

Putting Eating Disorders on the Radar *of* Primary Care Providers

ASSESSMENT TOOLS
GUIDELINES
RESOURCES

Dear Practitioner,

We are delighted to present to you, the resource binder and learning DVD entitled: ***Putting Eating Disorders on the Radar of Primary Care Providers: Assessment Tools, Guidelines and Resources***. Inside you will find practical written materials and tools for your day-to-day interactions with patients. These are designed to promote comfort and confidence in identifying and managing those patients in your practice with eating disorders. These materials are not designed to replace a multidisciplinary team, but rather to promote collaborative working relationships.

The resources have been designed to get patients with eating disorders and their families comfortably started on the road to recovery from your office. They do not replace comprehensive specialized care. We encourage you to build a supportive 'virtual' multi-disciplinary team to whom you can refer. The list of services that we have provided includes the outpatient eating disorder programs in your area as well as contact information for physician- to- physician support. Each of these sites in turn can help you connect with private practitioners in your community should the need arise. These professionals are often needed given the shortage of specialized resources in our communities.

We will be updating this binder regularly through the '**Professionals**' section of our website (www.cwedp.ca). We have also created links to popular journals, upcoming educational events and referral documents and information for each of our programs. We encourage you to connect with us online to provide us with your contact information. Clients and family members are also encouraged to check out the resources within the '**Public**' section of our website.

We welcome all feedback and have included an evaluation form that can be faxed or mailed. This resource tool is intended to reflect current resources and practices in the field. If you have updates or information that might be of assistance to other physicians or healthcare practitioners, we would like to encourage you to pass this information along to us.

With appreciation for your continued interest and compassion,

CWEDP- Regional Team
905-815-5124

ACKNOWLEDGEMENTS

We would like to express our heartfelt thanks to all the family physicians and clinical nurse practitioners from across the region who took the time to complete the needs assessment, attend the training sessions and let us know what they needed to develop greater comfort and confidence in identifying and managing those patients in their practices with eating disorders.

We would like to thank our physician team who planned the learning day, facilitated the mentoring sessions and reviewed materials including Dr. Colleen Flynn, Dr. Christina Grant, Dr. Erinn Owens, Dr. Janos Pataki, Dr. Barry Simon, Dr. Rod Wachsmuth and Dr. Blake Woodside. We would also like to extend huge thanks to Mike Pollington of Pollington Productions for his expertise and patience in creating the DVD set. Thanks to the great folks at Gateway Reproductions for their help in printing the binders. To our clients and family members, we are grateful for your feedback and participation. Our thanks also go to the staff of the Central West Eating Disorder Program (CWEDP) partner sites that completed questionnaires, contributed materials, followed clients and provided general feedback.

The members of the CWEDP Regional team are to be congratulated for their hard work in proposing, delivering, reporting and disseminating this information. At various points the team included: Alison Colavecchia, Tracey Curwen, Darla Da Costa, Diane Fahey, Amanda Ninaber, Jenn Nourse and Kristina Trim.

The completion of this project has been made possible through a Primary Health Care Transition Fund Grant.

TABLE OF CONTENTS

	PAGE
Welcome	3
Acknowledgements	5
ORGANIZING YOUR APPROACH	
Organizing Your Approach	11
The Role of the Primary Care Physician	13
Providing General Feedback to Patients with Eating Disorders and Their Families	15
SCREENING TOOLS	
Quick Screening Tools	19
Behavior of Parents and Children Associated with the Onset of an Eating Disorder	21
General Eating Disorder Screen	23
Anorexia Nervosa Quick Screen	25
Bulimia Nervosa Quick Screen	27
Binge Eating Disorder Quick Screen	29
ASSESSMENT AND DIAGNOSIS	
Comprehensive General Assessment: Eating Disorders	33
Possible Signs and Symptoms Accompanying Significant Weight Loss in Eating Disorders:	
Female and Male	41
Comprehensive Medical Assessment: Eating Disorders	45
Body Mass Index (BMI)	49
CD Growth Charts: Body Mass Index for Age Percentiles: Boys 2-20 years	51
CD Growth Charts: Body Mass Index for Age Percentiles: Girls 2-20 years	53
CD Growth Charts: Weight for Age Percentiles: Boys 2-20 years	55
CD Growth Charts: Weight for Age Percentiles: Girls 2-20 years	57
DSM-IV Criteria: Eating Disorders	59
Tips on Conferring an Eating Disorder Diagnosis	61
ONGOING MANAGEMENT	
Ongoing Medical Management and Monitoring: Overview	65
Checklist for Ongoing Medical Monitoring of Patients with Eating Disorders	67
What To and What Not To Say	69
Levels of Eating Disorder Care	71
Readiness for Change	73
Indications for Hospitalization in Children, Adolescents and Adults	75
Weighing Your Patients	79
Discussing Nutrition	81
Activity Levels, Sports Involvement and Eating Disorder Recovery	83
Preparing for an Eating Disorder Hospitalization: Information for Physicians	85
Ethical Issues in the Compassionate Care of Those with Eating Disorders	87

TABLE OF CONTENTS

	PAGE
HELPING PATIENTS HELP THEMSELVES	
Helping Your Patients to Help Themselves: An Introduction for Physicians	91
Helping Yourself Recover	93
Readiness for Change	95
Thinking About Getting Better	97
Food Journal	99
Managing Binges	103
Preparing for an Eating Disorder Hospitalization: Information for Patients	105
Eating Disorder Resources for Patients and Families	107
Danielle's Place- Support and Resource Centre	109
Sheena's Place- Support and Resource Centre	111
HELPING FAMILIES	
Helping Families: An Introduction for Physicians	115
Guidelines for Families and Friends	117
Readiness for Change	119
Fathers Helping Daughters with Eating Disorders	121
Getting Through Meals	123
Preparing for an Eating Disorder Hospitalization: Information for Families	125
Eating Disorder Resources for Patients and Families	127
Family Psychoeducation Group	129
Danielle's Place: Support and Resource Centre	131
Sheena's Place: Support and Resource Centre	133
PHYSICIAN SUPPORT	
Support Resources for Primary Care Providers	137
Physicians: Eating Disorder Connections and Links	139
SUPPLEMENTAL RESOURCES	
Contact Us	141
References	145
Evaluation	147

ORGANIZING YOUR APPROACH

CENTRAL WEST | EATING DISORDER PROGRAM

"The big challenge family practitioners face is not being overwhelmed by the severity of this illness."

Dr. Colleen Flynn, MD, FRCPC

Previously- Psychiatrist/Medical Director
Eating Disorder Program
Credit Valley Hospital

"In this kind of work, doctors need to set aside the classic vision of the doctor and the patient only. This is team work where the doctor is at the centre of a whole team network."

Dr. Rod Wachsmuth, MD DipCPsy, FRCPC

Staff Consultant, Eating Disorders Program
Toronto General Hospital

ORGANIZING YOUR APPROACH

Eating disorders are complicated and difficult to treat. They often remain resistant in the face of even the very best practices and practitioners. They require attention to both medical and psychiatric information. Symptoms if left untreated, can lead to a broad range of chronic health problems. Treating these disorders, however, can also be very rewarding as you bear witness to one individual, or even an entire family, reclaiming their lives and health.

There are two key roles for primary care providers in the treatment of eating disorders. The first is to **develop your radar** for identifying those people for whom more detailed tracking is necessary. Through early identification and timely and thorough medical follow-up, you may limit the potential chronicity of these disorders. Your investment early in the course of the illness can help prevent significant suffering in the long term. The second role is to **closely monitor the medical health of your patient**, and to advocate for their health as much as possible. Remember, you are likely to be the most consistent health care provider in the patient's life.

Once you have identified that someone in your practice has an eating disorder, assessed his/her medical health and have an idea of how ready for change they are, you will need to consider what other resources might be needed for the care of this person. It is important to remember the impact of starvation and/or malnourishment on both your patient's brain functioning and personality. Keep in mind how terrified most eating disordered patients are of eating, food and weight gain and typically, efforts to trick those around them are anxiety-based management strategies, rather than symptoms of core personality deficits. Despite the significant role nutrition plays in recovery, eating disorders are not just about food ! Assessing the individual's family functioning and supportive network is also very important. Encourage parents not to permit the eating disorder to "run the household" and help the family as a whole support their loved one who is attempting to recover, often in the face of tremendous ambivalence.

Below are recommended steps to take in getting organized. Each item has a sheet for your reference and use. Refer to the accompanying DVD set for expanded information on each item.

ORGANIZING YOUR APPROACH		Page
1. Screen		19
2. Assess	A) General Information	23
	B) Medical	45
	C) Supports – schools, friends, family/parents, siblings	40
3. Diagnose		59
4. Medically Monitor – Check-ins		65
	* younger more often	
	* more acute more often	
5. Discuss the role of weigh-ins		79
6. Discuss the role of nutrition		81
7. Discuss levels of appropriate activity and sports		83
8. Discuss readiness for change		95
9. Provide resource and referral information		105-107
10. Access physician support needs		137
11. Monitor overall health and revise goals and treatment approach as required		65

The Role of the Primary Care Provider in the Provision of Care to Children, Adolescents and Adults with Eating Disorders

Primary care providers are an integral component of the care provided to children, adolescents and adults with eating disorders both over the course of the illness and perhaps more importantly, over the lifespan of the patient. Eating disorders can persist over decades, waxing and waning in their severity over time and developmental/life milestones. The establishment of a strong therapeutic alliance is ultimately the best tool in the practitioner's toolbox no matter the age of the patient. A strong alliance facilitates early detection of symptoms, positive collaborative working relationships with family members and secondary providers, and for ongoing medical monitoring and management. The therapeutic alliance helps the physician-patient relationship to survive those rare occasions where difficult decisions around competence and breaches of confidentiality must be made. A strong alliance is essential when working with children and adolescents or young adults still living at home. Appropriate parental involvement, supported by you, is critical.

Your Role	Main Focus	Key Recommendations	Binder Resource	Page
Early Identification	Who is at risk? Who to follow?	-Establish alliance with patient and parents as appropriate -Keep a growth chart -Monitor general coping skills -Assess family history -For children and adolescents, get parents on board right from day one, they are needed!	-Warning Signs -Growth charts -Comprehensive General and Medical Assessment -Resources for patients, families and physicians	21 51 33 45 117
Medical Management	Preventing patient mortality	-Monitor medical status as appropriate (1 – 2 X per week) -Brief hospitalizations for stabilization -Monitor suicidality	-When to Admit -Preparing for a Hospitalization-physician, family and patient sheets -Physician Support service	75 85,105,125 137,139
Medical Monitoring	Monitor physical and mental health	-Maintain alliance with patient and his/her family -Monitor blood work with a frequency appropriate to medical status -Maintain growth charts	-Ongoing Medical Monitoring -Symptoms Associated with an Eating Disorder -Growth charts	65,67 41,43 51-57
Treatment	Improving quality of life	-Monitor patient's stage of change and refer for specialized treatment as appropriate -Encourage patient to assess pros and cons of illness -Establish linkages with local and tertiary providers -Seek consultations	-Readiness for Change -Treatment Resources Sheet -Worksheets for patients -CWEDP Site Information (www.cwedp.ca)	95 107,127 97-101 107,127,139 107,127
Advocacy	Improving opportunities for self/health care	-Advocate for timely and appropriate medical admissions -Encourage help seeking -Encourage parents to advocate for appropriate resources	-Treatment Resources sheet	107,127,139

Early Identification

Identifying children and adolescents at risk for developing an eating disorder versus those who are 'picky eaters' or have other metabolic issues can be challenging.

Recommendations may focus on:

- Rule out other metabolic conditions
- Keep a detailed, frequently plotted growth chart
- Ensure supports for the child exist, assess general stress management and coping skills
- Assess for co-morbid conditions, family history (e.g. mood disorders, substance abuse, post-traumatic stress disorder)
- Ask parents to note what the child eats and describe family eating patterns
- Develop strong supportive and coaching style relationship with parents of children, adolescents and young adults

Medical Management

Keeping patients alive largely through medical stabilization is the main focus.

Recommendations may focus on:

- Nutritional stabilization through the use of food and/or supplemental nutrition as necessary (e.g., oral supplements, tube feeding, TPN)
- Safety: is the patient suicidal or engaging in self-harm behaviors that warrant a psychiatric assessment or admission?
- Palliative care- is the patient in the final stages of the illness i.e. vital organs are now shutting down?

Medical Monitoring

Ongoing medical monitoring ensures that the overall health of the patient is always front and centre. Changes in health can be detected right away to enable more timely access to care.

Recommendations may focus on:

- Regular bloodwork
- Regular height/weight measurement (varies with age and level of acuity)
- Regular assessment of achievement of life milestones
- Regular check-ins with family members to ensure adequate coping, perception of treatment progress and/or concerns, participation in treatment plan

Treatment

The Primary Care Provider should not expect to provide all aspects of care or they are likely to end up feeling overwhelmed and isolated given the dual components of these disorders: medical and psychiatric. They are best supported in their work as a member of a "virtual team" i.e. a group of professionals brought together to meet the multidisciplinary needs of the patient despite not being from the same practice or organization. Members may or may not include a multi-disciplinary specialized eating disorder program, consulting dietitian, psychiatrist or therapist.

Recommendations may focus on:

- A referral to a specialized outpatient eating disorder program for a comprehensive assessment, diagnosis and treatment plan
- Consultations with a:
 - Psychiatrist
 - Dentist
 - Dietitian
- Education- for clients and families. Provide resource lists, support group information and family psychoeducation
- Encourage families not to let the eating disorder run the household through continued maintenance of family meals, non-food or weight oriented discussions and an emphasis on whole health for the whole family

Advocacy

To build a "virtual team" and to access acute care should the need arise; the primary care provider must be willing to connect with other sites, providers and/or physicians. Given the paucity of specialized acute resources in most communities, speaking directly with specialized care providers can ensure clarification around admission criteria, bed availability, and steps to take while waiting for a bed. Alternative or temporary care options can better be explored and facilitated through direct physician-to-physician contact should no local/regional tertiary care facility be able to offer care.

Recommendations may focus on:

- Advocating for the right admission at the right time
- Establishing collaborative linkages with local specialized providers
- Establishing collaborative linkages with tertiary care providers
- Utilizing physician-to-physician support services
- Encouraging families to advocate for improved access to specialized resources where none or few exist

References: Silber et al (1991); Weiner in Piran et al (1999)

Providing General Feedback to Patients with Eating Disorders and Their Families

1. Communicate your role as an advocate for your patient's health.
2. Communicate the importance of food as medicine. Regular intake of 2-3,000 calories is normal, depending on the age and sex of the patient- See "Nutrition Guidelines" sheet.
3. Communicate diagnosis as appropriate- see "Conferring a Diagnosis" sheet for tips.
4. Communicate appreciation for ambivalence patient may have around recovery, despite clear messages from everyone else around him/her.
5. Communicate understanding of the challenging and often exhausting role parents and partners play in recovery. They are responsible for living out the treatment plan 24/7.
6. Communicate importance of non-dieting, cessation of excessive exercise and other purging behaviors including vomiting and laxatives abuse.
7. Discuss role of weight and weigh-ins. This represents one measure of medical health which can be handled in a dignified and respectful way as agreed between the patient (see "Weighing your Patient Tips" Sheet) and practitioner. The goal is sustained medical health and improved quality of life. Encourage patients to get rid of their scales at home.
8. Communicate circumstances under which you will breach confidentiality (e.g., concerns that patient's health is in danger zone, risk of self-harm, suicidality).
9. Communicate belief that everyone is on the 'team' and that you alone are not the key to patient's recovery. You will refer as appropriate.
10. Acknowledge that recovery from an eating disorder is complicated and can be lengthy, but that you are willing to be involved for the long term.

SCREENING TOOLS

*"Often the problem presents during the middle of a busy day...
Practitioners need to have some idea of how to do a quick screen to
make the diagnosis and understand that their existing knowledge is
very applicable to the medical management of these patients."*

Dr. Blake Woodside, MD, FRCPC

Director, Inpatient Eating Disorders Program
The Toronto Hospital

*"Take the time to ask the overweight or obese patient who
comes into your office recurrently asking about weight loss programs:
"Many people overeat in an out of control fashion...
does this happen to you?"*

Dr. Barry Simon, MD, FRCPC

Psychiatrist, Leadership Centre for Diabetes
Mount Sinai Hospital

Quick Screening Tools

These quick screens have been put together to help you to determine whether a more comprehensive assessment for an eating disorder may be warranted. They are not meant to be lengthy or comprehensive; rather they are intended to raise flags for further investigation. Individual screens are on printable sheets designed so that you can use them during an appointment. They include space for name, date and notes.

- 1. Consider asking the general questions of all new patients.**
- 2. Use the General Screen followed by the specific screen where/when warranted.**
- 3. Consider using the screens when these or similar questions are raised:**
 - A mother asks about her daughter who has been hiding food
 - A girl asks about why her periods have stopped
 - A woman expresses concerns about her weight gain
 - You are asked about the long-term impact of laxatives
 - A mother indicates that her daughter is not seeing her friends anymore, spends most of her time doing school work, and is avoiding eating meals with the family
 - A teen has a significant drop in his or her weight, changing the trajectory of his/her growth curve
 - A woman complains about a sudden unexplained weight increase, states it is non-food related and is now dieting to reduce weight (use the screens to link metabolic issues to an eating disorder)
 - A man asks about getting help for his unmanageable nighttime food cravings
- 4. Refer to the 'Possible Signs and Symptoms Accompanying Significant Weight Loss in Eating Disorders' Figures.**

Behavior of Parents and Children that Might be Associated With the Onset of Eating Disorders or Impaired Eating Attitudes and Behaviours: Guideline for Healthcare Providers

1. Parents express degree of worry about child's shape, appearance, or weight that is not supported by the primary care physician's clinical findings or observations.
2. Child expresses dissatisfaction with body shape and weight to parents or pediatrician.
3. Child imposes food restrictions in a variety or quantity that:
 - a. compromises nutritional status
 - b. stimulates family conflict
 - c. suggests child is concerned about body shape or weight or is engaged in a control battle with parents
4. In response to questions about the child/parent interaction around eating, parents or child reveal information that suggests that:
 - a. parent is uncomfortable with child having food preferences or feeding him or herself
 - b. child is reluctant to experiment with food of variable textures, smells, consistency, and taste
 - c. there is no structure to mealtime and few family interactions around food consumption or there is heightened tension in family at mealtimes
 - d. parents anxiety about child's eating behaviours or weight intrudes upon interactions with child around food purchase, preparation, presentation and consumption
 - e. there is an intense emphasis in the family on physical fitness and low-fat eating patterns, which may promote an overly restricted pediatric diet and a child who feels compelled to work-out beyond child's interest, body capacity or need
5. Child sneaks [hoards or hides] food.
6. Child resists parent's efforts to involve them in physical activities, or parents believe child should only engage in physical activities that are of interest to them (parents).
7. Parents express discomfort about establishing expectations and consequences for child regarding eating behaviours. [A helpful benchmark is to compare this to the parent's capacity to instruct regarding toilet training, sleep behaviours and brushing teeth.]
8. There is a history of eating disorders or impaired eating behaviours in the family, including parent, grandparent, siblings or cousins.

Weiner (1999)

General Eating Disorders Quick Screen

Name: _____ **Date:** _____

- 1) Are you unhappy with your body weight and shape?
- 2) Are you dieting? Have you dieted much in the past?
- 3) Have you lost weight?
- 4) Some people eat large quantities of food in an out of control way. Has this ever happened to you?

If yes, continue:

- 5) Many people, after eating in this way, feel very badly about themselves. Do you ever feel badly about yourself after eating in this way?
- 6) Many people then try to compensate for this eating or to get rid of the food somehow. Has this ever happened to you?
- 7) How often do you currently exercise? Do you feel comfortable missing a day here and there? Does your exercise feel out of control?
- 8) Have others expressed concerns about your eating, exercising or weight?
- 9) Are you concerned about your health?

Key

Those with bulimia tend to express concerns for their health unlike those with anorexia who may report that others have indicated concern for their health, but that they, themselves, are not concerned (may be in state of denial). Those struggling with issues related to bulimia or binge eating disorder are more likely to report that they have not told anyone of their struggles and physically there may be less visible evidence of ongoing issues.

Other Notes:

Follow-Up Plan:

Anorexia Nervosa (AN) Quick Screen

Name: _____ **Date:** _____

- 1) What is the most you have ever weighed? When was that?
- 2) What is the least you have ever weighed? When?
- 3) What do you think you should weigh?
- 4) When you look in the mirror do you think you should gain weight, lose weight or stay the same?
- 5) How often do you exercise each week? How long does each session last?
- 6) Is your menstrual cycle regular?

Key

Consider the age of patient and the period of time during which weight loss has occurred and whether menstrual irregularity is present. The most distinguishing feature of AN is a perception that despite being at a healthy weight for age they still see themselves as needing to lose more weight or still feel dissatisfied with their weight and shape.

Notes:

Follow-Up Plan:

Bulimia Nervosa (BN) Quick Screen

Name: _____ **Date:** _____

- 1) Has your weight fluctuated much over the last few years?
- 2) Some people eat large quantities of food in an out of control way. Does this ever happen to you?
- 3) Many people, after eating in this way, feel very badly. Do you ever feel badly about yourself after eating in this way?
- 4) Many people, then try to compensate for this eating by getting rid of the food or compensating for it somehow. Has this ever happened to you?
 - a. Have you ever tried to make yourself sick/vomit?
 - b. Have you ever taken laxatives?
 - c. Have you ever exercised to make up for a meal/snack/binge?
- 5) How frequently do you exercise each week and how long does each session last?
- 6) What is your motivation for exercising?
- 7) Do you feel your exercise is out of control?

*Adapted from Mehler & Anderson, A Guide to Medical Care and Complications:
Eating Disorders. John Hopkins, 1999*

Key

The main difference between BED and BN is that those who struggle with BN purge or try to compensate for the binges in some way. In BN, binges tend to be shorter, but more intense, as compared to those with BED.

Notes:

Follow-Up Plan:

Binge Eating Disorder (BED) Quick Screen

Name: _____ **Date:** _____

- 1) Many people eat large quantities of food in an out of control way. Does this ever happen to you?
How often?
- 2) How long does each eating session last?
- 3) Many people, after eating in this way feel very badly. Do you ever feel badly about yourself after eating in this way? e.g., experience guilt, shame or despair?
- 4) Many people then try to compensate for this eating by getting rid of the food or compensating for it somehow. Has this ever happened to you? E.g. making yourself sick/ exercising/using laxatives?
- 5) Have you undergone any surgery to help with your weight concerns? E.g. Bariatric surgery?

Key

The main difference between BED and BN is that those who struggle with BED do not purge or try to compensate for their binges. Binges also tend to last over a longer period of time as compared to those with BN.

Notes:

Follow-Up Plan:

ASSESSMENT AND DIAGNOSIS

CENTRAL WEST | EATING DISORDER PROGRAM

"I think there are probably a hidden number of patients in every practice that have an eating disorder."

Dr. Erinn Owens, MD, FRCPC

Consultant to Eating Disorder Program
Grand River Hospital

"A direct, compassionate approach will help people talk about things they otherwise are too ashamed to bring up spontaneously."

Dr. Blake Woodside, MD, FRCPC

Director, Inpatient Eating Disorders Program
The Toronto Hospital

Comprehensive General Assessment: Eating Disorders

You may wish to keep this assessment as part of your patient file and/or sign off and use to forward to a secondary provider. Completion will likely require more than 1 visit.

SUMMARY

NAME _____ DATE _____

AGE _____ FAMILY DOCTOR _____

PRESENTING COMPLAINT

SUMMARY OF HISTORY OF PRESENTING COMPLAINT

GENERAL INFORMATION:

PERSONAL SITUATION: (INCLUDE MARITAL STATUS, STUDENT/EMPLOYED, LIVING ARRANGEMENTS)

EATING DISORDER DIAGNOSIS AND COMORBID CONDITIONS:

RECOMMENDATIONS:

☐ Reviewed with Patient

☐ Reviewed with Family

WEIGHT HISTORY

Height: _____ inches Current weight: _____ lbs.

How much would you like to weigh? _____ lbs.

How old were you when you became serious about trying to control your weight? _____ Years old

What is the heaviest weight you remember being at? _____ lbs. How old were you? _____

What is the lightest weight you remember being at? _____ lb. How old were you? _____

MENSTRUAL HISTORY

At what age did you first start menstruating?

_____ Years old **OR** ☐ I have never had a period

Do you have menstrual periods now?

- ☐ Yes, regularly every month
- ☐ Yes, but I skip a month once in a while
- ☐ Yes, but not very often (i.e. once in 3 months)
- ☐ No, I have not had a period in at least 3 months
- ☐ I am post-menopausal or have had a hysterectomy

How long has it been since your last period?

_____ weeks **OR** _____ months **OR** _____ years

Where was your weight when your periods became irregular/stopped? _____ lbs.

Have you previously been prescribed birth control? For what purpose?

BODY IMAGE

When you look in the mirror do you feel you need to

- ☐ gain a little weight ☐ lose a little weight ☐ stay just where I am

Are there specific body parts that you are uncomfortable with?

Have you undergone any procedures to alter your physical appearance including such things as bariatric surgery, plastic surgery or breast augmentation/reduction?

PROCEDURE	DATE OF PROCEDURE

NUTRITION

How many meals do you eat each day? _____ How many snacks do you eat each day? _____

Please describe a typical day of eating:

How many calories do you estimate you eat each day? _____

How many meals each week do you eat with your family?

☐ none ☐ 1-2 ☐ 3 - 5 ☐ 6-10 ☐ 11-15 ☐ 15+

Do you eat what the rest of your family is eating?

☐ yes, always ☐ most of the time ☐ once and a while ☐ never

Are you vegetarian? ☐ yes – Since when? _____ ☐ no

WEIGHT CONTROL

Have you ever restricted your food intake due to concern about your body size or weight?

☐ yes ☐ no

How old were you the very first time that you began to restrict your food intake due to concern about your body size?

_____ years old

How old were you when you became very serious about trying to control your weight?

_____ years old

How often do you exercise in a typical week? _____ times a week

How long do you exercise each time? _____ minutes

What kinds of exercise do you like to do? Why do you exercise?

Do you ever experience episodes of eating a very large amount of food (binge) in a relatively short period of time?

☐ yes ☐ no

How old were you when you first had a binge? _____ years old

How old were you when you began binge eating on a regular basis? _____ years old

During the last 3 months, how often have you typically had an eating binge?

- ☐ I have not binged in the last 3 months.
☐ Monthly, I usually binge _____ time(s) a month.
☐ Weekly, I usually binge _____ time(s) a week.
☐ Daily, I usually binge _____ time(s) a day.

What is the longest period you have had without bingeing since you began bingeing on a regular basis?

_____ days

How long does a binge usually last?

- ☐ Less than one hour ☐ 1 – 2 hours
☐ More than 2 hours ☐ All day or all evening

Many people find it embarrassing to talk about their binges but it would be helpful for me to understand a little bit about them. What do you typically eat during a binge?

Many people try to rid themselves of the food when the binge is over, have you ever tried to make yourself sick (vomit)?

☐ yes ☐ no

How old were you when you made yourself sick (vomited) for the first time? _____ years old

When things were at their worst, how often did you make yourself sick (vomit) each week?

a) _____ times per week

b) How long ago was that? _____ months

What is the longest period you have had without vomiting since you began vomiting on a regular basis?

_____ days

How often do you eat a "normal" meal without binge eating and/or without vomiting?

- ☐ Never ☐ Less than one meal a week
☐ About one meal a week ☐ Several meals a week
☐ One meal a day ☐ More than one meal a day

Have you ever used laxatives to control your weight or to "get rid of food"?

☐ yes ☐ no

How old were you when you first took laxatives to control your weight? _____ years old

How old were you when you began taking laxatives on a regular basis? _____ years old

During the last 3 months how often have you taken laxatives to help control your weight?

- ☐ I have not taken laxatives in the last 3 months.
☐ Monthly, I usually take laxatives _____ time(s) a month.
☐ Weekly, I usually take laxatives _____ time(s) a month.
☐ Daily, I usually take laxatives _____ time(s) a day.

How many laxatives do you usually take each time? _____ laxatives

Have you ever taken diet pills?

☐ yes – What kind? _____ ☐ no

During the last 3 months, how often have you typically taken diet pills?

- ☐ I have not taken diet pills in the last 3 months.
☐ Monthly, I usually take diet pills _____ time(s) a month.
☐ Weekly, I usually take diet pills _____ time(s) a week.
☐ Daily, I usually take diet pills _____ time(s) a day.

Have you ever taken diuretics (water pills)?

☐ yes ☐ no

During the last 3 months, how often have you typically taken diuretics?

- ☐ I have not taken diuretics in the last 3 months.
☐ Monthly, I usually take diuretics _____ time(s) a month.
☐ Weekly, I usually take diuretics _____ time(s) a week.
☐ Daily, I usually take diuretics _____ time(s) a day.

TREATMENT HISTORY

Have you ever received treatment for an eating disorder?

- ☐ no ☐ yes – please indicate type and when (Check all that apply)
- ☐ inpatient when I was _____ years old for _____ months
 - ☐ day hospital when I was _____ years old for _____ months
 - ☐ outpatient when I was _____ years old for _____ months
 - ☐ individual therapy when I was _____ years old for _____ months
 - ☐ group when I was _____ years old for _____ months
 - ☐ family when I was _____ years old for _____ months
 - ☐ other _____ when I was _____ years old for _____ months

Have you ever attended treatment for issues other than your eating disorder?

- ☐ no ☐ yes – please indicate type and when (Check all that apply)
- ☐ inpatient when I was _____ years old for _____ months
 - ☐ day hospital when I was _____ years old for _____ months
 - ☐ outpatient when I was _____ years old for _____ months
 - ☐ individual therapy when I was _____ years old for _____ months
 - ☐ group when I was _____ years old for _____ months
 - ☐ family when I was _____ years old for _____ months
 - ☐ other _____ when I was _____ years old for _____ months

These treatments were for help with:

Have you been admitted to the hospital in the past 2 months?

☐ Yes ☐ No

If yes, how many times were you in the hospital?

_____ times

If yes, how many days in total were you in the hospital?

_____ days

Have you ever been hospitalized for eating problems?

☐ no ☐ yes how many times _____

CURRENT AND PAST BEHAVIOURS

Alcohol Use

Drug Use

Self-Harm

ABUSE HISTORY

Have you been physically, emotionally or sexually abused in the past? Are you currently in an abusive relationship?

FAMILY HISTORY AND RELATIONSHIPS

(Note: substitute any significant family member/guardian/caregiver who has raised or is raising the individual)

Which category best describes/or described your mother's weight?

☐ Underweight ☐ Normal weight ☐ Above average weight ☐ Very overweight

How preoccupied with food or weight is/was your mother?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very much ☐ Extremely

Which category best describes/or described your other guardian/father's weight?

☐ Underweight ☐ Normal weight ☐ Above average weight ☐ Very overweight

How preoccupied with food or weight is/was your other guardian/father?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very much ☐ Extremely

How many siblings do you have? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How many siblings are underweight? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How many siblings are normal weight? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How many siblings are above average weight?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How would you describe the quality of your relationship with your mother? Or other significant caregiver?

How would you describe the quality of your relationship with your father? Or other significant caregiver?

How would you describe the quality of your relationship with your siblings?

How would you describe the quality of your relationship with your spouse/partner/boyfriend/girlfriend?

How would you describe the quality of your relationship with your children?

SOCIAL SUPPORTS/RELATIONSHIPS

How many close friends do you have?

☐ no one ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5

How many people (including family) could you talk to about an important personal problem?

☐ no one ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5

How many hours a week do you socialize with friends outside of work/school hours? (e.g. dinner, talk on phone, etc.)

☐ less than one hour ☐ 1-2 hours ☐ 3 - 4 hours ☐ 5-6 hours
☐ 7-8 hours ☐ 9-10 hours ☐ more than 10 hours

How many hours a week do you engage in family activities?

☐ less than one hour ☐ 1-2 hours ☐ 3 - 4 hours ☐ 5-6 hours
☐ 7-8 hours ☐ 9-10 hours ☐ more than 10 hours

With whom have you discussed your current concerns?

Are they concerned for your health?

How motivated are you to do something about your current health issues?

(on a scale of 0-10, where 0=not at all, 10= do whatever I have to)

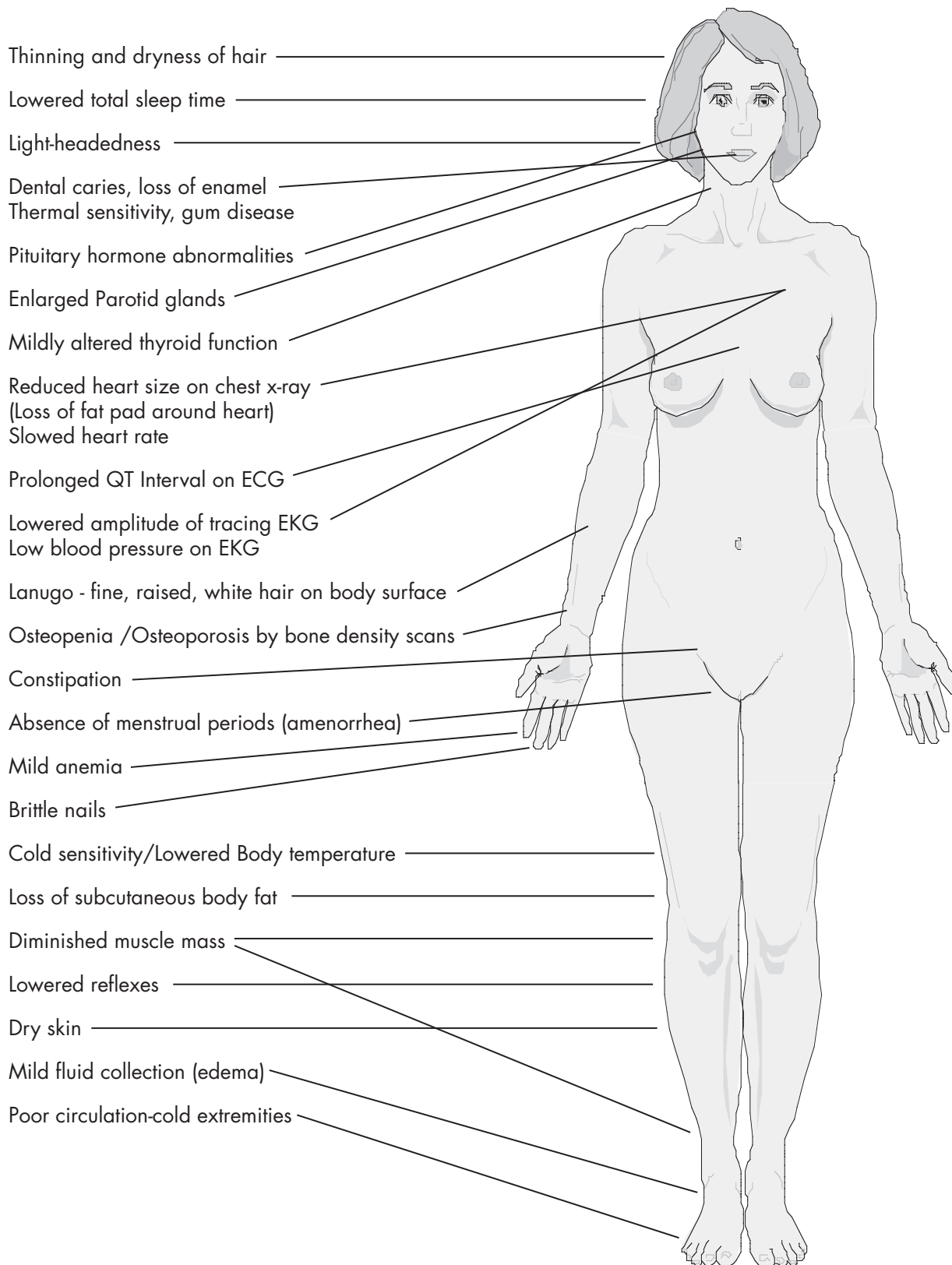
Completing Physician

Date

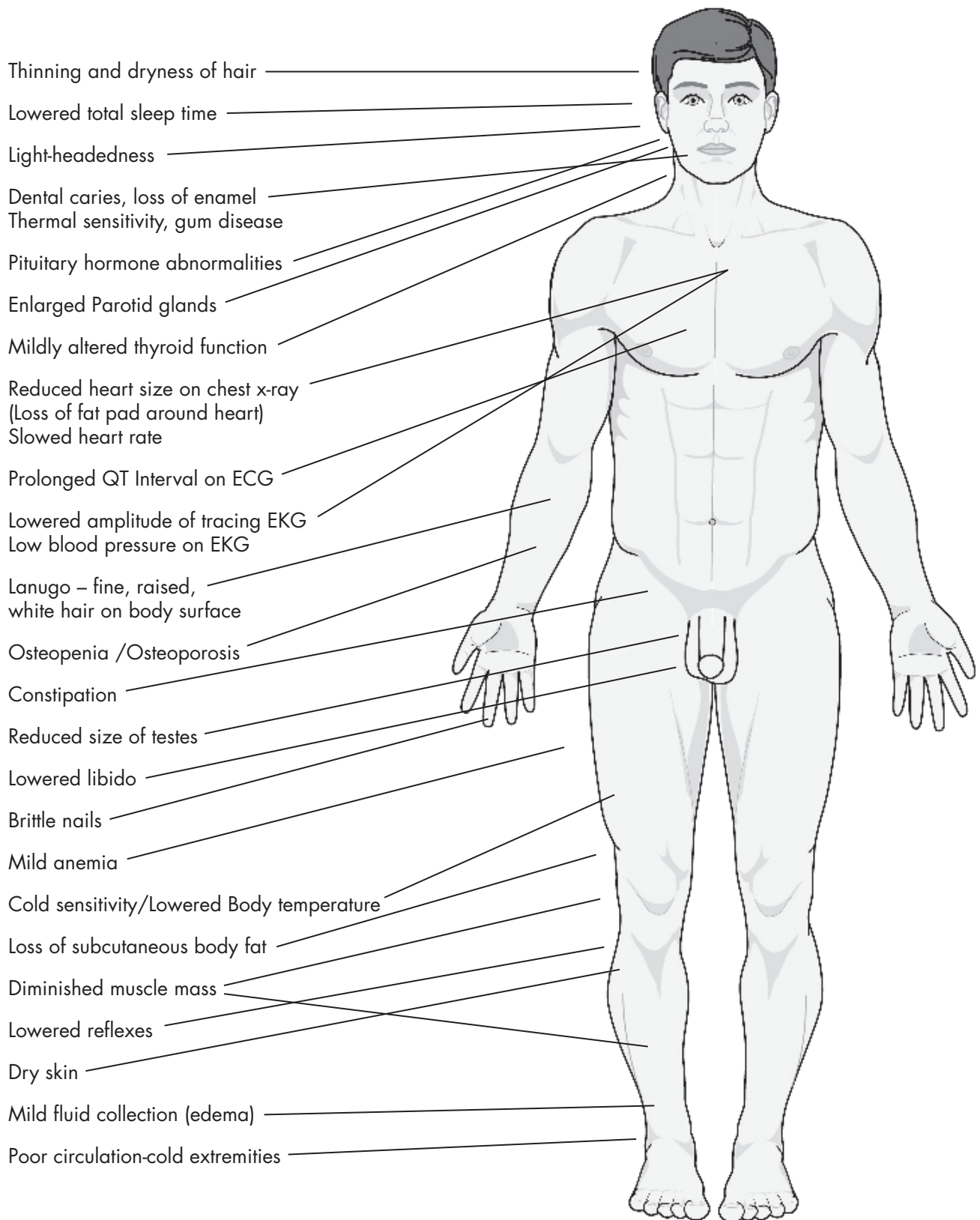
Adapted from Johnson (1985) and Northern Health (2006)

Possible Signs and Symptoms Accompanying Significant Weight Loss in Eating Disorders: Females

Northern Health, Prince George Eating Disorders Clinic, 2006



Possible Signs and Symptoms Accompanying Significant Weight Loss in Eating Disorders: Males



Comprehensive Medical Assessment: Eating Disorders

You may wish to keep this assessment as part of your patient file and/or sign off and use to forward to a secondary provider.

LAST PHYSICAL ASSESSMENT _____

APPEARANCE DURING ASSESSMENT _____

CURRENT REVIEW OF SYSTEMS

- ☐ Cardiovascular
☐ Gynaecologic

- ☐ Gastrointestinal
☐ Dermatologic

- ☐ Endocrine
☐ musculoskeletal

DIAGNOSIS:

PHYSICAL COMPLICATIONS: Summary

LABORATORY INVESTIGATIONS: Summary

Routine Completed:

- | | |
|--|---|
| ☐ CBC | ☐ Electrolytes |
| ☐ BUN | ☐ FBG |
| ☐ Creatinine | ☐ Liver Function |
| ☐ Fasting Insulin | ☐ Hormone Panel |

Further Recommended:

- ☐ EKG (chest pain, palpitations)
☐ Liver function (Weight loss, alcohol abuse)
☐ CPK (abusing lpecac)
☐ Amylase (gastrointestinal symptom)
☐ Calcium, phosphorous (chronic amenorrhea or fractures) magnesium
☐ Endoscope or x-ray exams

OTHER:

Insight into illness/eating disorder (0-10, 10= high) _____

Motivation to work towards recovery (0-10, 10= high) _____

MEDICATIONS:

ALLERGIES:

SLEEP PATTERN

CARDIOVASCULAR FUNCTIONING (dizziness, blackouts, postural hypotension, chest pain, palpitations and edema)

GASTROINTESTINAL FUNCTIONING (Vomiting with ____, without ____ blood, constipation, diarrhea, bloating, abdominal pain, nausea)

DENTAL HISTORY (Issues reported, recent dental exam)

HAIR AND SKIN (hair loss, dullness, thinness, dryness, fingernails, lanugo)

GYNOCOLOGICAL HISTORY (secondary sexual characteristics, onset menarche, birth control, periods, sexual history, pregnancies, fertility, PCOS)

MUSCOLOSKELETAL (weakness, cramps, pain, fractures)

NEUROLOGICAL FUNCTIONING (headaches, seizures, night vision, visual disturbances, 'black outs')

Physical Examination

Height _____

Weight _____ * undressed- preferably facing away from the scale (See 'Weighing your Patients' sheet

Blood Pressure:

Sitting _____ Standing _____ Pulse _____

Vision: _____

Parotid: _____

Thyroid: _____

Dentition and Hydration: _____

Skin: (lanugo, stria, fingernails, palm excoriation/Russell's sign) _____

Extremities: (cyanosis, temperature) _____

CNS: (reflexes, strength) _____

Heart: (chest pains, palpitations) _____

Chest: _____

Mental Status: (as appropriate) _____

Measurements: _____

BMI- (see 'BMI' instruction sheet) _____

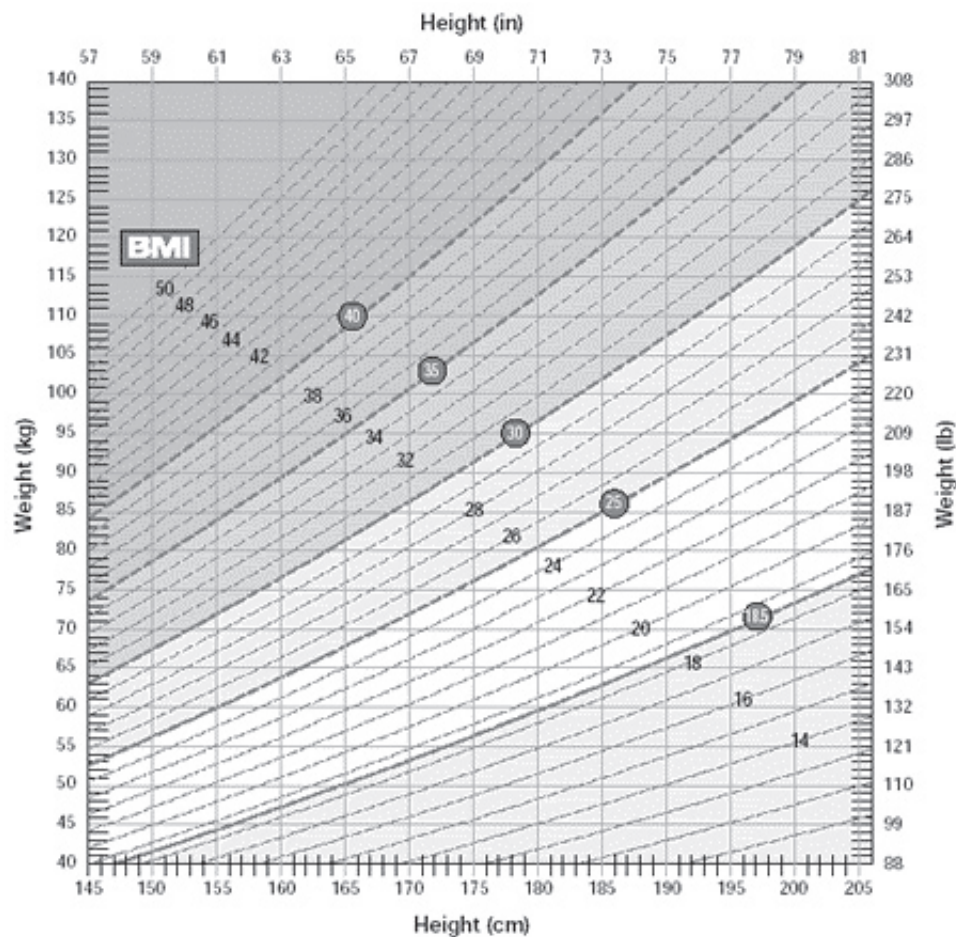
Completing Physician

Date

Adapted from Johnson (1985) and Northern Health (2006)

Body Mass Index (BMI)

- **CWEDP note:** The use of BMI as a sole measure of health is not recommended. In children and adolescents, the use of BMI as a sole assessment of height/weight ratio is especially not recommended. Calculations are based on an adult population. Consider using ideal weight for age and plotting growth charts as per the attached child and adolescent charts.
- To estimate BMI, locate the point (on the attached charts or below) where patients' height and weight intersect. Read the number on the dashed line closest to this point. For example, if patient weighs 69 kg and is 173 cm tall, the BMI will be approximately 23
- You can also calculate BMI using this formula:
$$\text{BMI} = \frac{\text{weight (kg)}}{\text{height (m)}^2}$$

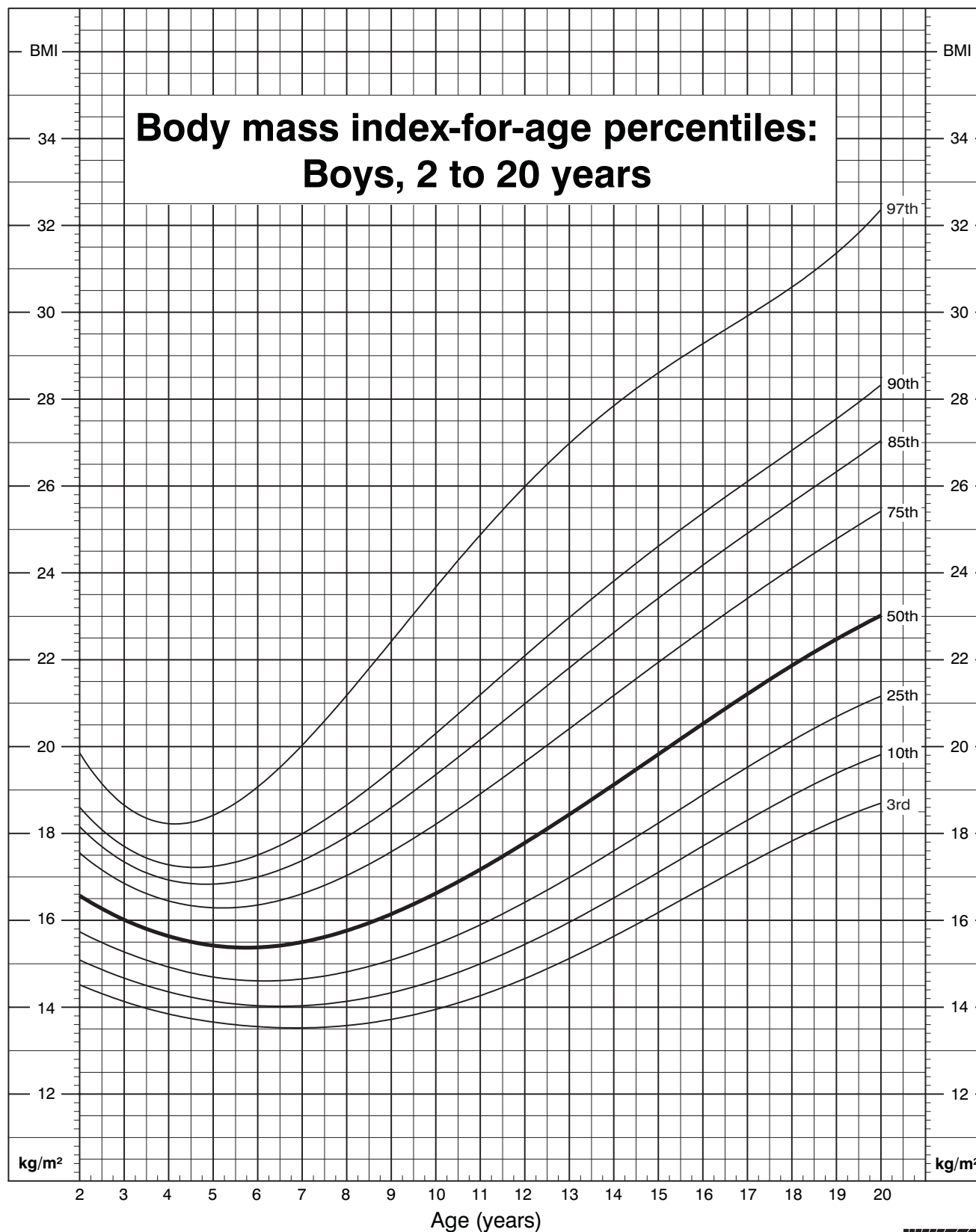


Zone	BMI	Health Effects
A	<20	Below Average
B	20-25	Average
C	25-30	Above Average
D	>30	Obese

Source: Health and Welfare Canada, Promoting Healthy Weights: A Discussion Paper, Minister of Supply and Services Canada: Ottawa, Ontario, 1988

http://www.hc-sc.gc.ca/fn-an/nutrition/weights-poids/guide-lt-adult/bmi_chart_java-graph_imc_java_e.html

CDC Growth Charts: United States



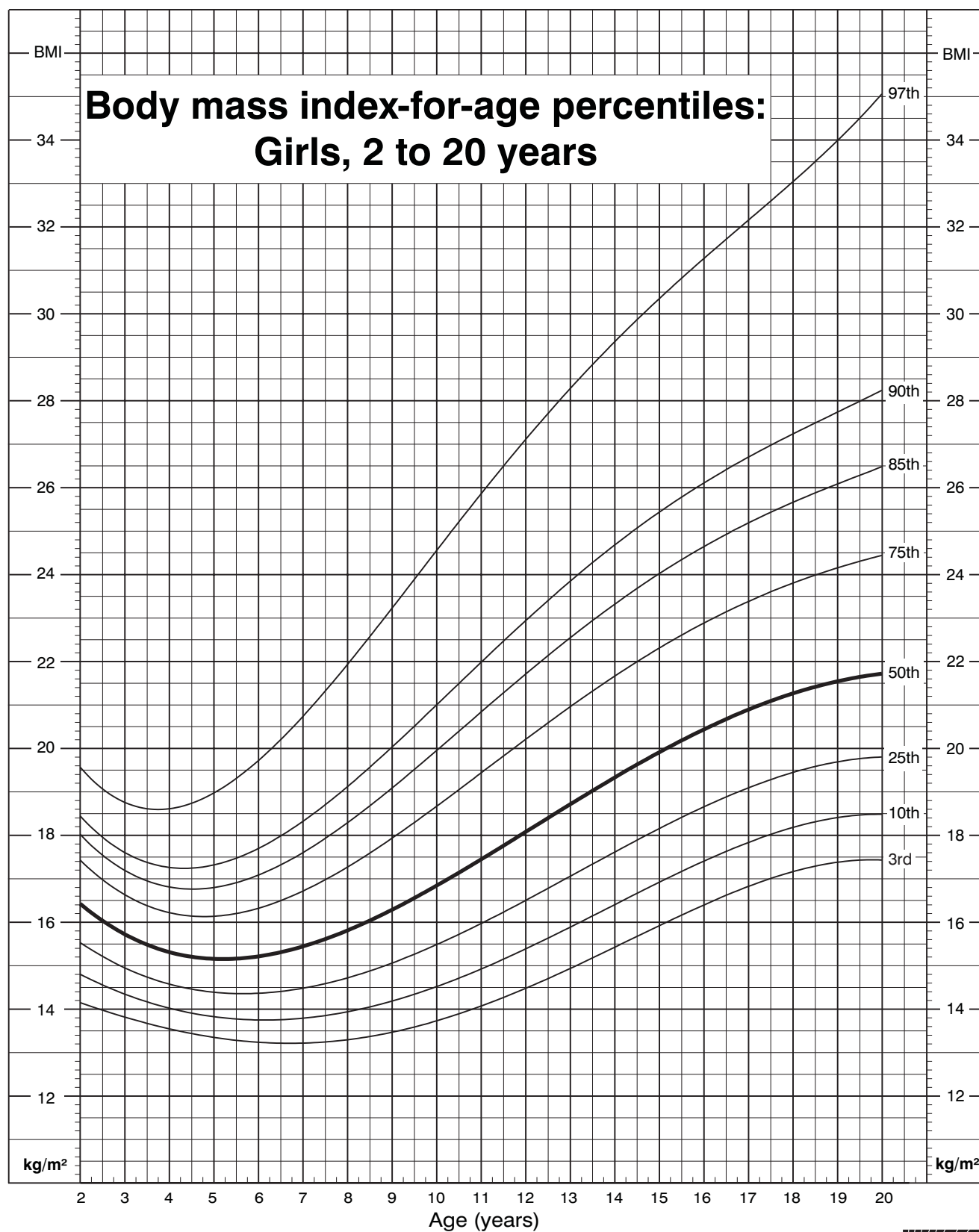
Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



SAFER • HEALTHIER • PEOPLE™

CDC Growth Charts: United States



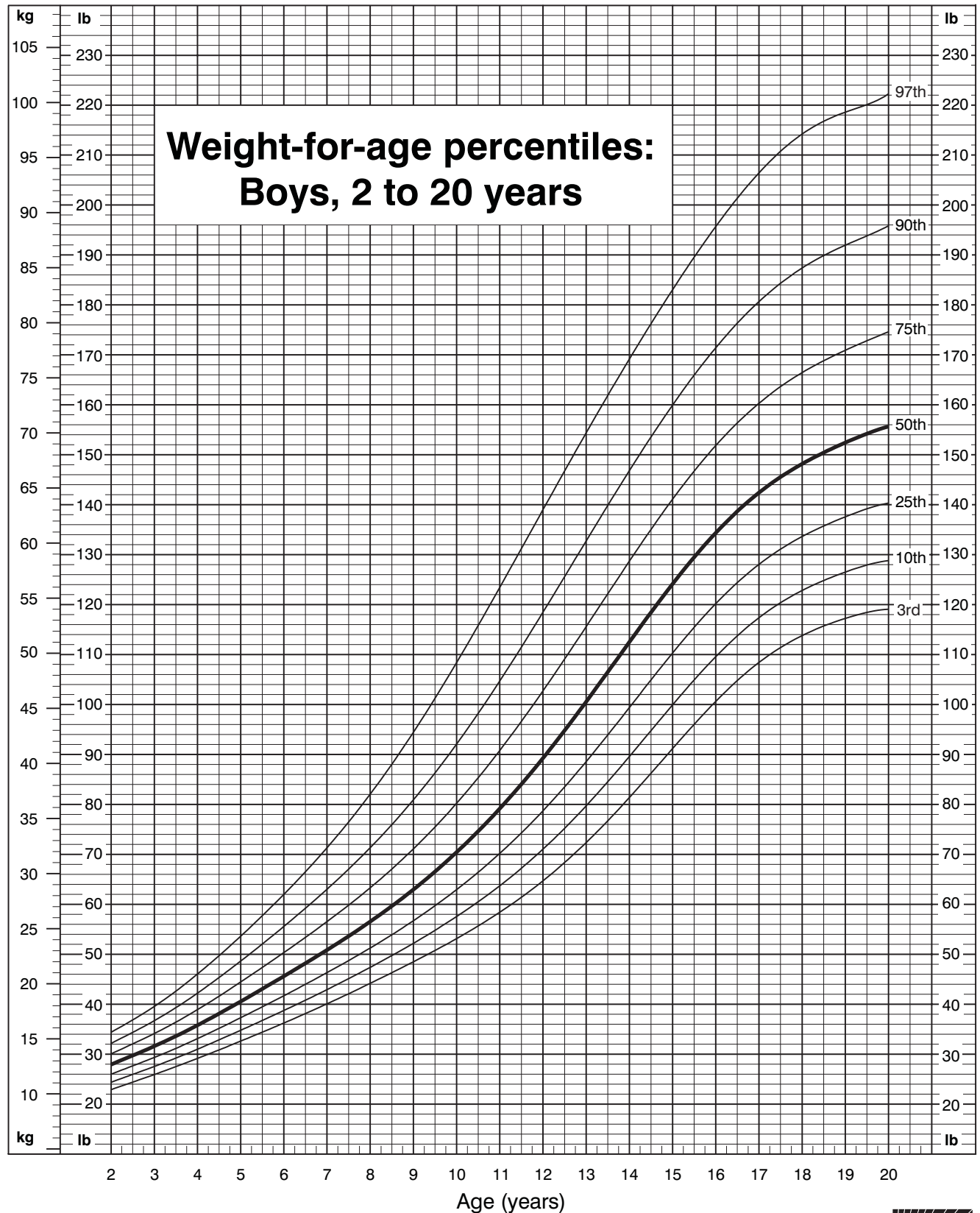
Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



SAFER • HEALTHIER • PEOPLE™

CDC Growth Charts: United States



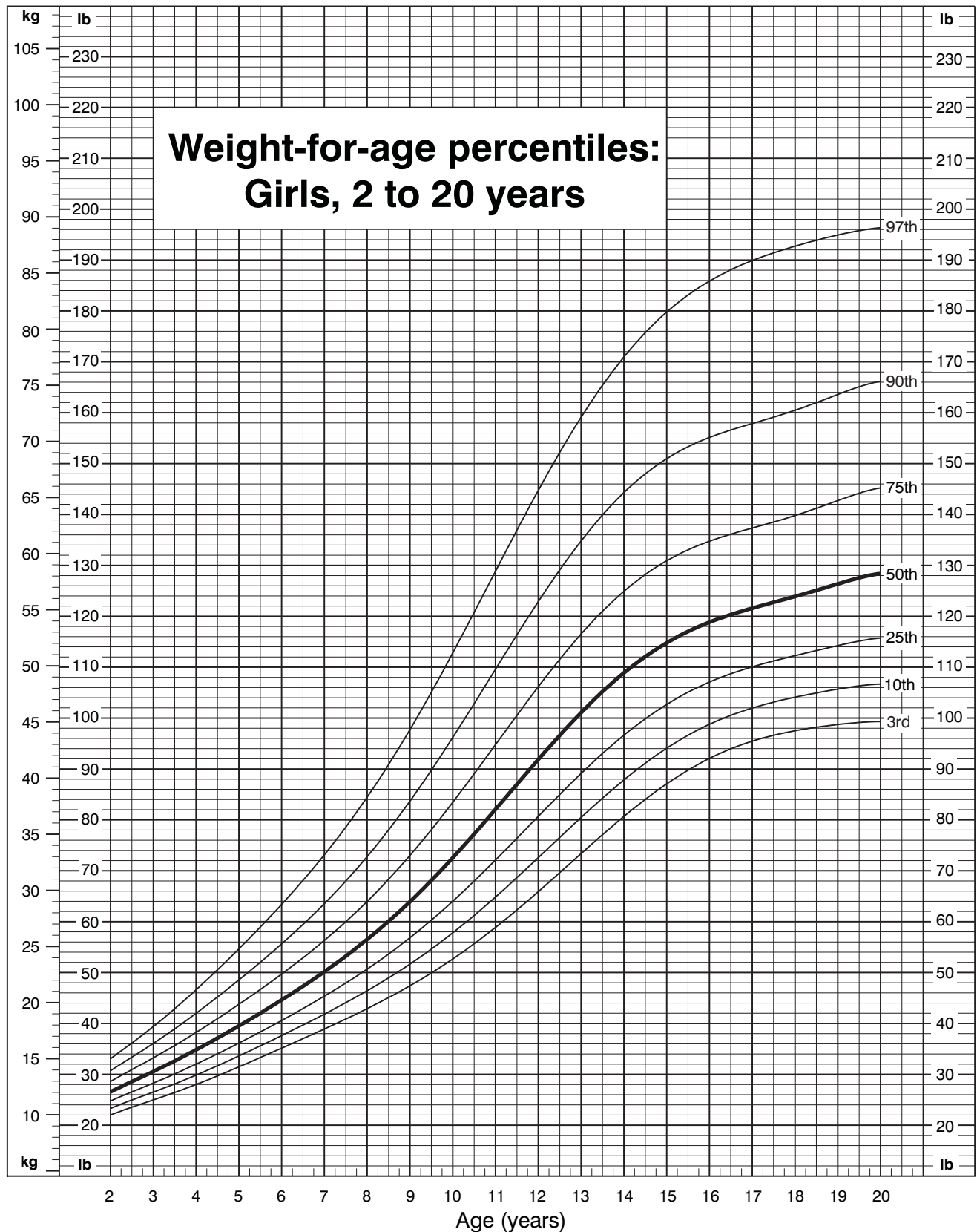
Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



SAFER • HEALTHIER • PEOPLE™

CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



SAFER • HEALTHIER • PEOPLE™

DSM-IV Criteria: Eating Disorders

307.1 – Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height; e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. 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 denial of the seriousness of the current low body weight.
- D. Amenorrhea in Postmenarcheal females i.e., the absence of at least three consecutive menstrual cycles (a woman is considered to have amenorrhea if her periods occur only following hormone administration).

Specific Types:

Restricting Type: During the current episode of Anorexia Nervosa; the person has not regularly engaged in binge-eating or purging behaviors. i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Binge-Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviors; i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

307.51 – Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - (1) Eating, in a discrete period of time (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.
 - (2) A sense of lack of control over eating during the episode; e.g., a feeling that one cannot stop eating or control what or how much one is eating.
- B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during Anorexia Nervosa.

Specific Types:

Purging Type: During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Non Purging Type: During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Research Criteria for Binge Eating Disorder

- B. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - (1) eating, in a discrete period of time (e.g., within a 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
 - (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
- C. The binge eating episodes are associated with three (or more) of the following:
 - (1) eating much more rapidly than normal
 - (2) eating until feeling uncomfortably full
 - (3) eating large amounts of food when not feeling physically hungry
 - (4) eating alone because of being embarrassed by how much one is eating
 - (5) feeling disgusted with oneself, depressed, or very guilty after overeating
- D. Marked distress regarding binge eating.
- E. The binge eating occurs, on average, at least 2 days a week for 6 months.
- F. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise etc...) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.

307.5 – Eating Disorder Not Otherwise Specified

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include:

- A. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
- B. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
- C. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week over the last three months.
- D. The regular use of inappropriate compensatory behaviors by an individual of normal body weight after eating small amounts of food; e.g., self-induced vomiting after the consumption of two cookies.
- E. Repeatedly chewing and spitting out, but now swallowing, large amounts of food.
- F. Binge-Eating Disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.

Tips on Conferring an Eating Disorder Diagnosis

1. **There are only five eating disorder diagnoses you can make.** These are: Anorexia Nervosa, Restricting or Purging Subtype, Bulimia Nervosa, Purging or Non-Purging Subtype, and Eating Disorder Not Otherwise Specified. The latter is actually the most common eating disorder diagnosis made, and applies to all individuals with clinical eating disorders who do not meet full criteria for AN or BN.
2. **Be sure you're clear on the meaning of diagnostic terms.** A frequent misconception, on the part of both patients and health care professionals, is that when someone is "bulimic," they are vomiting. Bulimia, in fact, is "ox-like eating" and refers to bingeing, not purging, behavior. Not all individuals with bulimia nervosa vomit. The diagnosis is divided into the purging and non-purging subtypes and only the former may involve regular vomiting.
3. **Patients are often surprised by their eating disorder diagnosis.** This is often the case even among severely ill individuals with very obvious and repetitive symptoms. Be gentle and respectful when conferring a diagnosis. Hearing it formally is often very upsetting and can take time for patients and families to integrate.
4. **Remember, diagnoses can, and do, change.** This is significant, as it may mean the onset of new symptoms and new medical challenges which previously were not part of the picture. A common example is the transition from the restricting form of anorexia nervosa to the purging form of bulimia nervosa. When patients begin to re-feed, they often find it difficult to manage food and sometimes enter a cycle of bingeing and purging.
5. **Don't forget about Binge Eating Disorder!** This is actually a form of an Eating Disorder Not Otherwise Specified and is often undetected and under diagnosed. A common problem here is the mistaken assumption that all obese individuals are alike. However, we know from the research literature that obese binge eaters tend to differ from obese non-binge eaters in a number of important ways. For example, they tend to have more psychiatric co-morbidities (e.g., depression, alcohol abuse), poorer outcomes in weight loss programs, and more challenges after bariatric surgery. There may also be underlying metabolic abnormalities that increase food cravings and promote overeating (e.g., hyperinsulinemia, insulin resistance, diabetes and PCOS). Thus, correct diagnosis is of critical importance in determining primary treatment targets. These may include management of psychiatric comorbidities, reduction of bingeing, and/or direct management of weight. Binge eating is often kept secret by patients due to feelings of shame. Thus, it is incumbent on health care professionals to develop sensitive and respectful ways of asking about this behavior.

Mary Lees, Ph.D., C. Psych
Credit Valley Hospital Eating Disorders Tea

ONGOING MEDICAL MONITORING AND MANAGEMENT

CENTRAL | EATING DISORDER WEST | PROGRAM

*"Intervene early, and follow frequently if there
is ANY cause for concern."*

Dr. Christina Grant, MD, FRCPC

Adolescent Medicine, Department of Pediatrics
McMaster University

"You want to create a sense that... it's going to take a lot of time."

Dr. Barry Simon, MD, FRCPC

Psychiatrist, Leadership Centre for Diabetes
Mount Sinai Hospital

Ongoing Medical Management and Monitoring: Overview

Eating Disorders

Once you have confirmed an eating disorder diagnosis, regular check-ins are the cornerstone of your patient care.

PHYSICAL – You will need to monitor the following on an ongoing basis:

- ☐ WEIGHT
- ☐ FLUID AND ELECTROLYTE STATUS
- ☐ CARDIAC FUNCTIONING
- ☐ PSYCHIATRIC STATUS (E.G., SUICIDALITY)

CONSULTATIONS – You may wish to consider the following consultations:

- ☐ Psychiatric
- ☐ Dental
- ☐ Nutritional
- ☐ Internal Medicine

HOSPITALIZATIONS – You may periodically need to make a referral to an acute care facility. Acute services typically involve either day hospital or inpatient care. Unfortunately they are scarce, may not be in your immediate vicinity and often have lengthy wait times.

- ☐ See “Levels of Care” Sheet
- ☐ See “Ongoing Medical Monitoring” sheet

KEY

It is important to remember that you have a critical role to play in ongoing medical monitoring while your patient is waiting for, or has recently been discharged from, an acute care facility.

Pre-Admission – It is advisable to connect with the physicians at the site (including Emergency departments) when you are making a referral or hoping to arrange stabilization through ER. An admission may be better facilitated through physician-to-physician contact. A simple phone call can save your patient much time and prevent unnecessary disappointment.

Post-Admission – Monitor the patient weekly until their health has stabilized, and then move to bi-weekly/monthly as appropriate. Obtain discharge notes from the treatment centre or liaise with the site physician. Connect with the family as appropriate. Assess level of client motivation to sustain changes and plans for follow-up care.

Checklist for Ongoing Medical Monitoring of Patients with Eating Disorders

The following are suggestions for the medical management of eating disordered patients in your outpatient practice.

Medical Goals:

For Anorexics:

- normalization of eating patterns
- weight restoration to > 90% Ideal Body Weight (IBW)
- resumption/maintenance of menses

For Bulimics:

- normalization of eating patterns
- cessation of bingeing, purging and excessive exercise behaviors
- maintenance of a healthy, stable weight

For Binge Eating Disorder:

- normalization of eating patterns
- cessation of bingeing
- stabilization of weight

Visits:

The frequency of visits will be determined by age, level of illness severity and whether the patient is transitioning into or out of an acute admission.

Each Visit:

Record information in the table attached. Review with the patient and other providers as may be required /necessary.

Weekly and Bi-Weekly monitoring:

Recommendations are included in table attached which can be copied and kept within patient's file.

Additionally:

Once per month (or more frequently if chest pains or palpitations):

EKG:

Every 6 months or so as needed:

LH: (if amenorrheic)

FSH: (if amenorrheic)

Ferritin:

TSH

Annually:

Bone density (should be performed if amenorrheic >6 months or if past history of osteopenia/osteoporosis)

NAME: _____ **PATIENT FILE #:** _____

PATIENT FILE #:

Date of Initial Assessment: _____ **Height:** _____ **Weight:** _____ **IBW:** _____

Weight: _____ **IBW:** _____

[illegible]

“What to... What not to say”

We receive a great deal of feedback from patients and families about the kind of language that is helpful to recovery. ‘What not to say’ comments often speak to biases whereas ‘What to say’ comments seem to communicate an appreciation for the monumental task before families and patients in overcoming an eating disorder.

What NOT to Say to Patients

“You look better”
“You look so much healthier now”
“Your weight is healthier”
“You are looking more normal”
“You’ll grow out of it”
“I promise you won’t get fat”
“I promise you won’t die”
“Wow, you’ve lost/gained a lot of weight lately”
“What you are feeling is completely normal for your age”
“Why can’t you just eat something?”
“You’ll probably end up back in the hospital again”
“Your weight is good this week”
“You don’t need to come to my office anymore, you are fine”
“You can choose what you want to eat” (kids)

What TO Say to Patients...

“You are thinking so much more clearly”
“It’s good to see your sense of humour”
“Re-nourishment has made you much more effective at communicating your needs”
“Your concentration has really improved”
“Your personality is really coming through now that your physical health has improved a little”
“You should be proud of yourself for the steps you are taking to get/stay healthy”
“You can talk to me if you need to”
“This illness has a long course but there is hope”
“Your health is improving”
“Your parents will have to plan your meals for awhile”

What NOT to Say to Families

"You should have brought her in sooner"

"She'll outgrow this; it's just a phase"

"People with eating disorders are very manipulative."

"I think you are worrying too much"

"This illness seems to run a course of about seven years no matter what you do"

"Maybe if you just tried to cook foods she likes she would start to eat"

"She most likely does not have a problem; her weight is normal for her age and height"

"Everyone has stress with teenagers"

"Isn't this illness about controlling too much?"

What TO Say to Families...

"I can appreciate that you are dealing with this all day, everyday"

"I respect how vigilant you are being; it must be exhausting but is so important to your child's recovery. You are doing the right thing"

"I understand why you are feeling so anxious about your child's eating as she begins steps toward her recovery. It will be a hard balance around slowly letting go of vigilance"

"During this stage, let me closely monitor your child's weight and I will be able to tell you if your child appears to be sliding back into the illness"

"This illness impacts every member of the family"

"It's not your child fighting and resisting your efforts to help; it is the illness"

"If your child had cancer, you would be doing everything in your power to fight it. The challenging thing about eating disorders is that, unlike cancer, however, your child may appear to be fighting the treatment process. Always remember that it is the eating disorder fighting you and your child. It is the common enemy. Your recovered child will tell you this some day"

"It is important for you to take care of yourselves also and find ways to release stress in a positive way"

"This journey could be a long or short one, but continue to have hope that recovery is possible"

"It's important for you to stay on top of this illness"

"Of course you would be stressed. What supports do you have?"

"You may have to take more control of his/her meals for a while"

Adapted in part from Northern Health, Prince George Eating Disorders Clinic, 2005

Levels of Eating Disorder Care

Although your local Level 1 or Level 2 specialized provider may not offer acute care services, we recommend that you connect with the program as a routine part of your approach as there may be a need to transition patients to these services prior to or following an acute care admission.

	Support services Non-medical Model	Level 1	Level 2 Intensive Outpatient	Level 3 Partial Hospitalization (Day Hospital)	Level 4 Residential	Level 5 Inpatient hospitalization
Patient characteristics *Medical Status	All Levels	stable	stable	History of instability or often hovers on the border of instability	History of instability or hovers on the border of instability- special feeding not required	Medically unstable, may require special feeding; psychiatrically unstable(e.g. suicidal); pregnant; poorly controlled diabetes
*Motivation	All levels	Fair-good	Fair	Partial	Poor-to-Fair	Very Poor to Poor
*Structure Needed for eating/gaining weight	All Levels	Self-Sufficient	Requires more frequent contact but is reasonably self-sufficient	Needs some structure	Needs supervision at all meals	Needs supervision at all times including before and after all meals, may require special feeding
*Purging Behavior (laxatives and diuretics)	All levels	Can reduce without structured environment	Can reduce without structured environment	Can use support from others or use therapeutic strategies to reduce behaviors	Can use support from others or use therapeutic strategies to reduce behaviors	Needs supervision at all times
Availability in Central West Ontario Region	Danielle's Place Eating Disorder Awareness Coalition	CWEDP Sites: *Credit Valley Hospital (CVH) *Trellis *Healthcare Services-Oakville(HHS) *William Osler Health Centre- Brampton (WOHC)	CVH Trellis HHS WOHC	Adults: CVH Children and Adolescents: William Osler- tbd	16+ Homewood Health Centre	Adults: CVH Children and Adolescents not yet available
Availability outside of region	*Sheena's Place-Toronto *Hope's Garden-London *Hopewell-Ottawa		CAMH- Comorbid ED + Substance Abuse	Adults: North York General (NYG) Ottawa General Hospital (OGH) Toronto General Hospital (TGH) Children and Adolescents: Children's Hospital of Eastern Ontario (CHEO) Hospital for Sick Children(HSC) North York General(NYG) Southlake Regional Health Centre (SRHC)	Bellwood-Toronto	Adults: TGH OGH NYG Children and Adolescents: HSC CHEO LHSC-London Health Sciences Centre- psychiatric beds only

Adapted and Modified from APA Practice Guideline for the Treatment of Patients with Eating Disorders, Third Edition

Readiness for Change

Changing our behavior is difficult. The Transtheoretical Model of Change (Prochaska et al., 1992) suggests there is a series of stages we go through before we actually make and sustain behavioural change. This theory also suggests that we must first develop an **intention** to change before we can begin to do things differently. People with eating disorders often struggle with their decision to overcome their eating disorder. This may be related to society's support of a thin body ideal; or the eating disorder may have become a 'friend' that they are not sure they can live without. Supportive others are often ready for recovery long before the person with the disorder is. Consequently, it is important to match helping strategies with where the person is at in terms of their interest in and willingness to change. The table below provides some helpful information about the stages of change, what each stage looks like in terms of illness behavior and what to keep in mind to encourage, support or maintain change. In the treatment of children and adolescents, we don't always wait for there to be interest in change. Ensuring continued physical growth and development is critical and so often work will start with parents if kids are not yet ready for change.

Stage of Change	General: Clients	Suggestions for Parents/ Supportive Others	Suggestions for Health Care Practitioners
Pre-contemplation (1 month +)	- "As far as I am concerned, I don't have an eating disorder" - No intention to change and not aware there is a problem - Makes changes only because they are under pressure- when pressure goes, so does change - Does not see that action is required on their part - Will receive help for consequences of E.D. only	- Avoid forcing loved one to pursue change - Encourage general self-care including visit to family doctor - Describe out loud, impact of eating disorder on you - Listen & validate feelings - Consider how <u>you</u> support the E.D.	- The client wants help to fix the consequences of the E.D., not the E.D. itself - Focus on client's denial - Provide education - Listen & validate feelings - Assess for co-morbid conditions e.g. depression and anxiety
Contemplation (1 month +)	- "I accept that I have problems related to an E.D., but I am not yet ready to do anything about it" - Usually has motivational crisis- e.g. something goes wrong with health, family, finances etc... - Begins to consider costs and benefits of overcoming E.D. - Beginning of the end of denial	- Continue to notice consequences of E.D. - Continue to listen & validate feelings - Understand that some of your own ways of coping, parenting even though well-intentioned may be helping to support the eating disorder - Consider benefits of doing things differently	- Key issue is the client's ambivalence - Identify issues that keep client stuck - Identify and monitor emotional states that leave the client feeling overwhelmed, strategize around ways to contain these feelings - Continue education around healthier self-care and medical check-ups
Preparation (1 month +)	- "I am planning to do something about my E.D. in the next six months" - Makes the decision to change - Experiences a number of false starts - Seeks out information about recovery options and other needed sources of help	- Support your loved one's beliefs that they can change - Find support for yourself in your own efforts to change - Trial and error during meals, discussion times with efforts to handle things differently	- Support the client's belief that they can change - Homework has the client altering their E.D. behaviors in small ways (e.g. delayed binges) - Provide cognitive and behavioral strategies to facilitate change
Action (1.5 years +)	- "I have taken active steps to address my E.D. in the last 6 months" - Symptoms are interrupted - Confident in and committed to recovery - Therapy can feel like a full time job - Develops affective skills to reduce power of triggers - Reorganizes life and roles to support recovery	- Firm yet compassionate caring - Have expectations that are in keeping with loved ones life in recovery - Feels like work sometimes - Develop skills that help you not to get drawn into power struggles - Your own and your family life no longer revolve around the eating disorder	- Provide range of tools for clients to use in the management of their symptoms - Establish recovery through cessation of problematic behaviors, and enhancement of beneficial ones (e.g. fewer binge-purge episodes but increased healthier meals/snacks) - Work on learning to cope with life without the E.D. - Identify what improved quality of life looks like - Build affective tolerance and capacity for addressing unresolved emotional issues
Maintenance (varies)	- "I am working to maintain the changes I have made against my E.D." - Productive living, living a full life - Changes are consolidated - Active use of relapse prevention strategies	- Work on maintaining new ways of communicating with loved one that are both comfortable and automatic. - Now and again you might have to remind yourself not to slip back - 'New normal' begins to be established	- Follow-ups as needed e.g. booster sessions - Reinforce use of relapse prevention tools

Prochaska et al., 1992; and The Integrated Recovery Model

Indications for Hospitalization in Children, Adolescents and Adults

General

The following criteria represent guidelines for you to consider in assessing patient acuity. Needless to say, they do not replace your best clinical judgment and knowledge of your patient.

Treatment Reality

Unfortunately, at times hospitalization will be indicated but not immediately possible. There is a paucity of care available for the specialized treatment of eating disorders for children, adolescents and adults. Many community hospitals are very cautious about admitting patients with eating disorders fearing their capacity to provide specialized care will fall short of the patient's needs. This may be the case when there is no physician with eating disorder expertise in the hospital. Nevertheless, if in your estimation a patient's symptom constellation warrants an admission you should seek a medical stabilization admission at the nearest community hospital. A referral to a specialized tertiary care facility can be arranged while your patient is being stabilized. It is possible that several stabilization admissions may be required before a spot in a tertiary care setting becomes available.

It is important to remember and remind everyone, including the patient and his/her family, that the initial goal is medical stabilization, not comprehensive care or complete weight restoration.

Children and adolescents deteriorate much more rapidly than adults do. As well, the optimal opportunity for intervention comes within the first two years of the illness. Therefore, intervening **swiftly is especially critical with young people.**

Many patients can be followed safely on an outpatient basis even when they are medically compromised depending on their access to regular medical monitoring, outpatient multi-disciplinary care and family support. As the monitoring physician, ensure that you have the support you require to comfortably provide this care (see "Physician Support" sheet).

Indications for Hospitalization: Children and Adolescents

*Adapted From Society for Adolescent Medicine
Position Paper (2003) & APA Practice Guideline
for the Treatment of Patients with Eating Disorders
(2006)*

1. Weight loss as defined by:
 - a. <75% healthy body weight for age, sex and height
 - b. rapid weight loss even if not at <75% e.g. > 15% in one month,
 - c. weightloss associated with physiologic instability unexplained by any other medical condition
 - d. patient rapidly approaching weight at which physiologic instability has occurred in the past.
2. Dehydration
3. Electrolyte disturbances (hypokalemia, hyponatremia, hypophosphatemia, Serum K <2.5mmol/L Serum Cl <88mmol/L)
4. Cardiac dysrhythmia
5. Physiologic instability:
 - a. Heart Rate -resting daytime near 40 bpm
 - b. Orthostatic hypotension (with an increase in pulse of >20 bpm or a drop in blood pressure of >10-20 mm Hg/minute from supine to standing
 - c. Blood Pressure <80/50 mm Hg
 - d. Hypothermic (Body temp <36°C)
 - e. Cardiac edema
6. Acute refusal to eat
7. Acute medical complications due to starvation (syncope, seizures, cardiac failure, pancreatitis etc...)
8. Symptomatic hypoglycemia or fasting glucose, 3.0 mmol per litre
9. Esophageal Tears
10. Intractable Vomiting +/- Hematemesis
11. Lack of improvement or worsening despite outpatient treatment
12. Arrested growth and development as per growth chart
13. Acute psychiatric emergencies (e.g. suicidal, psychotic)
14. Comorbid diagnosis that interferes with the treatment of an eating disorder (e.g. severe depression, obsessive compulsive disorder, severe family dysfunction)

Indications for Hospitalization: Adults

*Adapted From APA Practice Guidelines for the
Treatment of Patients with Eating Disorders
(2006)*

1. Weight loss as defined by:
 - a. <75% healthy body weight
 - b. rapid weight loss even if not at <75% e.g. > 15% in one month,
 - c. weight loss associated with physiologic instability unexplained by any other medical condition
 - d. patient rapidly approaching weight at which physiologic instability has occurred in the past.
2. BMI < 16
3. Acute refusal to eat
4. Heart Rate -resting daytime near 40 bpm
4. Blood Pressure <90/60 mmHg
5. Dehydration
6. Orthostatic hypotension (with an increase in pulse of >20 bpm or a drop in blood pressure of >10-20 mm Hg/minute from supine to standing
7. Hypothermic Body temp < 36°C
8. Syncope
9. Symptomatic hypoglycemia-glucose <60 mg/dl
10. K <2.5
11. Serum Cl <88mmol/L
12. Esophageal Tears
13. Intractable Vomiting +/- Hematemesis
14. Suicidal
15. Special considerations: poorly controlled diabetes, pregnancy

Weighing Your Patients

KEY: Weight provides information about overall health and well-being. When weight is unstable or dangerously low, family doctors need to be the professional who advocates for weight restoration through weight gain or weight stabilization depending on the disorder being treated. It is the basis for the restoration of health.

Weighing your patient with an eating disorder is different than weighing other patients in your practice. For patients with eating disorders, the experience is often a very emotional one. The numbers on the scale will often determine how they feel about themselves. Their weight can reflect for them how in control they are of their food intake and bodies. For some people it can be like a challenge or competition, to be weighed every week. For others, the very thought of stepping on the scales can intensify fears and eating disorder behaviors.

It is important to establish the role of and method for collecting weight data **WITH** your patient. Be clear that being weighed is a necessary part of the treatment and ongoing medical management, but ideally, is a collaborative effort between the physician and the patient.

Guidelines for weighing and providing feedback to your patient:

- It is best to weigh your patient in a consistent fashion (e.g., clothed, mornings).
- It is usually recommended to weigh your patient with his/her back to the scale so the number cannot be seen. This however, can be discussed depending on the stage of illness, progress towards recovery and age and maturity level of the patient.
- Sometimes seemingly innocent comments can be twisted and misinterpreted by the patient with an eating disorder, and so it is helpful for everyone (nurses and doctors) to remember not to comment on the number after weight has been taken (*See “What to and What not to Say” Sheet*).
- If the person insists on knowing his/her weight, but you have determined this is not appropriate explore with him/her why they want to know and explain how it can do more harm than good to focus on a number.
- Remind patients of all ages that weight is just one piece of data used to monitor what is going on with his/her body, health and progress towards recovery. Encourage him/her to get rid of or not use the scales at home to reduce the focus on numbers.
- If the parents of an adolescent want to know their child’s weight, tell them when the child is not in the room.
- In the end, if you decide to share a patient’s weight with him/her, explain that body weight will fluctuate due to many factors including water retention, bladder and bowel contents, etc.

Lynette McGarrell, B.A. Sc., RD, Halton Healthcare- Eating Disorder Program

Discussing Nutrition

Normalization of eating is the first step in recovery from an eating disorder. Once nutritionally stable, the individual is better able to deal with the issues underlying the eating disorder and can proceed with further aspects of recovery. The following nutrition points provide a starting point on the road to recovery. Optimally, physicians should provide general guidelines only and refer to a registered dietitian for ongoing, specialized nutritional counselling. Canada's new Food Guide can be found at http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

1. **Normalize eating:** Normalized eating or "mechanical eating" means eating 3 non-dieting meals plus 2 to 3 snacks each day, based on guidelines provided in 'Canada's Food Guide to Healthy Eating.'
2. **Timing of meals:** Each meal and snack should be eaten at approximately the same time each day. This focus on mechanical eating facilitates a return to a normal metabolism and natural hunger and satiety cues. Note: the body needs fuel every 3 to 4 hours.
3. **Variety:** Normalized eating means choosing a variety of foods from each food group, eating a fat at each meal, and eating normal portion sizes as outlined in 'Canada's Food Guide to Healthy Eating.' A snack should consist of 1-2 food groups and meals including 3-4.
4. **Energy:** Daily energy or caloric intake should total a minimum of 2000 calories per day or more depending on current BMI, age and level of activity.
5. **High risk foods or phobic foods:** There are no "good" foods or "bad" foods. All foods have their place within the context of healthy, normalized eating. Diet foods or low fat food choices are not generally considered part of normalized eating.
6. **Planning Ahead:** Planning is of utmost importance. A meal and snack schedule needs to be set and adequate food variety and snack choices need to be available by making a grocery list and shopping regularly. It is desirable for the individual with the eating disorder to be involved in shopping, food choices and food preparation, as well as planning ahead by packing meals and snacks when away from home.
7. **Family Meals:** Meal time should not be about policing food intake. Family meals should focus on topics of conversation other than food. Older individuals and young adults should be given independence in regard to meal planning, while more family involvement is expected with younger children.
8. **Consultation:** When possible involve a dietitian experienced in treating individuals with eating disorders. Referrals can be arranged directly or through an eating disorder program.

Kathryn Duke RD, Registered Dietitian, Credit Valley Hospital Eating Disorders Team

Activity Levels, Sports Involvement and Eating Disorder Recovery

There are few clear guidelines that provide direction for this fairly controversial and largely unstudied area. As a result, different approaches are followed depending on whether the individual concerned is a child, adolescent or adult, recreational or elite athlete, in stable or unstable medical condition. Some points for your consideration:

1. **Goal:** The goal is to promote a healthy approach to active living so that health benefits and not health costs can be derived. This includes the promotion of activities that develop optimal bone (some impact) and cardiac health, are social and not isolatory, are time limited and not inappropriately physically taxing and have a positive impact on emotional well being. Promoting this approach among compulsive, obsessive and excessive exercisers is exceptionally challenging, the goals however remain the same with safety being the most paramount.
2. **Medical Acuity:** No matter the age or athletic status, an individual in an acute and medically compromised state is not to be engaging in strenuous physical activity. Acute status might include but is not limited to: recent episode(s) of fainting; cardiac instability; electrolyte disturbances due to multiple daily binge-purge episodes, frequent daily laxative abuse; absence of adequate nutritional intake and/or chronic dehydration.
3. **Nutritional Rehabilitation:** This is the first treatment of choice and must be clearly defined. Health goals including body weight and medical status need to be established at the outset and can be linked to activities that are to be curtailed or resumed. It is best for everyone to know up front what the rules are.
4. **Excessive Exercisers (McGough, 2004; Shroff et al., 2006):**
 - choose to pursue activities in isolation
 - are motivated to be active, based on compensation for calories consumed
 - limit other age appropriate activities in order to exercise
 - exercise at inappropriate times and in inappropriate places
 - struggle to resist the urge to exercise
 - exercise despite injury or medical instability
 - may be in the latter stages of their illness if they have a chronic eating disorder history
5. **Athletes:** In the case of some athletes full cessation of participation in their chosen sport may not be required (Alleyne, 2006):
 - If the athlete is found to have disordered eating rather than an eating disorder i.e. may have eating patterns that do not match their caloric expenditures but are not demonstrating significant body image disturbance and are not acutely medically compromised
 - If they are willing to receive nutritional education to learn how to better match nutritional intake with athletic activities
 - If once they are provided with relevant education are willing to take active steps to improve their nutritional intake

- If they understand and are willing to modify activities until a more optimal health state is achieved
 - If their participation in their sport is not significantly linked to body shape and weight issues i.e. they are inspired to make changes in their eating and activities for the benefit of their sport performance rather than reluctant to make changes for the potential impact this might have on their body shape and weight.
6. **Menses:** Refrain from early use of oral contraception to assist with loss of menses as this will mask a key determinant of physical health and nutritional rehabilitation. This is particularly critical in those in the midst of or close to puberty. Nutritional rehabilitation and weight gain remain the treatment of first choice for loss of menses as resumption of menses is a significant marker for improved health and therefore an indication that activity levels may cautiously be increased.
 7. **Parents:** Those that model active living and not exercise for weight loss are in the best position to help their children establish a healthy relationship to sports and physical activity. Encouraging parents to examine their own relationship to exercise and active living is important.
 8. **Have a Plan!:** Most active living best practice guidelines promote 30-60 minutes of activity 3-5 days per week. For recreational athletes, this then becomes the benchmark for those seeking to improve their relationship to exercise. Many treatment programs have adopted a graded activity schedule that reflects changes in medical stability for example moving from complete bedrest to weekly unescorted trips to a local gym (Thien et al., 2000). This same philosophy can be applied to working with children at home as long as their medical status is monitored and fine. Starting out with 15 minutes per day of physical activity and building to 30 minutes is not an uncommon strategy. An agreement with an adult patient could use a similar strategy.
 9. **Anorexics:** Encourage a range of activities rather than pursuit of only a few that follows a rigid/fixed schedule. Monitor medical status very carefully and adjust activity levels as health improves or declines. Promote exercise as a way to maintain overall health and not simply as a method for weightloss.
 10. **Bulimics:** Encourage physical activity not as a method for caloric compensation but rather as a way to more effectively manage emotions (anxiety and depression) and derive overall health benefits. Promote physical activity as pleasure not pain, play not work using structured activities that help to promote a sense of consistency, predictability and routine.
 11. **Education:** Excessive exercise may not be accomplishing what an individual believes it to be doing. For those who always engage in the same activities that do not include strength building, fitness might in fact be being compromised rather than built. This is particularly the case where someone is additionally nutritionally compromised.
 12. **Children and School:** You may need to work with parents to support requests that a child be exempt from gym and /or temporarily removed from school teams while their health is being restored. Children in schools today face multiple stressors that can aggravate or trigger body image concerns and/or disordered eating. Parents can be encouraged to become aware of their child's school environment particularly around policies pertaining to weight based teasing, starve-a-thons, unwarranted use of fat callipers and BMI testing by individuals ill equipped to deal with individual responses to the testing, and promotion of physical activities that are inclusive of all sizes, shapes and skill levels.

Preparing for an Eating Disorder Hospitalization: Information for Physicians

Physician's Role

1. Assess:

- Assess the patient's medical status immediately prior to making a referral. You will be asked for information pertaining to weight, BMI, and other vitals. It helps if this information is recent.

2. Refer and Connect:

- Liaise with a Physician at the site you are sending the patient to
- If it is a Community Hospital Emergency Physician, be clear that you are seeking a Medical Stabilization stay right now and **not** comprehensive care for the eating disorder. Explain that you are aware the stay may be short
- If it is a Tertiary Care Centre **PLEASE** do not recommend to families that they simply show up at the Emergency Department. We are seeking to streamline and coordinate admissions rather than handle them reactively

Encourage families to follow up in the order as follows:

1. Family Physician

2. Community Hospital- Emergency Department-with advance call from GP

3. Tertiary Care Centre- with advance call from GP

4. Out-of-Country Referral- last resort, must be handled through GP or Psychiatrist

3. Educate Families and Patients:

- Provide Hospitalization Information sheets to patients and families
- Distinguish between types of hospitalizations:
 - Medical stabilization stays are typically short and predominantly attend to medical issues aimed at keeping the patient alive and reducing medical risk of further complications. Specialized expertise is often not available on general pediatric or medical floors. Stays are typically 2-8 days
 - A specialized comprehensive eating disorder admission is typically longer, attends first to weight and nutritional stabilization followed by therapies aimed at addressing motivation for change and underpinnings of the disorder. Stays are typically 2-6 months. Admissions are voluntary and patients will need to be willing to follow a treatment program
 - Outpatient care addresses motivation for change, psychological issues and relapse prevention, is typically 2-7 years in duration and can precede/follow hospitalization
- During Hospitalizations:
 - **Weight-** will be taken regularly
 - **Nutritional intake** will vary with medical status, type of facility admitted to and staff training on the unit where admitted. Meals are typically regular hospital fare- 3 meals and 2 snacks
 - **Privileges** on units will often vary with medical status
 - **Admissions-** sometimes it takes more than one admission for individuals to stabilize. While admissions are voluntary patients are expected to follow the program protocol while in the hospital. If patients are not ready for this type of treatment they can be encouraged to return to the hospital when more ready to progress in care

4. Follow-Up:

- Schedule regular monitoring appointments following discharge. Ideally, care should be planned and coordinated with an outpatient program. Make a referral to an outpatient eating disorder program if not already done

Ethical Issues in the Compassionate Care of Those with Eating Disorders

In the provision of care to those with eating disorders, a number of ethical issues can arise. Most often these surface with increased illness severity, and mortality risk. Practitioners must reconcile their sense of duty to protect the health of their patients with the rights of patients to make their own healthcare decisions also bearing in mind their own personal values and beliefs. The following is a very brief list of some of the most common issues and dilemmas:

Physician self-knowledge – It is essential that you understand your own views about body image, dieting and weight loss in order to provide the best possible healthcare information and advice to patients and families. Communicating what is normal and abnormal around body image, nutrition and weight and shape preoccupation without personal biases is essential. It is helpful to examine your own beliefs about those who suffer from eating disorders. If you see these disorders as a normal phase of adolescence to be outgrown, or only as deliberate attempts to manipulate those around them and not as serious mental health illnesses with potentially debilitating and chronic medical sequelae, you will likely miss opportunities to educate and help families, reduce medical risk and advocate for timely and compassionate care.

Therapeutic alliance – A strong therapeutic alliance with the patient is fundamental but having one can raise some ethical issues. The physician may feel genuinely torn when faced with the task of breaching confidentiality should a patient's medical health become compromised. When very ill the patient may no longer be deemed competent to make his/her own healthcare decisions and must receive compulsory medical treatment. The cost to the therapeutic alliance must be weighed against both the short and long term health risks to the patient.

Competence to consent to and refuse treatment – Patients with eating disorders are often bright, articulate individuals even when severely medically compromised. They typically demonstrate an understanding of the treatment being advised and seemingly of the consequences associated with treatment refusal. However, their eating disorder may severely restrict their insight and ability to make healthy treatment decisions. The health risks to the patient must be balanced with due respect for patient autonomy.

Exercise/Sports and Anorexia – The question of whether those suffering from anorexia should be permitted to participate in fitness classes or other sports, particularly when severely medically compromised, is receiving increased attention (Giordano 2005). A key issue is that anorexics are not likely to tell their instructors/coaches or physicians, who then are not able to make informed choices around whether to permit participation. Giordano differentiates between other types of medical illnesses and anorexia in that the exercise is PART of the anorexic's condition and therefore the risks outweigh the benefits. However, this argument is countered with issues of safety. For someone who is likely to exercise anyway, perhaps doing so within the confines of a class or group may be the more effective response since supervision and time limits are part of such forms of exercise.

Behavioral Programs – Behavioral programming has long been used in the treatment of eating disorders. Some view such programs as reward based, whereas others see the treatment as punitive and coercive. Behavioral strategies continue to be used in one form or another in most treatment programs but efforts are being made to make them more collaborative and humane.

Palliative Care – When someone with an eating disorder is in the final stage of his/her illness, issues around palliative care may need to be discussed. Being mindful of your own beliefs and values around eating disorders at this stage is important. How you advocate for your patient to the staff of the hospital can impact the care he/she receives. These patients, just as anyone else with any other illness, deserve to die with dignity and in comfort. A very controversial issue concerns when cessation of treatment is compassionate and palliative and when it constitutes passive euthanasia.

Multidisciplinary Teams and Multidisciplinary Views – The treatment of eating disorders typically requires the involvement of multidisciplinary professionals in addition to the patient's family physician and family. When complicated issues arise such as that of compulsory treatment, differing opinions in the face of a treatment resistant patient can fracture even the most well intended professionals and families.

Gender Issues – This is an important issue given that the majority of eating disorder patients are female. While female physicians may be more likely to appreciate the social pressures of their female patients, there is no body of evidence to suggest that they are better care providers than their male counterparts. Competent physicians can provide competent care, regardless of gender. Being aware of your own gender biases is helpful in negotiating the challenges that form part of the physician-patient relationship.

HELPING PATIENTS HELP THEMSELVES

CENTRAL | EATING DISORDER WEST | PROGRAM

*"Be non judgmental, take what your patient is saying seriously,
not making light of something that was difficult
for the patient to bring up."*

Dr. Colleen Flynn, MD FRCPC
Previously Medical Director, EDP
Credit Valley Hospital

*"Be really clear and transparent, up front (with adolescents)
regarding confidentiality and their rights."*

Dr. Christina Grant, MD, FRCPC
Adolescent Medicine, Department of Pediatrics
McMaster University

Helping Your Patients to Help Themselves: An Introduction for Physicians

Motivation... Motivation... Motivation

One of the greatest challenges for most eating disorder patients is staying motivated for recovery. It is very hard work to recover from an eating disorder given that so many systems: physical, mental, emotional and social, are affected. Given that the typical course of illness is approximately 7 years and that there is significant social support for the pursuit of a thin body ideal, this can represent an overwhelming challenge.

Individuals must seek their own reasons for overcoming their illness. These are often related to those things that provide them with a sense of quality of life. Helping individuals to identify and then stay focused on these despite the ups and downs, is critical to their long term recovery and overall quality of life.

Children and Adolescents and Motivation

Although motivation issues are equally relevant in the recovery of children and adolescents, the need to restore physical health to minimize the permanent impact on growth and development supersedes the need to wait for motivation to 'hit'. Parents need to be encouraged, coached even, to reestablish parental authority around eating adequately, seeking medical attention and personal safety. For example reasserting that "in our family we take care of ourselves by eating properly, going to the doctors when we are not well and through not taking safety risks when we are undernourished e.g. drive a car or exercise rigorously when we have not eaten in days.

Health Monitoring... Health Monitoring.... Health Monitoring

Through helping your patients to stay focused on the things that matter most to them *outside of body shape and weight concerns* at any age or stage of illness, it then becomes a little easier to point out that without medical health and stability these things will not be possible. Through regular medical monitoring their physical health becomes the key vehicle through which they can return to or move towards those things they miss most in their lives. Spending time with friends, returning to work or school, having a relationship or being able to participate in activities they have not been able to for some time are all possible when their health permits it.

The worksheets in this section are designed to help you help your patients think about and stay focused on what recovery means to them. You have a few tools to help get them started and these coupled with your ongoing health monitoring and involvement of other professionals as necessary will help your patients to better help themselves.

Helping Yourself Recover

Recovering from an eating disorder is not easy. Many think it is just about getting back to eating again. If only it were that simple. While there are things others around you can do to help, the key person is you. Change takes time and energy, both emotional and physical. This can feel lonely, overwhelming and frustrating at times. Take some time to think about the following:

1. **Your role in your recovery.** One of the hardest things to do in recovering from an eating disorder is to decide that you do indeed want to 'give up' the eating disorder and take better, more healthful care of yourself. Ultimately, this is the decision that everyone must make at some point before change is possible. We understand that making this decision is complicated. Most people remain ambivalent or uncertain for a long time. Ask your doctor for the 'Thinking about Getting Better' worksheet.

The following are a few reasons why people find it hard to recover:

- They feel pressure to stay thin or diet for their sports, family, friends or boyfriends/girlfriends
- The eating disorder is a life preserver, something they can hang onto during tough times
- They're scared that they will gain a lot of weight
- The eating disorder helps to distract them from other more upsetting issues
- They are scared to consider what giving up the eating disorder might be like
- They don't know how to give it up, where to start or who to go to for help
- It is hard work!

The following are a few reasons why people choose to recover:

- They miss having certain people or activities in their life
- They want to feel better, less ashamed, more optimistic, less moody, more fun-loving
- They want more intimacy in their lives
- They don't want to feel depressed or completely emotionally drained anymore
- They would like to stop crying all the time
- They want to feel good about being in their own skin
- They resent all the time the eating disorder takes
- They want their life back

2. **Your role in your physical health.** You are the keeper of your body. You are in the best position to either ignore or honor the cues that your body sends you. If you ignore important signs and signals for long enough you will develop medical complications. If you are beginning to notice symptoms and/or are worried about your health, check in with your doctor. Doing this doesn't mean that you have to make up your mind about recovery. You can then decide whether and when to 'invite' your doctor to become part of your recovery team. While your family and friends may insist that you show up at a doctor's office, you can decide how much they get to participate by how honest you are with them, how much information you share. Your family doctor can monitor your health regularly and make specialist referrals such as to Counsellors, Dietitians, Psychiatrists, and Dentists etc.

3. **Your role in deciding what kind of care you need. Are you looking for support or treatment right now?**
 - **Support Services** are those that are offered free of charge through a Support Centre. Usually they ask few questions, do not require a referral, and offer no medical support or monitoring. You are free to decide which of the services offered you would like. Typically, you can come and go as your time and needs dictate.
 - **Treatment** is different in that you are usually assessed and given a treatment plan. The first step is usually to restore your medical health. There is usually a treatment team made up of different professionals who have designed a program for you. This usually consists of individual and/or group therapy. Group therapy is NOT second class care; the research supports group therapy treatment as best practice.
 - Both Treatment and Support can be used simultaneously to improve the overall quality of your life.
4. **Your role with your weight and getting weighed.** Weight is a very sensitive topic for people with eating disorders. It is however, a key indicator of your overall health. If your weight is too low you are at risk for complications just as it is when it is too high. This is why it is important to have your weight monitored. How you get weighed and the optimal weight you are aiming for in recovery can be worked out with your family doctor as part of your care plan.
5. **Your role with your eating.** If you are a student and still living at home, your parents bring food into the house. However, it is up to you to decide what and how much to eat. This is true *as long as you are making good health decisions*. When you stop making healthy choices, the people around you become concerned and want to get involved. As an adult, you have to both provide the food and decide what and how much to eat. Without a doubt though, **food is the medicine of choice for eating disorders**. Treatment and Support services are aimed at helping you to restore normal eating patterns and re-establish a healthier relationship with food and eating.
6. **Your role in creating a personal support team.** Recovery is hard to do alone. It is important, both when you're thinking about getting better and when you have made up your mind to do so, to have a few people who are on your team. You can help them help you by being honest, and letting them know how they can be helpful, even if it means just listening. Your support team might include your parents, husband/boyfriend, siblings, colleagues, friends, family doctor, teacher, coach or pastor. Sometimes the members of your team can have different roles or 'jobs'.

MY TEAM

Consider the Following Questions:

- ❖ Who listens the most and judges the least? _____
- ❖ Who 'shows up' when I need them most? _____
- ❖ Whose advice has my best interests at heart? _____
- ❖ Who do I trust? _____

Readiness for Change

Changing our behavior is difficult. The Transtheoretical Model of Change (Prochaska et al., 1992) suggests there is a series of stages we go through before we actually make and sustain behavioural change. This theory also suggests that we must first develop an **intention** to change before we can begin to do things differently. People with eating disorders often struggle with their decision to overcome their eating disorder. This may be related to society's support of a thin body ideal; or the eating disorder may have become a 'friend' that they are not sure they can live without. Supportive others are often ready for recovery long before the person with the disorder is. Consequently, it is important to match helping strategies with where the person is at in terms of their interest in and willingness to change. The table below provides some helpful information about the stages of change, what each stage looks like in terms of illness behavior and what to keep in mind to encourage, support or maintain change. In the treatment of children and adolescents, we don't always wait for there to be interest in change. Ensuring continued physical growth and development is critical and so often work will start with parents if kids are not yet ready for change.

Stage of Change	General: Clients	Suggestions for Parents/ Supportive Others	Suggestions for Health Care Practitioners
Pre-contemplation (1 month +)	- "As far as I am concerned, I don't have an eating disorder" - No intention to change and not aware there is a problem - Makes changes only because they are under pressure- when pressure goes, so does change - Does not see that action is required on their part - Will receive help for consequences of E.D. only	- Avoid forcing loved one to pursue change - Encourage general self-care including visit to family doctor - Describe out loud, impact of eating disorder on you - Listen & validate feelings - Consider how <u>you</u> support the E.D.	- The client wants help to fix the consequences of the E.D., not the E.D. itself - Focus on client's denial - Provide education - Listen & validate feelings - Assess for co-morbid conditions e.g. depression and anxiety
Contemplation (1 month +)	- "I accept that I have problems related to an E.D., but I am not yet ready to do anything about it" - Usually has motivational crisis- e.g. something goes wrong with health, family, finances etc... - Begins to consider costs and benefits of overcoming E.D. - Beginning of the end of denial	- Continue to notice consequences of E.D. - Continue to listen & validate feelings - Understand that some of your own ways of coping, parenting even though well-intentioned may be helping to support the eating disorder - Consider benefits of doing things differently	- Key issue is the client's ambivalence - Identify issues that keep client stuck - Identify and monitor emotional states that leave the client feeling overwhelmed, strategize around ways to contain these feelings - Continue education around healthier self-care and medical check-ups
Preparation (1 month +)	- "I am planning to do something about my E.D. in the next six months" - Makes the decision to change - Experiences a number of false starts - Seeks out information about recovery options and other needed sources of help	- Support your loved one's beliefs that they can change - Find support for yourself in your own efforts to change - Trial and error during meals, discussion times with efforts to handle things differently	- Support the client's belief that they can change - Homework has the client altering their E.D. behaviors in small ways (e.g. delayed binges) - Provide cognitive and behavioral strategies to facilitate change
Action (1.5 years +)	- "I have taken active steps to address my E.D. in the last 6 months" - Symptoms are interrupted - Confident in and committed to recovery - Therapy can feel like a full time job - Develops affective skills to reduce power of triggers - Reorganizes life and roles to support recovery	- Firm yet compassionate caring - Have expectations that are in keeping with loved ones life in recovery - Feels like work sometimes - Develop skills that help you not to get drawn into power struggles - Your own and your family life no longer revolve around the eating disorder	- Provide range of tools for clients to use in the management of their symptoms - Establish recovery through cessation of problematic behaviors, and enhancement of beneficial ones (e.g. fewer binge-purge episodes but increased healthier meals/snacks) - Work on learning to cope with life without the E.D. - Identify what improved quality of life looks like - Build affective tolerance and capacity for addressing unresolved emotional issues
Maintenance (varies)	- "I am working to maintain the changes I have made against my E.D." - Productive living, living a full life - Changes are consolidated - Active use of relapse prevention strategies	- Work on maintaining new ways of communicating with loved one that are both comfortable and automatic. - Now and again you might have to remind yourself not to slip back - 'New normal' begins to be established	- Follow-ups as needed e.g. booster sessions - Reinforce use of relapse prevention tools

Prochaska et al., 1992; and The Integrated Recovery Model

Thinking About Getting Better

Recovery can be hard work. You have to find some very **personal** reasons for wanting to change. Here are some questions to ask yourself to help you think about change and recovery in a positive way. Answer these, and put them in a private place so that you can find them when things get tough. Share them with your support team: a friend, your family doctor, parents or a counselor can help them understand why you would like to get better.

1. What would getting better change?

2. What might I be doing differently if I was feeling better?

3. Who would be back in my life or in it more often, if I were felt healthier?

4. What else would I be thinking about if I wasn't so preoccupied with thoughts about my body, food and dieting?

5. What do I find most helpful in my efforts to take better care of myself?

6. Who do I need to invite to be on my own personal recovery team? (See "Helping Yourself Sheet")

Food Journal

A food journal can be a helpful tool when you are trying to better manage your daily nutrition. It can help you understand the link between your eating, behaviors and emotions. Keeping a food journal can help you notice trends in how you manage your days, manage your body's basic nutritional needs and stay on track with health goals. You might consider sharing this information with your family doctor, counselor or other helper. This may help them understand how challenging this part of your recovery can be.

INSTRUCTIONS

Each time you eat something, **write** it down beside the date and time of day column. Indicate how much of each item you consumed (ate or drank). Then identify whether it was a **meal** (m), **snack** (s), or **binge** (b). In the forth column write down whether you had any urge to **binge** (b), **vomit** (v), use **laxatives** (l), **exercise** (e), or **restrict** (r). In the comments section, put any thoughts and feelings you may have had, and try to describe the situation, event or circumstances surrounding this occasion. For example, one entry might look like this:

Date and Time	Food Consumed	Type	Urges (1=minimum- 10=maximum)	Comments
Sat. 10am	Cereal, bagel, milk	m	B6	stayed in the kitchen too long after breakfast and started to get the urge to binge-left the kitchen and felt better!

Or this:

Date and Time	Food Consumed	Type	Urges	Comments
Sat. 10am	Cereal, bagel, milk	m	R10	Could only manage ½ the bagel, kept thinking it was all too much! Too scared

Please see page 2 of this worksheet for a blank copy that you can print & photocopy for use as often as needed.

My Food Journal

Date and Time	Food Consumed	Type m=meal s=snack b=binge	Urges: 1=min- 10=max	Comments

Managing Binges

It is hard to stop bingeing but it is possible. Below are some tips that have helped others in their struggle to overcome Bulimia. Remember that your binges are linked to how you eat throughout the day, and to your emotions. What works one day may not be so helpful the next. Try all the suggestions listed and see which ones work best for **YOU**.

1. **Try eating small meals through the day.** A binge is your body's way of screaming for nutrition. Even eating small meals or snacks throughout the day can help to reduce the urges to binge by keeping your blood sugar levels and mood controlling hormones stable.
2. **Ditch your scale.** Your personal worth should not be assessed by a scale. Ditch your scale, slowly if you have to. Discover what really makes you feel good.
3. **Track your emotions.** Sort out which emotions lead to you feeling like bingeing. Use a food journal to learn the where, what, when and who of your binges. This information will help you to determine which tools you need in your recovery toolbox so that you can handle tough situations, people and feelings. Use these tools to better cope and prevent relapses.
4. **Use visualization throughout the day.** Your mind is very powerful. Learn to use it in helpful rather than harmful ways. Before you start each day, visualize yourself moving through it with a sense of calm, eating your three meals with comfort and taking care of yourself in nurturing ways. During the day if you begin to feel like bingeing, close your eyes and visualize yourself getting through the urge and coping with whatever has come your way.
5. **Cost- benefits analysis of your binges.** Write a list of all the costs of your binges. Think about how much money they cost, the lost time they produce, how unable to do anything afterward and how exhausted you feel. Binges often produce a tremendous sense of shame. What are the benefits of your binges? Do the benefits outweigh the costs?
6. **Be active!** Go for a walk, get outside. Wear comfortable clothes, go with a friend. Relax. No pressure and no image related concerns. Have fun!
7. **Build your self-control muscles- slowly by using delay tactics.** Make a deal with yourself. Start by delaying binges or purges by five minutes. Then increase to 10, then 15 minutes or even half a day. If, after this time, you still feel the urge, you will still have helped to develop your self-control muscles for the future.
8. **Emergency card.** Make a list of all the things you have tried that have offered some help, even just some of the time. Put the list on a card and keep it in your wallet. When you are feeling overwhelmed and not quite sure what to do, pull the card out and pick one (e.g. go for a walk, take a few deep breaths, have a warm cup of tea, call a friend, take a bath etc.)
9. **Things I love to do.** Make a list of all the things you might enjoy doing with the time you now spend thinking about food, weight and shape issues. Write one on your mirror with lipstick or washable marker everyday. What time would you like to reclaim for your life?
10. **Remember, you are not alone.** It is easy to feel that others simply couldn't understand or be helpful. You would be amazed though at what a little support can do to help you feel less alone and less ashamed. Find someone you trust and lighten your load just a little by reaching out for support.
11. **See your doctor.** Get checked out physically to see if underlying and untreated metabolic abnormalities are contributing to your binge eating (e.g. elevated blood sugars, insulin resistance)

Preparing for an Eating Disorder Hospitalization: Information for Patients

Treatment

Depending on where you are admitted and why, you are likely to receive different levels of care, and have different expectations placed on you. It is important to remember that you will make the most of any treatment if you are able to think clearly, and that means being medically stable first. It is important to remember that a hospitalization stay is very often just the beginning of the recovery process and not a comprehensive eating disorder 'fix'. Sometimes it takes more than one admission.

- **Medical Stabilization:**

General community hospitals admit you to restore your medical health. Their goal is to reduce immediate risks to your life due to symptoms related to your eating disorder. Most often the staff working with you here **do not** have specialized eating disorder expertise, but do know how to restore your medical health. It is important to remember that the focus of the staff during this admission is to take care of your **MEDICAL** needs and to keep you alive. Stays are usually short and can range from 2-8 days.

- **Medical and Psychiatric Stabilization:**

Sometimes you may be at risk physically AND mentally. For example you may feel suicidal, have urges to seriously harm yourself, or be out of touch with reality. This is when both emergency mental AND physical care may be required. Unfortunately, this care is often hard to find. The job of the staff is to make sure you are safe both mentally and physically. These programs don't usually have staff with eating disorder expertise but are experienced with managing general mental health and medical crises. Once stable, you may go on to more specialized eating disorder care. Stays typically are short and can range from 1-4 weeks.

- **Specialized Eating Disorder Care: *We find at all levels of care, clients typically have ambivalent feelings about recovery.***

Inpatient Admissions:

Sometimes, prior to a specialized admission, a separate medical stabilization stay may be required. Specialized inpatient stays continue to maintain medical stability through 24 hour medical monitoring. Treatment encourages a resumption of more normalized eating. This may include supervised alternatives to solid food intake, safe withdrawal from laxatives, supervised meals for reduction of purging behaviors and monitoring for severe compromise to your physical health. Individuals who struggle to eat anything may be appropriate. Staff have specialized training.

Day Hospital Admissions:

These are programs where individuals are no longer at imminent medical risk. Clients can go home in the evenings and eat some foods on their own without needing supervision, but still struggle to maintain their activities of daily living. Motivation for change and deeper issues at the core of the eating disorder can begin to be addressed here. Treatment might include: group, individual and/or family therapy; nutrition assessments and counselling; activity groups; medication review; meal planning and support; medication treatment and team consultations. Clients are usually placed with people around their own age. Staff have specialized training.

Outpatient Programs:

These programs are offered to those in the middle, just starting treatment but not medically compromised and to those still undecided about recovery. Motivation to change and deeper issues underlying the eating disorder are often addressed. Most often, services include group, individual and/or family therapy; and nutritional assessments and counselling. Staff will usually have specialized training.

Eating Disorder Resources for Patients & Families

Websites

Central West Eating Disorder Program (CWEDP)	www.cwedp.ca
Danielle's Place	www.daniellesplace.org
Sheena's Place	www.sheenasplace.org
Homewood Health Centre	www.homewood.org
National Eating Disorders Information Centre (NEDIC)	www.nedic.ca
Something Fishy Website	www.something-fishy.org
National Institute of Mental Health (NIMH)	www.mentalhealth.com
Canadian Mental Health Association (CMHA)	www.cmha.ca
Canada's Food Guide	www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

Support Centres

Danielle's Place- Burlington	(905) 333-5548
Sheena's Place- Toronto	(416) 927-8900
EDAC- Waterloo	(519) 745-4875

Finding a Private Practitioner

National Eating Disorders Information Centre	www.nedic.ca
❖ Information and Resources	1-866-633-4220
❖ Service Provider Search Directory	(416) 340-4156

Specialized Treatment Contacts – CWEDP Sites

Trellis Mental Health and Developmental Services (serving Waterloo Region and Wellington County)	General Intake (519) 821-3582 1-800-471-1732
Credit Valley Hospital, Mississauga	(905) 813-4505
Halton Healthcare Services, Oakville Trafalgar Memorial Hospital	(905) 815-5127
William Osler Health Centre, Brampton Civic Hospital	(905) 453-1160

Coalitions/Prevention

Body Image Coalition of Peel	www.bodyimagecoalition.org
❖ Directory/Resources and Services	(905) 791-7800 ext. 2063
Eating Disorders Awareness Coalition of Waterloo Region	www.edacwr.com
❖ Directory/ Resources and Services	(519) 745-4875
Wellington-Dufferin-Guelph Eating Disorders Coalition	April Gates (519) 824-1010 (ext. 2292)
About Kids Health	www.aboutkidshealth.ca/thestudentbody/
BodySense: Promoting Positive Body Image in Sport	www.bodysense.ca



"I see incredible beauty in humanity, only most of it is unfulfilled potential hidden under the superficial."

~Danielle Mayeur

OUR HISTORY

Danielle's Place was created in memory of Danielle Mayer, who lost her battle with anorexia in September 2001 at age 25. Before her death, Danielle had a vision to build compassionate and humane services for the many sufferers of eating disorders. Together with her mother Carolyn, they formed goals that would see her vision become a reality.

WHO WE ARE TODAY

Danielle's Place continues with a voluntary Board of Directors, professional staff and volunteers. Since our first program in January 2005 we have served well over 420 clients across Ontario. We have addressed 4500 in audiences to develop eating disorder awareness and prevention. Our youngest client is ten years old, our eldest is sixty five years old. Although bulimia is two to three times more prevalent than anorexia, 57% of this year's clients are dealing with anorexia or anorexia-bulimia. Over 150 people have approached our organization to volunteer their time and without them we could not do what we do.

OUR MISSION

To complement traditional medical care through the provision of support and education. We are committed to offering non-judgmental, caring and supportive services to any individual whose life has been touched by an eating disorder.

OUR SERVICES

Danielle's Place is founded on the principle that clients have a voice and are experts in their own recovery. We provide a variety of resources from which clients can self-select based on their own needs. We offer evening support groups for teens, adults, binge-breaking and supportive others, led by qualified clinicians. We also offer yoga-meditation, stress reduction, art therapy and expressive arts. It is not mandatory that participants attend all sessions. One can start at any point in the ten-week cycle. Referrals are not required to access our programs. We also offer drop-in services, and have an ample lending library. There are no fees. As a registered charity, our services are provided through special grants and the generosity of donors.

For more program information please visit our website: www.daniellesplace.org or visit our centre.

895 Brant Street Unit #3 (at the south-east corner of Brant St. and Fairview St. in the Second Cup plaza)
Burlington, ON L7R 2J5

905-333-5548 / 1-866-277-9959



SHEENA'S PLACE

Support for eating disorders

OUR HISTORY

Over 13 years ago, Sheena Carpenter lost her battle with anorexia and bulimia. Sheena's Place resulted from this tragedy and through the dedication of our founders and supporters we have been able to honour Sheena's memory and serve thousands of other individuals and families affected by eating disorders.

WHO WE ARE

Sheena's Place is a community-based centre offering hope and support services to people affected by eating disorders. Since our incorporation in 1994 we have been committed to providing tangible help to individuals and families for whom resources are scarce to none. Sheena's Place is centrally located in a welcoming house in downtown Toronto.

OUR SERVICES

All those who participate in our programs do so by self-referral and there is no cost. We offer over 50 different groups at any one time in four main areas:

Support	Sharing feelings & strategies in an informal setting
Body Image	Heightening awareness about feelings towards the body
Expressive Art	Exploring various art materials as a form of expression
Skill Building	Offering new ways of coping or making changes

Sheena's Place also has an extensive lending library on eating disorders and related issues.

HOW TO FIND OUT MORE

You can drop in to have a tour, learn about the agency, the nature of our services or arrange an individual information interview to ask more specific questions and get help in finding the right group for you.

For appointments call 416 – 927-8900 or drop in on Wednesdays from 11 a.m. to 1 p.m.

For more program information please visit our website: www.sheenasplace.org or visit our centre. 87 Spadina Road, Toronto, Ontario M5R 2T1 416 927-8900

HELPING FAMILIES

CENTRAL | EATING DISORDER WEST | PROGRAM

"Never falsely reassure parents about issues with regard to possible eating disorders in their young teenage daughters."

And...

"Think of the parents; they are the ones that have to carry out the plan."

Dr. Rod Wachsmuth, MD DipCPsy, FRCPC
Staff Consultant, Eating Disorders Program
Toronto General Hospital

Helping Families: An Introduction for Physicians

Families can present in different ways. Some families may be in complete denial, minimizing symptoms or illness severity as well as the need for their loved one to receive treatment, a very few will be unwilling to ensure their loved one has access to available care. The vast majority will come forward feeling overwhelmed, exhausted and hopeless. They will have tried their best to address the eating disorder in the best ways they know how for better or for worse. Taking a punitive and blaming approach, no matter the family circumstances, typically does not produce positive results.

The presence of an eating disorder within a family can produce dramatic, broad and enduring consequences. Everything from how, what and when a family eats, to larger issues such as financial stability, trust and closeness can be impacted. If caught early, many of these impacts can be minimized but once family patterns are altered to accommodate the illness, change can be an uphill battle.

Fostering a strong alliance that is 'team' oriented with the parents of children and adolescents and an approach that promotes education and support for the parents of adult children with eating disorders is more critical to recovery than identifying the causes of the eating disorder. There remains no single recipe or family type that explains the reasons why someone develops an eating disorder.

Parents:

- Need help and support for themselves as individuals and as a couple
- Must consider the other siblings- the illness significantly impacts the quality of their lives and often they are forgotten
- They themselves are likely readier for their loved one's recovery than their loved one is. Parents are not usually struggling with the same ambivalence about recovery that their loved one is
- Once a child becomes an adult the emphasis of care changes from one of a family orientation to one that requires the individual to take on the responsibility for his/her recovery. This can greatly impact the flow of information and involvement parents have in their loved one's recovery
- Parents need to reflect on their own beliefs, lifestyle choices, healthcare practices and conversations, and consider whether these are conducive to recovery i.e. are they practicing a non-dieting approach to life and living, body size, weight and shape?
- Need to learn how to support recovery and not the eating disorder
- Family therapy for those with children and adolescents is the therapy of choice when available. Most typically this will be through a specialized treatment program

Spouses/Partners:

- Need to seek help and support for themselves
- Need to be reminded that they are not responsible for their partners recovery
- Need to continue to encourage participation in treatment and permit the physician and/or multi-disciplinary team to take on the “job” of helping their partner to recover
- Steer clear of questions such as “How do I look? Am I fat?”. There is no winning so best not to engage in this dialogue
- Consider whether their own lifestyle choices, beliefs, healthcare practices and conversations are conducive to recovery i.e. are they practicing a non-dieting approach to life and living, body size, weight and shape?
- Need to learn how to support recovery and not the eating disorder

Siblings:

- Often siblings are forgotten in the effort to get help for the sibling with the eating disorder
- Encourage parents to seek support for siblings so that their concerns can be expressed and addressed
- Ascertain that other siblings are not demonstrating signs and symptoms of an eating disorder. This is not uncommon and may be more or less likely depending on (Honey et al, 2006; Klump et al 2002) the following:
 - their own relationship to their parents
 - family characteristics
 - their involvement in the eating disorder of the first sibling
 - their understanding of the illness
 - professional interventions received to date
 - whether they themselves have been teased about their own weight
 - their own life events
 - their body size, weight and shape beliefs

Guidelines for Family and Friends

There are no quick or easy solutions for recovery from an eating disorder. Therapists, physicians and other experts have no magic that can cure your loved one. Be wary if someone offers guarantees or quick cures.

If the sufferer is to recover s/he will need to make some attitudinal and behavioral changes. You cannot make them for him/her. You and other loved ones will also need to make some changes to accommodate his/her growth. It is a good idea for all of you to take advantage of professional help to make the rough spots a little smoother.

1. **Allow yourself not to know all the answers about how to help the person you love.** This does not make you any less of a parent/partner/sibling/friend. Admitting your lack of understanding of the problem demonstrates you are human and allows the individual to seek professional help.
2. **If your child is under 19 (legal adulthood), GET HIM/HER INTO THERAPY IMMEDIATELY.** Do not hesitate out of fear that s/he will hate you.
3. **If the individual is over 19 years of age,** you need to recognize that you have no legal control over her/him. S/he can choose to be helped, or not. You do have control however, over how much you will let yourself be affected by the behavior. To protect yourself, you may have to negotiate limits on the amenities you provide which reinforce the eating disorder behaviors.
4. **Once the individual is in therapy,** avoid getting involved in discussions or arguments over weight and food behaviors. If you become concerned about weight loss, dehydration, or other signs of medical deterioration call the therapist, physician, or both. If your child over age 19, your concerns need to be discussed openly between the two of you, rather than contacting the doctor.
5. **Do not let family life or your relationship revolve around the eating disorder.** Make sure you and other members of the family take time for satisfying activities and fun. Do not spend all of your time with the person who has the eating disorder; you will encourage mutual dependence. Both of you need to maintain outside friendships.
6. **Do not give the eating disorder control over what the family eats,** which restaurants you patronize, or where you go on outings and vacations. Remember, other family members are entitled to have input into these kinds of decisions.
7. **Give the individual responsibility for the consequences of her/his words, actions, decisions, and behaviors.** Do not protect the individual by giving her/him the power to avoid all situations s/he finds distressing.
8. **Give him/her responsibility to replace what she/he has eaten on a binge, or to clean up the bathroom in which a purge has occurred.** This is intended to help the individual deal with reality without punishing the behavior. However, in some instances the person with the eating disorder is not always financially able to replace what she/he has consumed.

9. **Verbally and physically express unconditional love, acceptance and affection for the individual.**
Do not tie your caring to sermons about eating and demands concerning weight gain.
10. **Admit** you sometimes feel angry, frustrated, helpless, afraid, powerless, and hopeless. Allow yourself to show these feelings and allow her/him to see them. By sharing your feelings, you are providing the most direct permission for the individual to feel and express her/his own emotions.
11. **Participate** in family therapy or a support group. Don't become isolated with your problem; it only escalates feelings of isolation and resentment. Keeping the disorder a secret does not help anyone.
12. **Develop ways of sharing and socializing** that do not involve food. Develop dialogues about topics other than food, weight and diets at the meal table.
13. **Model healthy behavior.** Do not go on diets. Take an honest look at your reasons for dieting and exercise. Are you putting priority on your appearance over your health? It is hard for an individual with an eating disorder to try and change her/his thoughts about weight loss when significant others around him/her are reinforcing the importance of appearance and thinness.
14. **Recognize qualities, skills, abilities, values and talents** in the individual that are independent of her/his appearance. Share with him/her what you appreciate about her/him and are attracted to and this will help in developing a more positive sense of self.
15. **Avoid** power struggles over gaining weight; s/he will always win.
16. **Do not** make statements like, "If you won't change for yourself, do it for me (us)", "you are ruining the whole family", or "why are you doing this to me?" The individual will feel guilty and responsible for the welfare of the rest of the family. This will not change her/his attitudes and behaviors. **You must** take care of your own welfare. Do not make this individual responsible for your own happiness. That is too much for anyone to ask another.
17. **Offer your support, both emotionally and psychologically.** Ask "what kind of support could you use at this time?" or "how can I support you?"
18. **Do not ask**, "Are you better?" This is a loaded question and calls for the response, "yes, of course." Look for broader definitions of recovery than just changes in eating behaviors or weight. Attitude changes are not easily observable. You must learn to stop judging progress on behaviors and outside appearances.
19. **Realize** that at best s/he is probably ambivalent about wanting to get well. At times, s/he may want to be "normal"; at other times, s/he will retreat into old rituals and behaviors s/he perceives as safe and secure. Be patient. This small setback may be necessary for her/him at present. Do not reprimand her/him for these actions or add to her/his guilt.
20. **Realize that you are trying to do what is right and best in an extremely difficult situation. Recovery takes time, patience and professional help. Allow yourself to seek support and understanding from local resources for friends and families in your same situation.**

Root and Fallon (1983)

Readiness for Change

Changing our behavior is difficult. The Transtheoretical Model of Change (Prochaska et al., 1992) suggests there is a series of stages we go through before we actually make and sustain behavioural change. This theory also suggests that we must first develop an **intention** to change before we can begin to do things differently. People with eating disorders often struggle with their decision to overcome their eating disorder. This may be related to society's support of a thin body ideal; or the eating disorder may have become a 'friend' that they are not sure they can live without. Supportive others are often ready for recovery long before the person with the disorder is. Consequently, it is important to match helping strategies with where the person is at in terms of their interest in and willingness to change. The table below provides some helpful information about the stages of change, what each stage looks like in terms of illness behavior and what to keep in mind to encourage, support or maintain change. In the treatment of children and adolescents, we don't always wait for there to be interest in change. Ensuring continued physical growth and development is critical and so often work will start with parents if kids are not yet ready for change.

Stage of Change	General: Clients	Suggestions for Parents/ Supportive Others	Suggestions for Health Care Practitioners
Pre-contemplation (1 month +)	- "As far as I am concerned, I don't have an eating disorder" - No intention to change and not aware there is a problem - Makes changes only because they are under pressure- when pressure goes, so does change - Does not see that action is required on their part - Will receive help for consequences of E.D. only	- Avoid forcing loved one to pursue change - Encourage general self-care including visit to family doctor - Describe out loud, impact of eating disorder on you - Listen & validate feelings - Consider how <u>you</u> support the E.D.	- The client wants help to fix the consequences of the E.D., not the E.D. itself - Focus on client's denial - Provide education - Listen & validate feelings - Assess for co-morbid conditions e.g. depression and anxiety
Contemplation (1 month +)	- "I accept that I have problems related to an E.D., but I am not yet ready to do anything about it" - Usually has motivational crisis- e.g. something goes wrong with health, family, finances etc... - Begins to consider costs and benefits of overcoming E.D. - Beginning of the end of denial	- Continue to notice consequences of E.D. - Continue to listen & validate feelings - Understand that some of your own ways of coping, parenting even though well-intentioned may be helping to support the eating disorder - Consider benefits of doing things differently	- Key issue is the client's ambivalence - Identify issues that keep client stuck - Identify and monitor emotional states that leave the client feeling overwhelmed, strategize around ways to contain these feelings - Continue education around healthier self-care and medical check-ups
Preparation (1 month +)	- "I am planning to do something about my E.D. in the next six months" - Makes the decision to change - Experiences a number of false starts - Seeks out information about recovery options and other needed sources of help	- Support your loved one's beliefs that they can change - Find support for yourself in your own efforts to change - Trial and error during meals, discussion times with efforts to handle things differently	- Support the client's belief that they can change - Homework has the client altering their E.D. behaviors in small ways (e.g. delayed binges) - Provide cognitive and behavioral strategies to facilitate change
Action (1.5 years +)	- "I have taken active steps to address my E.D. in the last 6 months" - Symptoms are interrupted - Confident in and committed to recovery - Therapy can feel like a full time job - Develops affective skills to reduce power of triggers - Reorganizes life and roles to support recovery	- Firm yet compassionate caring - Have expectations that are in keeping with loved ones life in recovery - Feels like work sometimes - Develop skills that help you not to get drawn into power struggles - Your own and your family life no longer revolve around the eating disorder	- Provide range of tools for clients to use in the management of their symptoms - Establish recovery through cessation of problematic behaviors, and enhancement of beneficial ones (e.g. fewer binge-purge episodes but increased healthier meals/snacks) - Work on learning to cope with life without the E.D. - Identify what improved quality of life looks like - Build affective tolerance and capacity for addressing unresolved emotional issues
Maintenance (varies)	- "I am working to maintain the changes I have made against my E.D." - Productive living, living a full life - Changes are consolidated - Active use of relapse prevention strategies	- Work on maintaining new ways of communicating with loved one that are both comfortable and automatic. - Now and again you might have to remind yourself not to slip back - 'New normal' begins to be established	- Follow-ups as needed e.g. booster sessions - Reinforce use of relapse prevention tools

Prochaska et al., 1992; and The Integrated Recovery Model

Fathers Helping Daughters with Eating Disorders

Fathers often struggle with understanding their daughter's eating disorder and how they can be helpful throughout her efforts to recover. Fathers need to accept how important they are in the lives of their daughters and not assume that they are less important than mothers. This includes interactions at home or showing up for appointments. Adolescence may be when girls need their dads the most. Girls need to witness and understand through their fathers, that women can be valued for more than their physical beauty. Daughters need to be re-assured that their growing 'voices' are acceptable, and that the father-daughter relationship will continue to be important even through the challenges of adolescence. It is important to remember that these issues are related to normal development, but are often heightened in girls with eating disorders.

Tips for Dads

1. Evaluate your own messages to your daughter about weight, dieting, beauty and body image. Explore what you value most in women and how these values may or may not be communicated to your daughter. How you relate and speak to/about your daughters' mother demonstrates these values.
2. Let her know **out loud** that you love her no matter what she weighs.
3. Be a good role model around food and exercise. Live a non-dieting life; don't obsess about exercise.
4. Talk to her about the very real pressures she faces everyday to live up to a thin ideal, lose weight or to be attractive to please others.
5. Help her to discover or even rediscover what she values most in life that has nothing to do with food, shape or weight.
6. Appreciate that your role is to support your daughter in **her** efforts to address the problems she faces. For men, resisting the urge to 'fix' the problem can be a real challenge. Instead, focus on listening to your daughter, creating a supportive home environment, and living your own life in ways that support her recovery.
7. Show respect for her growing maturity by showing her that she can have opinions that differ from yours without it 'costing' her your affection, respect or company. This will teach her that she doesn't have to give herself up in order to please you and will foster her self-esteem.
8. Give your daughter(s) the same opportunities and encouragement you give your sons.
9. If you are a family that has separated or divorced, continue to be a presence in your daughters' life.
10. Communicate to your daughter that you are trying to appreciate the complexity of the problem she is facing, and that you know there is more to her recovery than just eating.

Margo Maine, Ph.D., Father Hunger (1991)

Getting through Meals

Family meals provide a chance for family members to reconnect, show an interest in each others daily lives, and nourish bodies and souls together. They are designed to meet emotional as well as nutritional needs. While today's busy family lifestyles make having regular family meals a challenge, this is further compounded when someone in the household has an eating disorder. Meals can then become tense and unpleasant, loaded with big issues around autonomy, power and control. Arguments can ensue about what foods are served, how they are cooked, whether everyone has to eat at the table, or how much food has to be eaten. It is important to consider what can be done to maintain familiar healthy family rituals around eating and meals, while at the same time supporting a loved one struggling with an eating disorder. This is not easy to do!

One important thing to remember is that the eating disorder should **not** be allowed to "run the house". This might look like favourite foods no longer being allowed at the table or in the house, different rules for different members, altering family rituals around eating and meals to accommodate the eating disorder. A second important thing to remember is that the eating disorder does not get to make decisions around safety. If your son or daughter has not taken care of their health consider whether they or those around them are at risk when involved in some activities such as driving a car or baby sitting. Remember that starvation changes how people think, feel and behave. Family meals can provide an opportunity to monitor how your loved one is managing this aspect of their health so that safety decisions can be made.

Many parents with the best of intentions end up supporting the eating disorder rather than their son or daughter, particularly at mealtimes.

Turn meals back into family time:

1. Talk to your kids about their day. Talk about things unrelated to dieting, calories, weight or shape.
2. Turn off the television.
3. Start out with a relaxing, pleasant atmosphere- lights, music, table place settings etc.
4. Don't nag, police, prompt or bribe your loved one to eat.
5. Enjoy your own meal.
6. Serve your traditional family foods from all food groups including those enjoyed by everyone.
The eating disorder shouldn't get to decide what everyone eats.
7. Don't use family times to scold, nag or fight.
8. Everyone gets a turn to talk.

Don't Say	Do Say
Don't you think you've had enough?	How are you doing with that?
Is that what the staff said?	What can I do to support you?
Is that on your meal plan?	What's going to be most helpful?

Satter (2005)

Preparing for an Eating Disorder Hospitalization: Information for Families

Treatment: It is important to remember that your loved one will typically not benefit from therapy unless they are medically stable. It is equally important to remember that a hospitalization stay is often just the beginning of the recovery process and not a comprehensive eating disorder 'fix'. Sometimes more than one admission is required.

Medical Stabilization:

General community hospitals admit to medically stabilize. That means they admit the person to Emergency, Pediatrics or General Medicine, to reduce imminent medical risk. Most often they do not have the expertise to provide specialized eating disorder care. It is important to remember that the job of the staff during this admission is to take care of the MEDICAL needs of your loved one. Their job is to keep your loved one alive. Stays typically are short and can range from 2-8 days

Medical and Psychiatric Stabilization:

Sometimes a loved one is both at risk physically AND psychiatrically; for example they may be very underweight and suicidal. In this case both mental health AND medical emergent care may be required. This care is often hard to access. The job of the staff is to stabilize the mental and physical health of your loved one so that they can go on to more comprehensive care. These programs will not typically have staff with eating disorder expertise, but the staff is experienced in managing general psychiatric and medical concerns. Stays typically are short and can range from 1-4 weeks.

Specialized Eating Disorder Care:

Hospital programs that provide specialized comprehensive care are typically scarce and as a result often have long waiting lists. Sites may offer inpatient beds, partial or day hospital programming and/or outpatient services. These programs have trained eating disorder staff with specialized expertise.

Inpatient:

Admissions aim to restore and maintain medical stability through 24 hour medical monitoring.

Treatment encourages a resumption of more normalized eating, may include supervised alternatives to solid food intake, safe withdrawal from laxatives, supervised meals for reduction of purging behaviors or medical monitoring for other complications. Individuals who have struggled to eat anything might be appropriate. Referrals are typically through physicians and admissions are typically made based on the level of illness severity of those currently awaiting admission. Clients may be uninterested in or uncertain about recovery. Stays can vary in length from 2- 6 months.

Day Hospital:

These are programs where individuals are no longer at imminent medical risk, can go home in the evenings, eat some foods on their own without needing supervision but are struggling to maintain their activities of daily living. Motivation for change, readiness for change and deeper issues at the core of the eating disorder can begin to be addressed. Treatment might include: group, individual and/or family therapy; nutrition assessments and counselling; activity groups; medication review; meal planning and support; medication treatment and team consultations. Clients are usually with peers. Admissions are typically made with a physician's referral and completion of a comprehensive multi-disciplinary assessment. Clients may have mixed feelings about recovery. Stays can vary in length from 2-12 months.

Outpatient:

These programs are offered to those at all stages of change i.e. those just beginning, in the middle of or completing their recovery process. Clients must be medically stable. Motivational issues are often addressed but so too are some of the deeper issues underlying the eating disorder. Most often, services include group, individual and/or family therapy; nutrition assessments and counselling. Admissions can be based on a physician's referral or clients, in some programs, may refer themselves. There is often a 2-6 month wait for admission but once admitted clients can typically remain for as long as they are motivated, attend their appointments and find the treatment beneficial. Clients can be both certain and uncertain about recovery. Stays can vary in length from 1-7yrs.

Leaving the Hospital**Support**

Leaving the hospital is usually very scary for families. Having had the support of professionals, and some respite for even a brief while, families are often anxious about being left alone to once again manage the eating disorder full time at home. It is important that you seek support for yourself and for you as a couple if appropriate. This may occur through formal supportive services (See "Resources for Patients and Families" Sheet) or through friends and family.

Follow-up Plan

Ensuring there is a follow-up plan in place for your son/daughter before they are sent home is important. This may involve follow-up appointments with your family doctor, and/or referrals to other more specialized providers and programs. If your family doctor has not been involved to date, now is a good time to update him/her about the status of your loved ones' health and establish a follow-up plan.

Re-admissions

Having everyone understand the terms and conditions that would lead to a readmission is also critical should things decline once again. Understand what the 'criteria' are. Examples include fainting, not eating anything for days/weeks or suicidality. Decide where you will go a relapse occur.

**Remember, the aim at all times is to provide compassionate care
that maintains the dignity of your loved one while reducing
the imminent risk to their life.**

Eating Disorder Resources for Patients & Families

Websites

Central West Eating Disorder Program (CWEDP)	www.cwedp.ca
Danielle's Place	www.daniellesplace.org
Sheena's Place	www.sheenasplace.org
Homewood Health Centre	www.homewood.org
National Eating Disorders Information Centre (NEDIC)	www.nedic.ca
Something Fishy Website	www.something-fishy.org
National Institute of Mental Health (NIMH)	www.mentalhealth.com
Canadian Mental Health Association (CMHA)	www.cmha.ca
Canada's Food Guide	www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

Support Centres

Danielle's Place- Burlington	(905) 333-5548
Sheena's Place- Toronto	(416) 927-8900
EDAC- Waterloo	(519) 745-4875

Finding a Private Practitioner

National Eating Disorders Information Centre	www.nedic.ca
❖ Information and Resources	1-866-633-4220
❖ Service Provider Search Directory	(416) 340-4156

Specialized Treatment Contacts – CWEDP Sites

Trellis Mental Health and Developmental Services (serving Waterloo Region and Wellington County)	General Intake (519) 821-3582 1-800-471-1732
Credit Valley Hospital, Mississauga	(905) 813-4505
Halton Healthcare Services, Oakville Trafalgar Memorial Hospital	(905) 815-5127
William Osler Health Centre, Brampton Civic Hospital	(905) 453-1160

Coalitions/Prevention

Body Image Coalition of Peel	www.bodyimagecoalition.org
❖ Directory/Resources and Services	(905) 791-7800 ext. 2063
Eating Disorders Awareness Coalition of Waterloo Region	www.edacwr.com
❖ Directory/ Resources and Services	(519) 745-4875
Wellington-Dufferin-Guelph Eating Disorders Coalition	April Gates (519) 824-1010 (ext. 2292)
About Kids Health	www.aboutkidshealth.ca/thestudentbody/
BodySense: Promoting Positive Body Image in Sport	www.bodysense.ca

FAMILY PSYCHOEDUCATION GROUP

PURPOSE

The group is intended for family members of individuals suffering from eating disorders, such as bulimia nervosa, anorexia nervosa and binge eating not otherwise specified (binge eating disorder). Its goal is to increase understanding of the nature and treatment of eating disorders and to offer suggestions about how to cope with the behavioral and emotional issues they engender.

WHO CAN PARTICIPATE?

Those eligible to participate include parents, siblings (age 16 and over), partner/spouse, boyfriend/girlfriend, concerned relatives, and where relevant, close friends of the individual with the eating disorder. Family members may participate regardless of whether the person with the eating disorder is currently receiving treatment, and regardless of that individual's age. Please note that this program is for family members and significant others only. Individuals with eating disorders are not eligible to participate in this particular group. On occasion, a limited number of professionals may be present to observe the Family Psychoeducation Group for ongoing professional development. Group facilitators will introduce observers at the beginning of the day. Observers adhere to the practice of confidentiality.

FORMAT

The group consists of a full day session from 9:00 am to 4:00 pm. It typically occurs on a Saturday. The group format will be both educational and supportive.

CONTENT

The group will be facilitated by members of the Credit Valley Hospital Eating Disorders Team. They will provide information on the development and maintenance of eating disorders, the regulation of body weight and the consequences of dieting, and the nature of treatment and recovery. The group facilitators will also recommend strategies for assisting and supporting recovery, and will address questions from audience members.

REFERRAL TO THE PROGRAM

To register, call The Credit Valley Hospital Eating Disorders Program at (905) 813-4505. Participants must provide their name, address, date of birth, phone number and health card number. For further information please contact (905) 813-4505.

CWEDP- 2007



"I see incredible beauty in humanity, only most of it is unfulfilled potential hidden under the superficial."

~Danielle Mayeur

OUR HISTORY

Danielle's Place was created in memory of Danielle Mayer, who lost her battle with anorexia in September 2001 at age 25. Before her death, Danielle had a vision to build compassionate and humane services for the many sufferers of eating disorders. Together with her mother Carolyn, they formed goals that would see her vision become a reality.

WHO WE ARE TODAY

Danielle's Place continues with a voluntary Board of Directors, professional staff and volunteers. Since our first program in January 2005 we have served well over 420 clients across Ontario. We have addressed 4500 in audiences to develop eating disorder awareness and prevention. Our youngest client is ten years old, our eldest is sixty five years old. Although bulimia is two to three times more prevalent than anorexia, 57% of this year's clients are dealing with anorexia or anorexia-bulimia. Over 150 people have approached our organization to volunteer their time and without them we could not do what we do.

OUR MISSION

To complement traditional medical care through the provision of support and education. We are committed to offering non-judgmental, caring and supportive services to any individual whose life has been touched by an eating disorder.

OUR SERVICES

Danielle's Place is founded on the principle that clients have a voice and are experts in their own recovery. We provide a variety of resources from which clients can self-select based on their own needs. We offer evening support groups for teens, adults, binge-breaking and supportive others, led by qualified clinicians. We also offer yoga-meditation, stress reduction, art therapy and expressive arts. It is not mandatory that participants attend all sessions. One can start at any point in the ten-week cycle. Referrals are not required to access our programs. We also offer drop-in services, and have an ample lending library. There are no fees. As a registered charity, our services are provided through special grants and the generosity of donors.

For more program information please visit our website: www.daniellesplace.org or visit our centre.

895 Brant Street Unit #3 (at the south-east corner of Brant St. and Fairview St. in the Second Cup plaza)
Burlington, ON L7R 2J5

905-333-5548 / 1-866-277-9959



SHEENA'S PLACE

Support for eating disorders

OUR HISTORY

Over 13 years ago, Sheena Carpenter lost her battle with anorexia and bulimia. Sheena's Place resulted from this tragedy and through the dedication of our founders and supporters we have been able to honour Sheena's memory and serve thousands of other individuals and families affected by eating disorders.

WHO WE ARE

Sheena's Place is a community-based centre offering hope and support services to people affected by eating disorders. Since our incorporation in 1994 we have been committed to providing tangible help to individuals and families for whom resources are scarce to none. Sheena's Place is centrally located in a welcoming house in downtown Toronto.

OUR SERVICES

All those who participate in our programs do so by self-referral and there is no cost. We offer over 50 different groups at any one time in four main areas:

Support	Sharing feelings & strategies in an informal setting
Body Image	Heightening awareness about feelings towards the body
Expressive Art	Exploring various art materials as a form of expression
Skill Building	Offering new ways of coping or making changes

Sheena's Place also has an extensive lending library on eating disorders and related issues.

HOW TO FIND OUT MORE

You can drop in to have a tour, learn about the agency, the nature of our services or arrange an individual information interview to ask more specific questions and get help in finding the right group for you.

For appointments call 416 – 927-8900 or drop in on Wednesdays from 11 a.m. to 1 p.m.

For more program information please visit our website: www.sheenasplace.org or visit our centre. 87 Spadina Road, Toronto, Ontario M5R 2T1 416 927-8900

PHYSICIAN SUPPORT

CENTRAL | EATING DISORDER WEST | PROGRAM

"I think family doctors have a tremendous ability to manage their patients with eating disorders. They often just need direction, encouragement and support."

Dr. Colleen Flynn, MD FRCPC
Previously Medical Director
Eating Disorder Program
Credit Valley Hospital

Support Resources for Primary Care Providers

- Contact our support service if you are uncertain about issues related to assessment, diagnosis and ongoing management
- Connect your patient and his/her family with the CWEDP Treatment Program and/or local Support Centre within their community as a first step (See 'Family and Patient Resources' and 'Physicians: Connections and Links' sheets). Doing so will facilitate referrals to alternate levels of care and transitioning back to community care following acute admissions. Families can receive support through both types of Centres

CWEDP PHYSICIAN SUPPORT

Please feel free to use the support services below- they have been established to assist you.

Phone Support/General Inquiry 905-815-5124

Please provide your name, question, patient age and return phone number. Your call will be forwarded to a local expert and returned within 24 hours.

Physicians: Eating Disorder Connections and Links

Local Connections: CWEDP Sites

Trellis Mental Health and Developmental Services Waterloo Region and Wellington County	General Intake (519) 821-3582 1-800-471-1732
Credit Valley Hospital, Mississauga	(905) 813-4505
Halton Healthcare Services, Oakville Trafalgar Memorial Hospital	(905) 815-5127
William Osler Health Centre, Brampton Civic Hospital	(905) 453-1160

Acute Connections: Physician to Physician

Children and Adolescents

The Hospital for Sick Children
Adolescent Medical Physician-On Call
Locating Tel (416) 813- 7500

McMaster Children's Hospital
Dr. Sheri Findlay- Medical Director,
Adolescent Eating Disorder Program
Tel (905) 512-2100 x 75644

London Health Science Centre
Dr. Jennifer Couturier- Physician Leader,
Eating Disorder Program
Tel (519) 685-8500 x 57422

Children's Hospital of Eastern Ontario
(CHEO)-(Ottawa)
Dr. Wendy Spettigue-Psychiatric Director,
Eating Disorder Program
Tel (613) 737-7600

Adults

Toronto General Hospital
Dr. Blake Woodside-Director,
Inpatient Program
Tel (416) 340-4445

Credit Valley Hospital
Dr. Randy Staab
Tel (905) 813-4505

Ottawa General Hospital
Dr. Hany Bissada-Head,
Eating Disorder Program
Tel (613)-737-8042

Homewood Health Centre
April Gates-Program Coordinator
Tel (519) 824-1010 x2292

Websites:

APA Best Practice Guidelines for the Treatment of Patients with Eating Disorders:

http://www.psych.org/psych_pract/treatg/pg/EatingDisorders3ePG_04-28-06.pdf

APA: Treating Eating Disorders; a Quick Reference Guide

http://www.psych.org/psych_pract/treatg/pg/EatingDisorders3ePG_04-28-06.pdf

Canada's Food Guide –

http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

Growth Charts-

<http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/charts.htm>

Health and Welfare Canada- BMI Calculator

http://www.hc-sc.gc.ca/fn-an/nutrition/weights-poids/guide-lt-adult/bmi_chart_java-graph_imc_java_e.html

SUPPLEMENTAL RESOURCES

CENTRAL | EATING DISORDER WEST | PROGRAM

"We must learn the virtue of patience [until our patients], freed from the shackles of anorexia or bulimia nervosa can [learn to be] their own valuable and unique selves, at which point we... should quietly withdraw and leave them to it"

Beaumont, Russell and Touyz, 1995

taken from Treating Eating Disorders: Ethical, Legal; and Personal Issues (1998).

Edited by Walter Vandereycken and Pierre J.V. Beaumont

Contact us for further information or to order additional copies of

Putting Eating Disorders on the Radar *of* Primary Care Providers

Please contact either of the following or go to the CWEDP website (www.cwedp.ca)

CWEDP Regional Office
Central West Eating Disorders Program
Ph: 905-815-5124
Fax: 905-815-5076

References

- Addiction Counselling Services of Peel (Peel Memorial Hospital), the Integrated Addiction Recovery Model.
- Alleyne, J. (2006) Athlete's @ Risk: Prevention and Treatment of Eating Disorders. Presentation made to CWEDP June 23, 2006.
- American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV), published by the American Psychiatric Association, Washington D.C.; 1994.
- American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Eating Disorders, Third Edition published by the American Psychiatric Association, Washington D.C; 2006.
- American Psychiatric Association, Treating Eating Disorders: A Quick Reference Guide based on Practice Guidelines for the Treatment of Patients with Eating Disorders, Third Edition published by the American Psychiatric Association, Washington D.C; 2006.
- Giordano, S. (2005). Risk and supervised exercise: the example of anorexia to illustrate a new ethical issue in the traditional debates of medical ethics. *Journal of Medical Ethics* 31, 15-20.
- Health and Welfare Canada (1988), Promoting Healthy Weights: A discussion paper, Minister of Supply and Services Canada: Ottawa Ontario.
- Honey, A.; Clarke, S.; Halse, C.; Kohn, M.; Madden, S. (2006). The influence of siblings on the experience of AN for adolescent girls. *European Eating Disorder Review* 14 (5), 315-322.
- Johnson, C, Initial consultation for patients with bulimia and anorexia nervosa. In D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of Psychotherapy for Anorexia and Bulimia* (19-51). New York: Guilford Press; 1985.
- Clump, K.; Wonderlich, S.; Lehoux, P.; Bulik, C. (2002) Does environment matter? A review of non-shared environment and eating disorders. *International Journal of Eating Disorders*, 31(2) 118-135.
- McGough, S. (2004) Exercise Addiction and Eating Disorders. McLean in the News. FitnessManagement.com (July).
- Maine, M. *Father Hunger* Carlsbad, CA Gurze Books; 1991.
- Mehler, PS.; Anderson, AE. *Eating Disorders: A Guide to Medical and Complications*. Baltimore, MD: Johns Hopkins University Press; 2000.
- National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). Individual Growth Charts. <http://www.cdc.gov/growthcharts>.
- Northern Health, Prince George Eating Disorders Clinic (2006) Physician's Resource Package.
- Prochaska, J. O., DiClemente, C. C., and Norcross, J. C., (1992) In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.
- Root, M; and Fallon, P. Guidelines for Family Members Who Want to Help a Family Member Recover (1983)
- Satter, E. *Your Child's Weight: Helping without harming* (birth through adolescence) Madison Wisconsin, Kelco Press; 2005.
- Shroff, H.; Reba, L.; et al., (2006) Features Associated with Excessive Exercise in Women with Eating Disorders. *International Journal of Eating Disorders*, 39, 454-461.
- Silber, T.J., D'Angelo, L.J. (1991). The role of the primary care physician in the diagnosis and management of anorexia nervosa *The Academy of Psychosomatic Medicine*, 32, 221-225.
- Society for Adolescent Medicine, Eating Disorders in Adolescents: Position paper of the Society for Adolescent medicine. *Journal of Adolescent Health* 33, 496-503
- Weiner, R. G. Working with physicians toward the goal of primary and secondary prevention. In Piran, N.; Levine, M.P., Steiner-Adar, C. (1999) *Preventing Eating Disorders: A handbook of special challenges*. 285-303. Philadelphia, P.A. Taylor and Francis.

Resource Evaluation

Please help us to refine this resource package so that it provides maximal practical assistance by completing the following brief questionnaire after you have had the opportunity to use it. Answer the following questions and send it back to us either by fax (905-815-5076) or by snail mail (CWEDP 700 Dorval Dr. 6th Floor Oakville, Ont. L6K 3V3).

1. How did you receive your copy of the Resource Binder and DVD?

- ☐ Received through an educational session (e.g. workshop; grand rounds presentation)
- ☐ Received from colleague
- ☐ Requested through CWEDP Website
- ☐ Other _____

2. Please let us know about your practice?

- ☐ Family Physician
- ☐ Clinical Nurse Practitioner
- ☐ Pediatrician
- ☐ Psychiatrist
- ☐ Other Please Specify: _____

3. Which items or sections in the binder were most helpful to you?

4. Which sections within the DVD were the most helpful?

5. Which items/sections were the least helpful to you?

6. Which items were most helpful for your patient(s)?

7. Which items were most helpful for your patients' family members?

see over

8. What do you feel is missing?

9. How many patients/clients do you see a year do you see with a diagnosis of an eating disorder?

_____ patients/clients

10. How many more patients/clients do you suspect having an eating disorder in addition to those who already have a diagnosis of an eating disorder?

_____ patients/clients

11. Has the information in this binder made you think differently about the *number of individuals you suspect may have an eating disorder*?

☐ Yes ☐ No ☐ Not Sure

12. Has the information in this binder made you think differently about how you would treat those you suspect may have an eating disorder?

☐ Yes ☐ No ☐ Not Sure

13. My confidence and comfort in identifying eating disorders in my practice has

☐ not improved at all ☐ improved somewhat ☐ improved significantly

14. I would be interested in receiving binder updates? ☐ Yes ☐ No

My e-mail address is _____

My fax number is _____

My Phone number is _____

My mailing address is _____

15. Other Comments or feedback?

Thank you in advance for providing your feedback. Please feel free to check out the CWEDP Website at www.cwdep.ca.