

Occupational therapy and eating disorders: When occupational needs support recovery



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Eating disorders are serious mental illnesses.

Eating disorders are frequently associated with other psychological and physical disorders such as **depression, anxiety disorders, substance abuse and personality disorders.**

Eating disorders are estimated to affect approximately **9%** of the population.



Risk factors for eating disorders can include dieting, negative body image, genetic vulnerability and psychological traits.



The total social and economic cost of eating disorders in Australia in 2012 was estimated at **\$69.7 BILLION.**

Getting help

If you suspect you or someone else you know has an eating disorder it is important to seek help immediately. Visit our website to find help in your area.

nedc.com.au

Eating disorders can occur in people as young as 7 or as old as 70; however evidence shows that young people are more at risk.

The risk of premature death for women with Anorexia Nervosa is **6-12 times higher** than the general population.



Snapshot

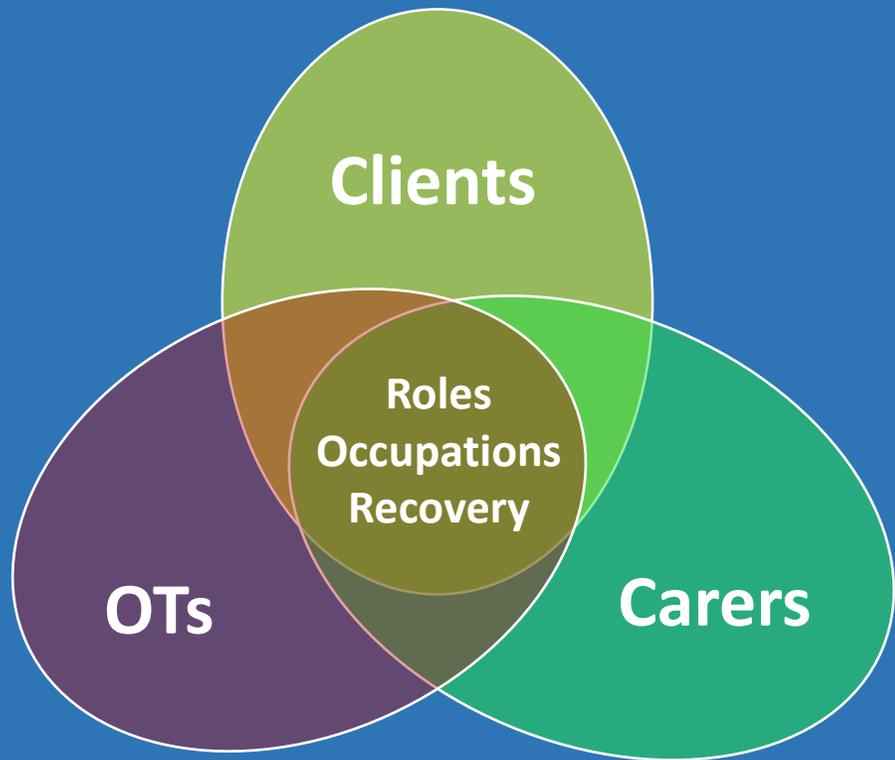


Eating disorders in Australia

<https://nedc.com.au/>



Occupational therapists make a unique contribution to the treatment of eating disorders by focussing on functional ability, engagement in meaningful occupations, communities and environments, participation in life roles, and providing client-centred and occupation-based interventions



What are the current occupational therapy services provided to adolescents and adults with Eating Disorders in Australia, Canada and the United Kingdom? (online survey design)

36



23.1%



26.9%



50%

- Mainly female (76.92%) between 31-40 years old (46.2%)
- Bachelor with or without honours
- Expertise in mental health 10.90 years (*SD 8.253*)
- Specialist eating disorders service (50%), inpatient unit (38.5%)

Practice settings



	Australia	Canada	UK
Inpatient Unit	3 (13%) ✓	2	5 (10%)
Outpatient Unit	1	2	4 (8%)
Acute admission wards	1	0	1
Psychiatric ICU	0	1	0
Rehabilitation unit	1	0	0
Specialist eating disorders service	2 (8.7%)	5 (18.6%) ✓	6 (12%) ✓
Child and adolescent unit	0	3 (11.1%)	1
Adult unit	2 (8.7%)	2	4 (8%)
Day hospital/ partial hospitalisation programme	0	4 (14.9%)	3
Day centre services	0	0	2
Community mental health team	1	0	0
Other	2 (8.7%)	2	2

Assessments

- 62% OT specific evaluations, MOHO
- 56% Standardised assessment tools

Canada: COPM

UK: Eating and Meal Preparation Skills Assessment (EMPSA)

Interventions

- social skills training (96.2%), stress management (96.2%), communication skills (96.2%), assertiveness training (92.3%), coping skills training (92.3%)

Australia: Sensory approaches

Canada: vocational/education

UK: projective media, ADLs incl shopping

- Family and carers

Re-evaluation

- Initial assessment tool and comparison of results (36.36%)
- Standardised assessment tool (not initial assessment tool) (36.36%)
- OT specific assessment tools (27.27%)

Australia: Sessions and program evaluation

Discharge

- Referral other specialised services (27.27%)
- OT goals met (27.27%)
- Decisions without OT input (length of stay, # of beds, psychiatrist's decision) (18.18%)

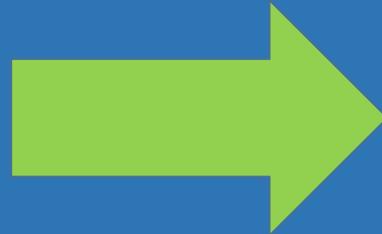
Australia: Formal discharge plan

UK: Structured follow-up



Challenges

- Complexity and nature of ED
- Lack of resources
- Lack of recognition and acknowledgement of contribution
- Role blurring



Strategies to overcome challenges

- Promote occupational therapy
- Develop (OT) evidence – effectiveness of occupation focussed interventions
- Build (OT) research
- Use of standardised assessments

What does it mean to be recovered from the perspective of young Australian adults who have had an eating disorder?

Qualitative phenomenological study, in-depth semi-structured interviews

- 10 participants (8 women:2 men)
- 23 years old (19-25 years)
- AN ($n=7$) and OSFED ($n=3$)
- 18 years old at diagnosis (14-23 years)
- 20.57 years old at recovery (17-24 years)
- 2.43 years recovered (0-7 years)
- Outpatient treatment only ($n=8$), inpatient and outpatient treatment ($n=2$)



Study 2: Clients

The Turning Point

Being Recovered

- a) The Freefall into Coping
- b) A Normal Life

From Unimaginable to Exceeding Expectations

Improving the Transition

Results



Recovery: The OT lens

- **Volition:** interest, meaning
 - Volitional process
- **Personal causation:** control
- **Habituation:** roles and habits
- **Occupational performance:** satisfaction
- **Occupational identity:** sense of self
- **Occupational adaptation:** using skills, knowing what to do
- **Environment:** support and traps

Support clients engaging in **activities that provide meaning and growth**



What is the lived experience of parents after the recovery of their child from an eating disorder?

Qualitative phenomenological study, in-depth semi structured interviews

- 10 mothers, 45-55 years old, 2-3 children
- Metropolitan Victoria, Australia (n=4), regional Victoria, Australia (n=6).
- Children diagnoses varied (anorexia=3, bulimia=4, EDNOS=3)
- Illness duration: 14 months to 5 years,
- Time since recovery: 10 months to 9 years.



The reality of being a carer

- a) Prioritising my child's care above all else
- b) Upheaval in the workplace

Extreme family dynamics

Finding support

- a) Formal support
- b) Informal support

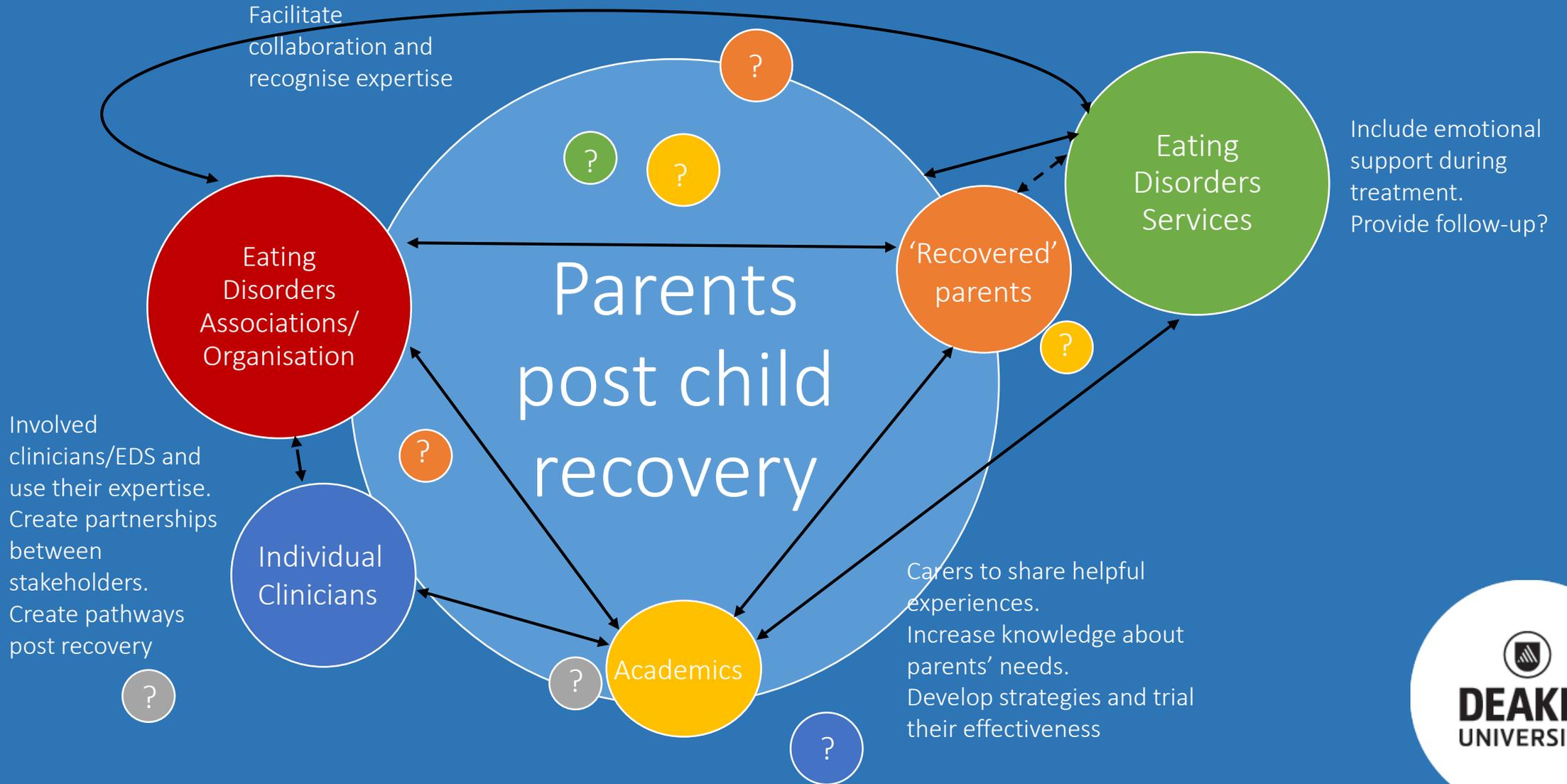
Reaching recovery

Results



What should we do? And who should do 'it'?

Study 3: Carers



So...

OTs use **OT specific and standardised assessments**, mostly MOHO based. **EMPSA** is gaining momentum. OT interventions focus on building skills that **support occupational engagement and participation**. OTs mostly use structured re-evaluation and discharge processes. Further OT specific evidence will **support recognition of the contribution of OT in ED**.

Recovery must support people **engage in meaningful occupations** that support community participation. Building a **strong and positive occupational identity** that supports adaptation to the environment is essential. ●

Carers need support to undertake a **very different version of their usual role** and deal with **significant changes in their environment** that can compromise volition and habituation.

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support occupational engagement and participation. OTs mostly use

structured re-evaluation of the environment. **OT specific evidence will**

support recognition of the contribution of OT in ED.

Recovery must support **occupations** that

support community participation. **Positive occupational**

identity that support adaptation to the environment is essential.

Carers need support to **family members/carers** **of their usual role**

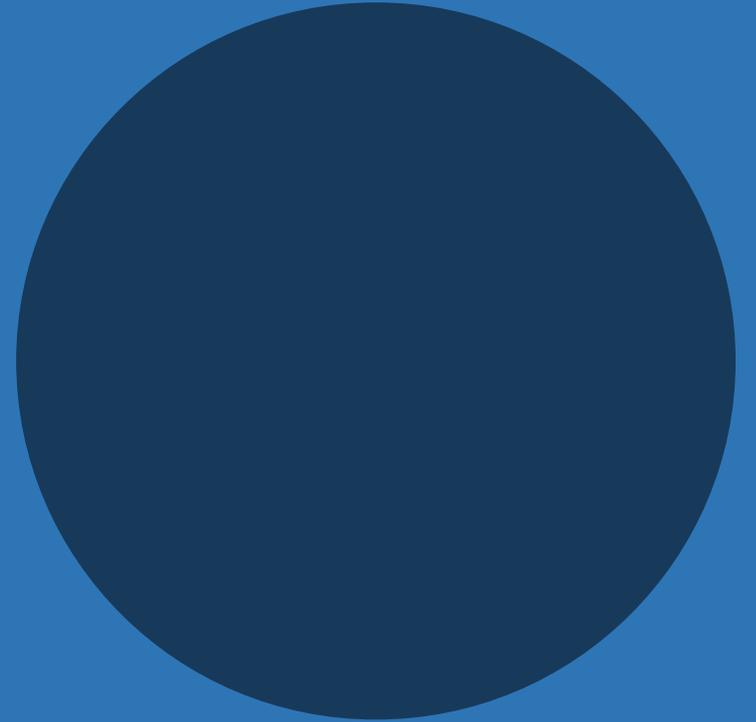
and deal with **significant change in their environment** that can compromise

volition and habituation.





Thank you!



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