**Renfrew Eating Disorder Presentation 5-18-16 (Dayna P. and Jessica Willard)**

* Renfrew is a national organization. It is expensive, but scholarships are available.
* Body dissatisfaction in young children is an early indicator of a possible future of eating disorders.
* Only 1 in 10 people actually get treatment.
* Now we are seeing an increase in the middle age population.
* It is about maintaining control and therefore they end up with a lot of physical and medical complications.
* Do parents pass it on? Yes and no. Often in the family there is a lot of disordered eating (nothing all day and then two sandwiches, pizza and ice cream for a late dinner) and talk of rigid types of eating. Kale, kale, kale.
* Renfrew tells patients that they have a choice to use their symptoms or not. They need to understand that these symptoms are symptoms of emotional distress.
* All ages and types of people can have eating disorders. It used to be that women of color had more body self-esteem, but now we are seeing more women of color getting eating disorders. The culture is not as tolerant of weight as it used to be.
* Unfortunately, eating disorders become confused with the patient’s identity of themselves. Patients find this resourceful as a motivation.
* Like an addition to anything else, you need several trials of treatment. 2 out of 3 patients come back to Renfrew. With the highest level of care (in-patient), 66% are successful.
* If a student is hospitalized, they should NOT come back to school right away. It needs to be a gradual re-entry.
* There is often c0-morbidity with Substance Abuse or Post Traumatic Stress Syndrome.
* Eating Disorders have the highest morbidity rate of all mental illnesses: 1. There are medical complications and 2. There are the highest successful attempts at suicide because they use the most lethal means. The pattern of their illness is to ignore their body’s physical symptoms. Therefore, they are not used to harm avoidance. They can easily go through with the lethal means of suicide.
* Types: Anorexia, Bulimia, Other non-specified types of eating disorders.
* The cycle is: Restriction >Binge>Purge.
* Behaviors that depict eating disorders are: hiding food out of shame, eating in the car, waiting until the dorm is empty, plan on going to bathrooms with single stall bathrooms, rituals such as drinking a lot of water before eating a meal, drinking a lot of water before being weighed, have very competitive natures and want to meet challenges (Fitbit!). WE should teach kids how to take a break from Fitbits; Fitbit recommends not getting one until age 13. Parents should set boundaries and know that it will cause distress…it’s OK!
* Recognize that all of this thinking is exhausting. Because of the obsessive thinking they cannot take part in normal conversations.
* Patients have low self-esteem, are high achievers, are very sensitive to rejection, have difficulty with complexity in cognition.
* Turtles Hares

Anxious Impulsive

Worry prone Seeks novelty

Low risk tolerance (afraid to ask questions) Easily bored

Avoidant defenses (I’m fine!) Chaotic lifestyle/thinking

* Turtles and hares can cross over.
* To achieve a healthy goal, early intervention really helps.
* How to assess and respond:

Warning signs: less lunch, or throwing it away; going to the bathroom alone; avoiding the cafeteria; shifts in weight and mood; increased isolation from activities with food or will say they have already eaten.

Listen: obsessive conversation around food, school writings and projects all have to do with food, poor self-worth statements, will cancel food related plans at the last minute, Sees food as “good” or “bad”, feels pride and power in restriction.

* Our nation talks about the national epidemic of obesity. Renfrew see this as an eating disorder.
* In the assessment: look at normal vs. concerning dieting, look at body dissatisfaction vs. “my body is how I judge my worth”, is it getting progressively worse, look for patterns and thoughts in behavior, seek out family feedback.
* Some restriction is very subtle: no longer eats condiments “I like my salads plain.”, Intense fear of weight gain. One Mom said that she would rather die than have her son have a fat Mom.
* There are a lot of rules and stress around eating. Look for shifts in eating.
* When obtaining feedback be aware that patients will minimize because there is shame and stigma. They want to maintain their power and have no desire for therapy.
* As a parents we always want to feed our children.
* Do’s and Don’ts of having “The Talk”:

Do: empower parents, prepare for denial from patient and family, set clear expectations for your school (i.e. When allowed to return), be aware that anxiety levels will go up and down, at times you may need to ELEVATE the family’s anxiety, express the need to utilize assessment tools, consults and interventions.

Don’t: Promise a level of care, comment on weight, don’t let emotions dictate what your recommendations are (tell crying family they may not have to hospitalize), begin any therapy without the doctor being or in contact with an eating disorder specialist, maintain secrets or sugar coat, don’t tell patient you are taking away their eating rituals because it is like saying you are taking away their life raft.

* There is an increase in orthorexia: taking clean eating (organic) eating to the extreme.
* Excessive exercising is also a type of purging.
* Renfrew encourages co-ed talks in high schools. The talks should also include nutrition.
* Post Treatment Support is crucial: Academic accommodations, nutrition and exercise (use cautiously), have contact with the healthcare providers, peer support and continuing education for families.
* Change the culture: practice feeling your feelings, food doesn’t have moral value, value your emotional health, watch what we say around people (to person not eating a cupcake, “You’re so good!”), and work on balance/variety/moderation.
* Symptoms are dangerous…not feelings!