A Conversation About…

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Peta Marks (00:18):

Welcome to this episode of MHPN Presents A Conversation About. My name is Peta Marks and I'm the Host of today's episode on eating disorders and multidisciplinary care. Joining me today is Stephanie Boulet. Hi Steph.

Stephanie Boulet (00:33):

Hi. Thanks for having me.

Peta Marks (00:34):

When I was asked who I'd like to join me on this episode, it was a pretty easy decision for me actually because first of all, Steph is a colleague of mind at inside out Institute for Eating Disorders research. We've worked together across a number of projects for quite a few years now. Steph's a provisional psychologist. She's a researcher currently doing her PhD. She was a journalist in a previous life, so who better to join me in a podcast. And she has a lived experience of an eating disorder, which I think obviously informs her work and her life. But she and I always have really interesting conversations about, so today's Steph, we're going to talk about multidisciplinary care in eating disorders, and I was thinking that maybe we should start with your lived experience of accessing treatment and I guess the impact and value of multidisciplinary treatment in regard to how things went in your experience.

Stephanie Boulet (01:27):

Yeah, sounds good. So I had anorexia for six or seven years, really severely, was in and out of hospital and spent 10 months in residential care. And it was hell actually having anorexia full blown for that long.

It was really, really hard. That was a long time ago, maybe 20 years ago, and I think things have really changed now, but we went to a lot of different places and no one really knew what to do. But eventually after coming out of hospital one time I found or happened upon or was sent to, I can't even remember how it happened to this amazing GP. And she referred me to a psychologist who also used to be a dietitian or was a dietitian at the same time. So she had this amazing skillset to work with people with eating disorders and that's when I got better. So when I was in a multidisciplinary care team in the community, I just felt held. I was able to come up against the challenges of life, feeling like I had backing and kind of learn how to overcome them with that care. And it was definitely not a straight line to recovery, but with those two kind of in the community talking to each other, I got better. So I am a very big fan of multidisciplinary care and that informs how I do treatment myself. Now, as a psychologist, I always work in a MDT.

Peta Marks (02:50):

And it's interesting, isn't it? I mean there are so many barriers to care for people with eating disorders, and I guess that's part of the reason that we're seeing such delays between accessing onset of illness and accessing treatment. There's barriers for people, but there's also hurdles and barriers for clinicians, right, looking after people with eating disorders. So there's this sort of double whammy, I guess, of opportunities for delay. And that's a huge problem, isn't it for our patient cohort.

Stephanie Boulet (03:23):

And it means by the time that people are getting care, they've already been in the illness and it's become quite entrenched often. So I was looking at the literature just before and we're looking at two and a half years of illness for people with anorexia before they're help seeking. And then for people with bulimia and binge eating disorder, it just goes up. So for nearly four and a half years for people with bulimia nervosa and five and a half years for people with binge eating disorder, and as you said, it comes from both sides, there's problems from both sides. And when you're in an eating disorder, so I guess as opposed to people with other illnesses, depression, anxiety, they do not want those symptoms. They are all ego dystonic. They are not helpful. But some of the symptoms of an eating disorder are really, really effective in helping you feel like you're more able to cope, feeling like there's a sense of order in a world that feels out of control and chaotic, you're kind of feeling a bit more safe. We know that starvation or restricting your food makes you feel less emotion. So there's overwhelming emotions feel easy to cope with. So there's so many reasons that you don't want to stop those behaviours. And then on top of that, there's the shame and the stigma of an eating disorder, which I think things are getting better. What do you reckon?

Peta Marks (04:39):

Well, there's certainly a lot more people know about eating disorders. They understand that eating disorders aren't just illnesses of rich white girls who want to be beautiful, that eating disorders are actually illnesses experienced by people across the population from all sociodemographic groups, from all cultural backgrounds and all body shapes and sizes. And I think possibly that is the group now that is the most left out in relation to identification or the most overlooked. And as you just said, people with bulimia nervosa, binge eating disorder - four years, five and a half years average amount of time before they are identified. And we also know that actually the majority of people with eating disorders never

get identified up to 70% or more, never get identified. So that means there's a big proportion of the people who are suffering and whose lives are being negatively impacted by eating disorders and disordered eating and they're never feeling safe enough or validated enough or brave enough to be able to approach a health professional, which is a massive problem.

Stephanie Boulet (05:46):

But we do know that they're often presenting to health services in the lead up to finally getting help four or five times they're presenting and they may be presenting with these kind vague symptoms like psychological symptoms, depression like, anxiety like, digestive complications or problems. They might often be wanting to lose weight or asking for interventions for weight control. So I guess there are opportunities for us to be identifying them maybe a little bit earlier.

Peta Marks (06:14):

And that's a huge part of what we're trying to focus on and trying to support practitioners to do at Inside Out, isn't it, right. It's about identifying those opportunities for earlier intervention. Because just thinking about it from the practitioners side at the moment, I'm a mental health nurse and a family therapist. I work in a regional area. I have a really small clinic. So I understand the challenges that practitioners have when people are presenting when an illness is moderate or severe and it's sort of down that acute end. Primary care practitioners can worry about holding someone who is that unwell. Whereas if we were all identifying people sooner, then a lot of the brain changes that we know happen over time with disordered eating, restrictive eating, starvation, those impacts don't have time to come into effect. There's a much better opportunity, I guess to align with the person around the potential impacts on their health, the mental health impacts of what's happening with their eating. And it's not such a scary prospect then looking after and working with people who have eating disorders at that earlier end of the spectrum. And we can help people out of the illness trajectory in a much quicker, less complicated, less high risk way. So that's a win for the person, obviously for their family, but also for the health professional because you don't then need the support of specialist services necessarily. You don't need referral options, which are admittedly limited and hard to access, particularly in regional areas.

Stephanie Boulet (07:55):

And I think to that, Peta, that a lot of the psychologists and primary health carers have the skills to be looking after people with eating disorders. And it's just about applying it kind of in a bit of a different context. I think therapeutic rapport we know is a massive predictor of how well someone's going to do, and there's kind of micro skills of that deep listening and validation and empathy count for so much in eating disorders. Often people with eating disorders, their motivation is really, really fluctuating throughout treatment, which can be quite challenging from the therapist's point of view. And feeling like you're getting momentum and then watching that motivation drop or feeling like progress is slowing can be a real challenge. And I think those kind of motivational interviewing skills, which you use for a lot of different presentations can really be applied to eating disorders. So instead of trying to reason or standing opposite the person saying, what about this, but what about that? You're kind of metaphorically moving your chair to sit alongside them and have the problem in front of you and just understanding together what's happening, why is this so hard to give up? How is it helping? How is it not

helping? At what moments is the evening disorder really, really strong and what moments is it not and why? And kind of understanding and staying in that space a little bit longer.

Peta Marks (09:16):

Yeah, that's such a great point, Steph. And I think that's also about acknowledging that ambivalence is a really big part of an eating disorder, that it's actually one of the symptoms. So just because someone is ambivalent, we have to work with that. We shouldn't see that as they're being manipulative or they're being oppositional or they're being hard to engage in treatment. They're actually feeling frightened and overwhelmed and unsure of how do I get through this in a way that feels safe and how do I trust the people that are around me and how do I make sure that what these health professionals and my family and what everyone is telling me to do is actually the right thing when I've got this strong voice in my head or thoughts that I should be doing the complete opposite. So building up that trust with a health professional to me is about really that recognition that ambivalence is, I would expect for someone to be ambivalent about treatment. And so you really have to adjust the way you talk to someone. And you're absolutely right. All mental health professionals have that kind of conversation all the time, I think.

Stephanie Boulet (10:32):

Yeah. Yeah. I think ambivalence is really a sign that they're struggling, that it's just too hard. The eating disorder is too strong, it's too hard. So maybe it's a sign actually of maybe we need to bulk up support. I was just reading a little bit of the mantra book today, and one of the things that said was in the end, you've just got to find something that you want to do more than your anorexia, but I guess that can be applied to any eating disorder. You just got to find what's the hook, what's the thing that you want more than anything that's going to give you that kind of motivation and that push to fight because it's going to be really uncomfortable to fight and to stop those behaviours which feel really safe and protective and to kind of go outside of that protection and take on the eating disorder, you're going to have to have something you really want and a few people in your corner. And that's why I think the treatment team is really powerful when there's multiple people saying the same message because an eating disorder is forceful and you need to be told the same thing multiple times in different ways over different challenges

Peta Marks (11:31):

And from different people from different perspectives.

Stephanie Boulet (11:33):

Yeah!

Peta Marks (11:33):

And I guess that's why multidisciplinary care is the gold standard for all of the eating disorders. And to my mind, that's obviously a team of people who have different backgrounds, different types of expertise. You always need a GP or someone with a medical background. You always generally need a mental health clinician, but a lot of gps actually have motivational interviewing skills and if they picked up someone early, for example, and used an evidence-based tool like the ones that we have at Inside

Out, for example, our e-therapy platform, you might not need to engage with another health professional if you get in early enough, but if you do need to draw in other members of the team, that team really can be a fluctuating team too. It's a step up team. When you need more support and advice, you can bring other people in and when you need less, you don't necessarily need all of the people all of the time.

(12:31):

In my local area, I work with a number of GP's quite closely, and there's a couple of dietitians who I engage with when a young person needs more nutritional support than I might offer in my role as a family therapist. And we form that little core team and then the GP brings in a psychiatrist, a paediatrician, the CAMHS team. We decide as a small group of clinicians who we need to get in contact with next based on the person's presentation. And that model works really well with a GP who's interested and able to hold the person, a dietitian who is an expert eating disorder dietitian, myself obviously with expert eating disorder skills, but we often are bringing in people who aren't eating disorder experts necessarily, but who have something to add to the team.

Stephanie Boulet (13:33):

And eating disorders are multifaceted, so you need multifaceted skill, like the physical issues, psychological issues, and then of course we have co-occurring conditions with eating disorders is the norm. And so for management of those risks, you need all these people.

Peta Marks (13:50):

Let's think about it in terms of the hurdles and things that make it hard for clinicians. Maybe the things that they're worried about. How do we support their thinking and how do we convince them that actually this is a really important area for them to get into and that they can make a really big difference by being involved early with people who have eating disorders. Confidence is a big issue. Obviously accessing specialist services and backup are things that I know that practitioners struggle with. Lack of education is something that people often point to in their undergraduate training, access to specialist services, problematic. How do we respond to that?

Stephanie Boulet (14:32):

Well, have you been to the Inside Out website lately? No, actually, I think one of the really awesome projects that we've been able to work on together Peta, has been in Headspace centres and we've partnered with them to start delivering early intervention therapies and supported for young people with these kind of early and emergent binge eating symptoms. And it's been really incredible actually working as well with the Headspace clinicians who often come in, haven't had much experience with eating disorders, but we have a few online learnings where you can learn CBT and community care for eating disorders. And I think a lot of it is about, as you said, increasing confidence so you can actually do it. You can open the conversation. We have some really cool prompts, as Peta kind of mentioned about the Inside Out screener, which have been developed with people with lived experience, which is a screener, it will come up with a result, but they're actually designed to start a conversation.

(15:34):

You know like - what is your relationship like with food? Not being scared to probe in a little bit deeper. Do you feel out of control sometimes when you are eating? What's that like? Do you purge afterwards? Do you ever feel like you have to do an undoing behaviour? Do you feel guilty? We hear sometimes that people feel guilty after, you know, asking those sort of questions can really open a conversation, which can be really helpful for the person they're living in it and experience it day to day. It might be difficult and there may be some shame for them to talk about it, but often there's also a sense of relief. So I guess increasing confidence is a big piece. And the really amazing thing in a lot of the Headspace interventions is that you're seeing some really basic behavioural strategies from CBTE, which is CBT for eating disorders being put into effect over four weeks, which can have really, really incredible impacts early on in the illness. Things like regular eating, following a three hour rule, self-monitoring your food. So quite basic behavioural interventions can have a really, really big impact, especially early in the illness. And in this young Headspace age group, it's changing the trajectory of an eating disorder with some really simple skills and some basic screening questions that starts that, which is really cool because sometimes in private practise we're seeing people, as we said, after five to 10 years of having an eating disorder and at that point it's a bit harder.

Peta Marks (16:55):

Yeah, I guess get around the idea that this is only specialist work and that to my mind, every practitioner when they're doing their assessment should be including some really simple screening questions around eating and people's relationship with food in their body. We know that so many people with eating disorders are presenting with other conditions, both physical and mental health. And so that would just be part of a holistic assessment really to my mind, asking everybody that comes into contact with you, what's your relationship with food? How do you feel about your body? All of those questions that you just ran through. And people might be surprised, I guess, that many more people than they think have eating issues, then feel, okay, maybe I can start to talk about this or maybe what I'm experiencing and how I'm feeling about eating and food, maybe those things are problematic and maybe I should be doing something about that.

Stephanie Boulet (17:57):

I did want to ask though, Peta, I was wondering how you got into eating disorders and what your path was?

Peta Marks (18:03):

Well, it's interesting actually. When I first did my psychiatric nurse training and moved from Brisbane down to Sydney, I got a job at Royal Prince Alfred at the Misson unit where at that stage there was an eating sort of programme with 12 to 14 people. So it was quite a large programme in the public health system. And my preceptor was a nurse who'd been the coordinator of the eating programme for a number of years. And so she was showing me around the ward, and I spent a lot of time with her in those first few weeks, but then not long after I arrived, she left and went to work somewhere else. So everybody on the ward said, oh, well now you can be the coordinator of the eating disorder programme, which I thought, okay, well that's fine. I've been doing this now for a couple of weeks with my preceptor.

(18:58):

And so I agreed to take on the role. So I had a programme, I knew what the programme was, and I just thought it would be as simple as implementing the programme, explaining the rules to people, and then helping them to get through meals and get out the door and it was eat and leave essentially. Needless to say, it was not that simple. And I really struggled actually in understanding what it was that I was doing wrong. I found it really overwhelming. I found it really difficult. These people were very unwell. They were in hospital, but there was this programme and I couldn't really understand why people were not doing what they needed to do in order to get better. So I was actually just about to give up and say, I don't want to do this anymore. And instead, I went to a conference in Brisbane and Kelly Bemisfatusek was there, she's a researcher with lived experience actually, who at that stage was focusing her work on motivation.

(20:05):

And she explained how she talks to psychology students about eating disorders to try and get them to understand the position that the person with the eating disorder finds himself in. And she told this amazing story, which I'll tell very quickly. She says to this room full of people, hands up if you've got children. And then the people who have kids put their hand up and then she says to them, okay, so I'm going to say to you that you've got these people, these new people in your life, you've just had a baby or you've got these children. And as an objective observer, I can see that since these people came into your life, your quality of life has deteriorated. You're not sleeping well, you barely get time to eat. You haven't had a hot cup of coffee for months, you don't see your friends anymore.

(20:57):

You feel overwhelmed sometimes. You don't even get out of your pyjamas, let alone have a shower. You're feeling terrible. So what I'm going to do is to take those children away from you and then you can return to the life that you previously had without them, you'll feel so much better. You'll be able to reconnect with your friends, you'll be able to get back to work, and your life will go on as normal. And just listening to her describing that situation to everybody who was at the conference really made me start to think about putting myself in the shoes of the person with the eating disorder and thinking, wow, how scary would that be? How much would you want to hold onto the illness if that was what people were trying to do to you? I said, this illness feels like the most important part of me.

(21:48):

Or if this illness feels like something that is helping me with my problems, or if this illness feels like a way of communicating my distress to the world, to my family, to the people around me of a way of expressing what's inside. And a health professional comes in and says, why aren't you following the rules? And this is all you need to do and what's wrong with you, essentially? Why are you not doing what you need to do that of course, I'm going to think nobody understands and try and hold on to that illness as hard as I possibly can to protect it, to not talk about it. Do everything in my power to try and keep it and keep it from you. That health professional is trying to take it away from me. So essentially my foray into eating disorders then, or my experience and thoughts about what I wanted to do and how I might operate in the programme changed. And I understood that my position was not to hold the rules of the programme as the only thing I offered that what I really needed to do was to understand the position of fear that the person was approaching recovery from, to understand that ambivalence was a core part of what they were feeling, and to somehow try and sit alongside them and let them know that

I understood how scary it was and they could do it, and that life on the other side of an eating disorder was going to be better.

Stephanie Boulet (23:18):

It's so powerful. Why the hell would you give it up? But there's always something, there's always a glimpse or there's always a healthy part of the person that is, I do not want to be in this hell, this is not the life that I want. This is too painful, too isolating. I don't want to be at the doctors and the psychologists every week. They don't want to live that life either. This is not a choice that they're making.

Peta Marks (23:41):

One of the things that I often say to clients and I think is helpful for practitioners in the team to sort of think about is that the illness to my mind is like a horse wearing blinkers. What it does for the person is gets them to focus on food, eating calories. How do I not eat this? Or how do I eat this to soothe myself? It really gets the person to focus on a very narrow set of parameters that are illness focused, and so that everything that it wants the person to do is focused on keeping them in the illness. And part of what we have to do as the care team around that person is to help them to step back and to take off the blinkers and to think about what it is that they want for their life. And is this illness serving them in the bigger picture of their life? What do they want to be when they grow up? What do they want to do with their friends, with their relationships, with their family, with their life, with their work, with their education? And how do we as health professionals get them to not get caught in an argument, as you said before, in that back and forth of the yes but yes, but try to have a logical conversation when the blinkers are on and they're really focused down on the minutiae of

(25:02):

the eating sword. How do we not get engaged in that tussle, but really acknowledge the feelings and the fear that the person is trapped in? It sounds like the eating disorder is really intense and scary for you right now. Let's think about the reasons that you might want to get better and what is it that you want to do in your life and how might you engage with that healthy part of yourself to remind yourself that there are bigger, better things in this world and that we know the eating disorder is going to want them to focus on that sort of minute detail, but how do we help them to manage those feelings in order to step away from it?

Stephanie Boulet (25:37):

Yeah, I think as a clinician, you need to do that over and over and over again. And that's so helpful because I'm just thinking, being in the illness, you're absolutely right. It just draws you back into the trees. You just get stuck in the trees. You can't see beyond that. And I think that's the impact of starvation and malnutrition as well. The cognitive impacts of that also keep you stuck. And then having someone bringing it's hope really that you're bringing, like looking out and looking at that bigger picture and looking beyond that food eating that's preoccupying. Your mind is so incredibly powerful. And then doing that at moments and bringing that back to the forefront, which is where I think family comes in and support people come in continually bring that perspective. Again, when you're in hard moments, like at the dinner table, it's not really about the past or whatever, zoom back, what do you want? Where

are you headed? Life is made up of all these tiny little decisions. You just have to make lots of little decisions over and over and over and over and over again. We just, exhausting. But you can do it. You can do it. It's been done before. People get better after 20 years, you can do it.

Peta Marks (26:38):

And the other thing I think, Steph, that's really important is that in the same way that our multidisciplinary team members can make a huge difference, we can also do harm. And I think we really have to be mindful of that quite a lot. I have heard from people who have had a negative experience initially, if they've gone and said to someone, I think I've got an eating disorder, I'm worried about an eating disorder, and they get dismissed, or their fears get minimised, or they get pushback based on maybe the way that they look. You're not underweight, you can't have an eating disorder, that type of approach. And those people have then basically gone underground for years and not sought help. So I think we have to also be mindful that first attempt that a person makes to get help is a really, really important one, and can be the one that will either help someone to stop that illness trajectory or that might actually push them underground for a long time and make things a lot worse.

(27:40):

And also, I mean, similarly, if a parent is saying to a GP or to a health professional, I'm worried that my child has an eating disorder, then you can pretty much bet that there is an eating disorder present because parents often, it takes them a bit of time to work things out because the illness might be hidden from them. But once they do bring that to the attention of a health professional, we really need to take those things seriously. And I remember the thing that I wanted to say before, and that is that I've talked a lot to people with eating disorders about their early experiences with health professionals, and they always say they don't actually expect health professionals to have all the answers or to necessarily understand, but what they want is for us to acknowledge that we don't have all the answers. So for example, if someone came and saw their GP, who wasn't an expert in eating disorders, who said, look, thank you so much for bringing this issue with me.

(28:42):

This is not an area of expertise for me, but I'm really prepared to walk this journey with you and let's find out together what needs to happen and where it might be best for me to refer you and who else we might get involved. Actually, that is what people want. They want someone who's going to be collaborative, who's going to admit that they don't know something, and who is going to walk that journey together so that they find out and muddle through this thing. And that sounds a little bit to me like what you were talking about right at the start with your experience with your GP who helped you and walked beside you with that. Let's find the people that you need for right now who are going to help.

Stephanie Boulet (29:21):

And the wild thing with that GP that really helped me is that a few years ago, we figured out that that GP was actually trained in eating disorders by you, Peta.

Peta Marks (29:32):

Oh, wow.

Stephanie Boulet (29:34):

Through some of your early trainings. I think for general practitioners. Yeah, real world impact.

Peta Marks (29:40):

Oh, there you go.

(29:41):

Okay. Well, certainly covered a lot of territory today Steph. I think we've established that even just those really common conditions, they're often hidden and they're often missed. And that mental health practitioners, gps have all the skills that they need really to be able to engage with someone, particularly in the early stages of illness. And really, we're looking at building the kind of teams, the multidisciplinary teams that people need. And that's a very individual thing actually. Inside Out's got resources that can help. We've got a lot of digital resources, and we will add some links to that on the landing page of this podcast. And I think really that the other takeaway that I hope people would leave with would be that from my perspective, and I'll ask you in a second, Steph, but my perspective would be that ambivalence is a core feature of an eating disorder, and it's an opportunity for us really to align ourselves with the person against the illness rather than see that as being a person being oppositional or adversarial. What do you think are the key takeaways from today from your perspective, Steph?

Stephanie Boulet (30:49):

I think you've nailed it. I also want to send a message of hope that I think the clinician's role is also to hold hope and to just know that your person can get better, because they can.

Peta Marks (31:02):

Absolutely. So look, if anyone wants to learn more about me or Steph, or if you want access to the resources that we've mentioned, please go to this episode's landing page and follow the hyperlinks. We'd also really love to hear what you thought of this episode. On the landing page, you'll find a link to a feedback survey. Please fill that out and let us know whether you got what you needed from the conversation or provide any other comments or suggestions about how MHPN might better meet your listening needs. In the meantime, if you want to stay up to date with MHPN podcasts, make sure you subscribe to MHPN Presents and keep an eye out for an MHPN webinar, exploring eating disorders later in the year. Thank you for your commitment to ongoing learning and to multidisciplinary mental health care. Thanks, Steph.

Stephanie Boulet (31:49):

Thanks Peta.

Host (31:51):

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