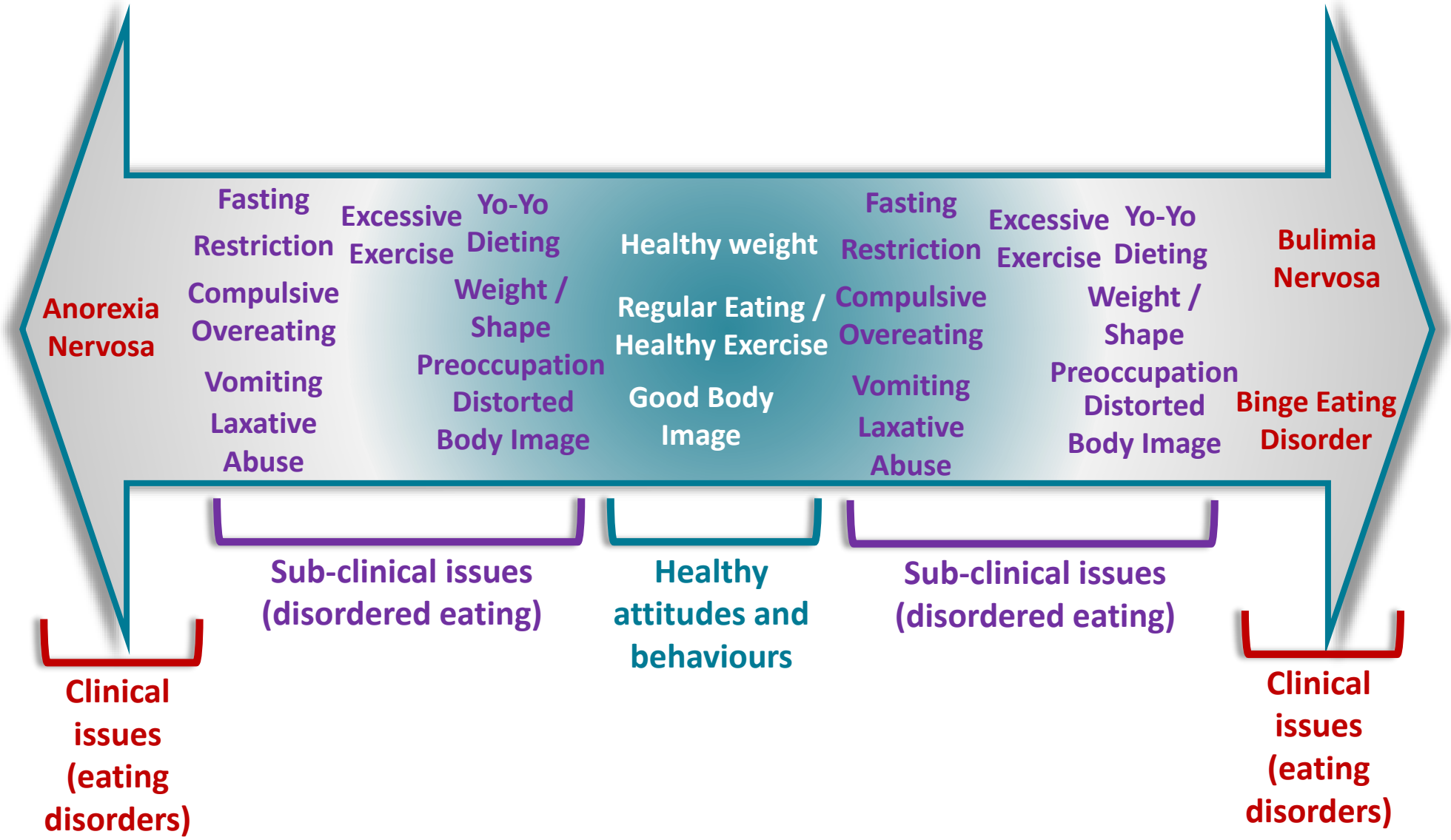
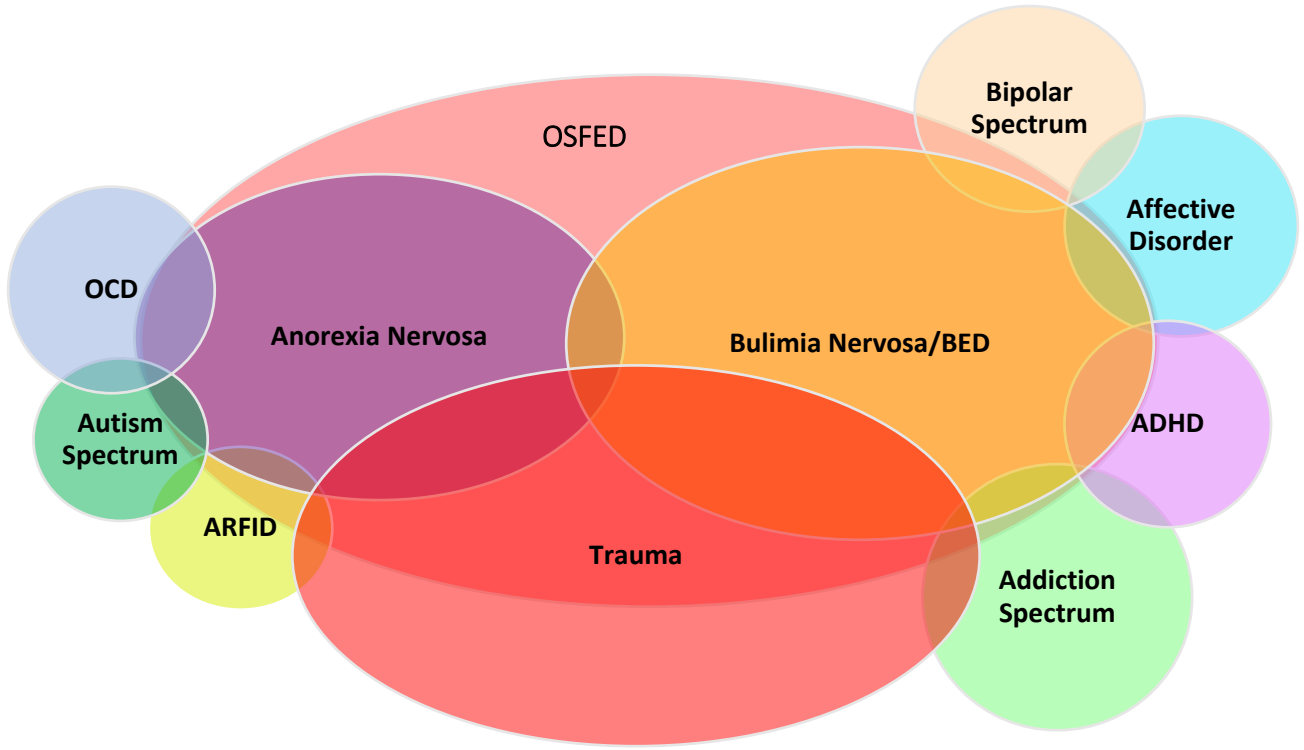
Continuum of Disordered Eating & Eating Disorders



Adapted from: Female coach Nwk on Twitter – Eating Disorder Webinar Disordered Eating vs Eating Disorders. Myers, E.S & Caperton-Kilburn, C. (2017). Winning the war within Nutrition Therapy for clients with eating disorders (3rd ed). Helm Publishing. Lake Dallas, Texas

Intersection of Eating Disorders and other Mental Health co-morbidities:

OCD	Obsessive Compulsive Disorder
OSFED	Otherwise Specified Feeding and Eating Disorder
ARFID	Avoidant Restrictive Feeding and Intake Disorder
ADHD	Attention Deficit Hyperactivity Disorder



Adapted from Essential Psychiatry, 4th Ed, Treasure J & Schmit U, 2009.

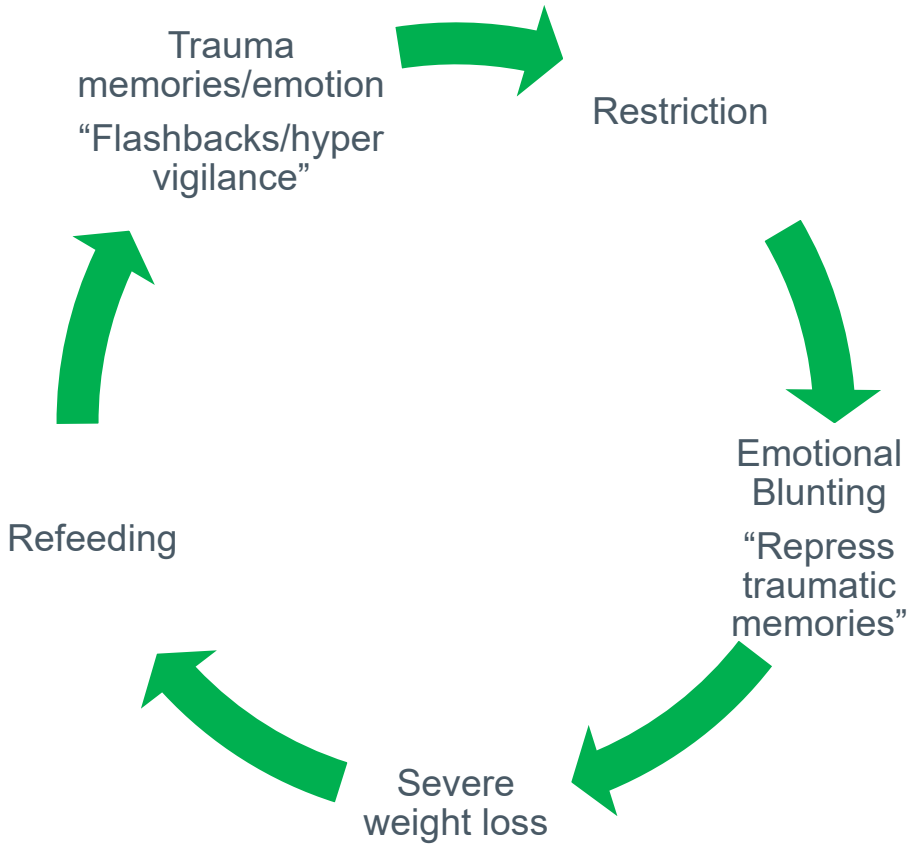
Trauma:

- Trauma has a significant neurobiological effect on brain development.
- Prolonged exposure to repeated stress/traumatic events, can result in increased internalised symptoms, diminished executive functioning, less responsive reward/positive feedback, and increased difficulties in social interactions.
- ***Damaged attachments*** in early relationships can cause issues with affect regulation. Causes difficulties in **interoceptive** awareness.

Trauma:

- Threat response and coping mechanism of PTSD/C-PTSD and compromised neurobiology of the Eating Disorder interact.
- Purpose of restriction/bingeing is to regulate affect.(Vagal Tone)
- “I lose weight so I disappear..” “Not be noticed”. “Be unattractive, so I can’t be hurt”.

Trauma:


Trauma memories/emotion
“Flashbacks/hyper vigilance”
Restriction
Emotional Blunting
“Repress traumatic memories”
Severe weight loss
Refeeding

Neurodevelopmental Disorders;

- Common co-occurring diagnoses with eating disorders (ED), appropriate assessment pivotal in addressing needs accurately.
- ED frequency in autism spectrum disorder (ASD); 1 in 7 people,
- Avoidant/restrictive food intake disorder (ARFID) most common initial presentation with anorexia nervosa (AN), anorexia nervosa and binge eating purging subtype (AN-BP), Binge Eating Disorder (BED) / Prader-Willi syndrome next…
- 5-17% ED patient meet attention-deficit/hyperactivity disorder (ADHD) criteria. (31)
- Females with ADHD 3.6 times more likely to develop any ED, 5.6 times more likely to present with BN. (31)
- Strong links with hyperactive/impulsive subtype of ADHD.
- Often mistaken as emotionally unstable personality disorder (EUPD).

Personality Disorders/Emotional Dysregulation:

- Often profound aversion to uncertainty; individuals will often tolerate **extremely painful**, but ***predictable*** coping strategies/behaviours/environments.
- Stepping into the maw of recovery is often overwhelming, leading to people reverting to unsustainable coping strategies.
- Very pertinent in Eating Disorders; the ED provides **certainty**, **predictability**, and a **false sense of control**.
- Many decisions ,particularly around treatment, are made from fear and not from an informed perspective.(Issues around full capacity)

Transdiagnostic Presentations:

- Containment of heightened emotion is paramount, along with **transparency**, **compassion** and **firmness** to give a sense of safety.
- **Co-regulation** is the “lighthouse in the maelstrom of intense and overwhelming emotions”.
- It provides guidance, safety, and an external reference for future behaviour in the presence of these emotional states.
- Be mindful that these seemingly unhelpful behaviours are **safety** behaviours!

Treatment Approaches:

- Aim is to change **language of care**; will need a *nuanced* and *compassionate* approach so as not to critically invalidate that persons experience.
- If this happens, likely to drive more extreme help eliciting behaviour and increase risk of severe DSH/ suicidality.
- Long term aim is to build up an identity and “a life worth living”, that is value driven.(“Where do you see yourself in 5 years time?” “How do you like people to describe you, outside of appearance?”)

Treatment Approaches:

- Assists in addressing lack of sense of self; gradually building up a framework from which to explore different facets of their identity.
- Give opportunity to develop self responsibility and accountability.
- Pitches Eating Disorder against valued needs; cognitive dissonance positive in this regard.
- Opens up therapeutic avenues to explore and elicit change.

Risk considerations:

- Acknowledging competing needs; the need to effectively collaborate and treat the individual vs inadvertently reinforcing a destructive iatrogenic cycle of harm.
- Systemic bias/stigma regarding co-occurring presentations.
- Mindful of “parental” approach to relieve clinician anxiety.

The community care team

Collaboration is the key to success

Contact

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Note: *The information in this presentation cannot be considered as legal advice but rather, outlines the broader legal context and parameters. If legal advice is required, processes may be sought via health services.*