This tool addresses common practice questions in eating disorder (ED) care and provides suggested strategies and approaches for health professionals. It is not intended to be a script for talking to your patient. Tailor care to the individual needs of your patient.

This information is intended as a general resource only to help guide practice and is not meant to replace training in the assessment and treatment of EDs. It is also not intended to replace the medical counsel of a physician or individual consultation with a registered dietitian (RD) or a psychologist.

Considerations: Scope of Practice, Competencies, and Roles

- It is the responsibility of health professionals to evaluate the situation of each patient in their care, ensure that they have the required competencies to provide ED care, and apply this tool appropriately.
- Consider the professional scope of practice, as well as program-specific roles and decisions to determine who is best suited to provide ED care to patients and families.
- Whenever possible, refer patients and caregivers to the appropriate health professional to receive specialized care tailored to their needs. Individuals:
  - with a possible ED should be medically monitored by a physician, and referred to a health professional who has training and experience in the assessment, diagnosis, and treatment of EDs. Patients can call the AHS Mental Health Help Line for support with finding a mental health provider (1-877-303-2642 or 811).
  - who are at high risk of malnutrition or who have a medical condition that is impacted by nutrition should be referred to an RD for nutrition care. For more information on referral to an RD and RD services available in Alberta Health Services (AHS), see Nutrition Guideline: Referral to a Registered Dietitian and visit Referring Patients for Nutrition Services.
- For more information and resources to support practice, refer to Point of Care Reference: Addressing a Possible Eating Disorder (see "Mental Health" section on Nutrition Guidelines for Health Professionals) and AHS Addictions and Mental Health Information for Health Professionals.

Common Practice Questions in Eating Disorder Care

Questions	Sample Dialogue
What if the patient breaks down crying?	
• Listen respectfully and quietly until the intensity subsides; maintain eye contact and offer tissues. • Don't interrupt or try to make them feel better. • Avoid touching the patient; this will shut down emotional processing. • Avoid minimizing their feelings (e.g. "These things happen all the time and we just have to move on"). • If the patient is embarrassed, reassure them that crying is a normal and therapeutic release of feelings. • It's important how you respond (i.e. your body language needs to express receptivity, and your tone of voice needs to acknowledge things are difficult right now).	• "That was a terrible experience, and it had a significant impact on your life." • "There is no need to worry about crying. It's a normal way to help us release and ease painful feelings." • "When you are able to… or if you are able to, I very much want to know in what way this upset you. If it's of any help, I'm here for you, so we can figure this out together."
What I if say or do the wrong thing?	
• Acknowledge your mistake; don't disregard it or try to cover it up. • Apologize if necessary. Make sure you explain what you are apologizing about. • Describe at what point you started to say things you now think you shouldn't have.	• "I'm sorry if that offended you. I am hoping to learn from you because I want to understand how things were for you." • "I made a mistake last week and I'd like to revisit [insert patient's name] growth chart and discuss the significance of the corrections."
What if the patient becomes unexpectedly hostile or confrontational?	
• Remain calm and listen attentively. • Don't interrupt, become defensive, or try to rationalize while the patient is venting. • Acknowledge their feelings; summarize or paraphrase what you have heard/understand and ask for clarity if needed. • Ask the patient what they feel should be done. • Apologize if appropriate.	• "I can see you are really upset. From what you've just said, you disagree with my suggestion that you might have an eating disorder. I can appreciate this is not what you were expecting to hear today. You came here to get a diet for weight loss, and I'm recommending we focus instead on eating behaviours." • "Okay, let's pause for a minute. I just realized I'm so caught up in what I'm saying that I neglected to look at things from your side. I apologize for that. There are obviously a few things I've missed, and I'm actually relieved you could say these things. Can you tell me more?" • "If you wish, you can consult with a different health professional for a second opinion. Or, if you are willing to stay, we can talk about what it might mean if you did have an eating disorder. What do you think?

Questions	Sample Dialogue
What if the patient starts to discuss psychological issues and I am not a mental health provider?	
• Listen and provide general emotional support. • Patients may share because they feel they can trust you. • Acknowledge what they are saying and how they are feeling. • Patient disclosures can deepen your understanding of your patient and the things potentially influencing their care. • Avoid probing too deeply into psychological issues or offering advice for content outside of your scope of practice. • Suggest seeing a mental health provider if needed. • When the patient appears ready, gently turn the conversation back to the original focus of the appointment.	• "Thank you for sharing this". • "I can see this is a painful issue and difficult to talk about. Have you ever discussed this with anyone? Do you think it would be helpful to talk to a mental health provider to help you work through this?" • "I don't know if you are at all suggesting that these difficulties have something to do with your eating. Am I getting this right?' • "Are you okay now going ahead with the rest of the appointment?"
Are there any contraindications for goal setting in the first visit?	
• Don't rush to set goals with patients, even if they ask. • Many patients are accustomed to an all-or-nothing approach, which inadvertently supports ED behaviours. • Use clinical judgment, and if appropriate, suggest a smaller goal as an experiment versus a goal. • Frame experiments as an opportunity to learn.	• "I can see you're anxious to get started. Trying to stop all binge eating and purging at once may be hard to sustain." • Many of my patients find it's helpful to take one step at a time by making smaller changes and building on them over time." • "How would you feel about experimenting with one small change until we next meet? There's no pass or fail with an experiment. Rather, it is an opportunity to learn about what works and what might be potential barriers to moving forward."
Are food records helpful for assessment or interventions with this patient population?	
• Be cautious with using food records as part of your assessment or intervention as many patients fear judgement. • Food records may be inappropriate for compulsive patients who have a previous negative experience with food recording or are not ready to share the details of their eating behaviours. • Patients may not provide accurate information (e.g. those with restrictive eating tend to exaggerate amounts eaten, and those with binge eating tend to underestimate intake). • Food records are best used as a patient discovery tool at various stages of recovery, versus providing the health professional with information to ensure the patient is on track. • If a food record is being used, ask the patient what they have learned or noticed.	• "Have you ever kept food records in the past? If so, what was this like for you?' • "I don't usually suggest food records unless there is something we want to discover about your eating behaviours at some point during treatment. Many patients feel food records reinforce a dieting mindset, which does not support their recovery." • "As you reflect on your food records, I'm wondering if you noticed or learned anything new about your eating?"

Questions	Sample Dialogue
Is it okay if I share something personal with the patient?	
• Consider what you are saying and how it might impact the patient. For example, getting into emotionally-loaded events or a personal history of your life should be minimized or avoided. • Disclosing information about your own dieting/weight experience is not recommended. • Disclosing things in the "present moment" is considered appropriate as it can show readiness to meet eye-to-eye.	Examples of **inappropriate** disclosures: • "I also grew up in an abusive household. My mother was an alcoholic, and my dad was never home." • "I know what you mean about keto diets. I lost weight quickly!" Example of **appropriate** disclosures: • "I'm sorry, I'm a bit late. The roads were slippery this morning." • "I'm having a bit of a dilemma bringing something up because the last time we talked about it we did not understand each other."
What if the patient asks me something personal?	
• Maintain boundaries about what you are comfortable sharing with a patient. • Consider deflecting the question back to the patient if you feel it would be appropriate. • You are not obligated to answer personal questions or anything that feels uncomfortable or might influence the patient's care. • Keep in mind that patients deflect attention away from themselves, not always because they want to know about you, but rather because of their own discomfort of being the centre of your attention.	Example: • The patient asks: "Have you ever had an eating disorder or struggled with your weight? Health Professional: "I prefer to keep the focus on you. If we talk about me, we're moving away from what can help you. Example: • The patient insists they need to know if you have a personal history of an eating disorder or weight concerns: Health Professional: "It might be challenging that the focus is on you and your health. I'd like you to consider that you do deserve attention on these issues. I also have to go by my knowledge about nutrition, and that applies regardless of my life, or my relationship to food. Does that make sense?"
At what age can I see a patient without getting parental consent?	
• A patient under the age of 18 is presumed to be a minor patient without capacity unless they have been determined a mature minor. Otherwise, parent/legal guardian consent is needed. • If a parent has made the appointment specifically for ED care, consent is inferred; however, parents still need to be kept informed of overall treatment progress and advised of any potential risks to the child unless the patient is a mature minor.	• "I'm obligated to let your parents know about some of the health risks we've just discussed. How do you feel about inviting your mom to the next session so we can discuss this further?"

Questions	Sample Dialogue
What are some of the considerations associated with the determination of a mature minor status for patients with EDs?	
• Determination of mature minor status is a legal matter. • Each patient's situation is unique. • Due to the health and psychiatric risks associated with an ED, the determination of mature minor status is best made in conjunction with other members of the patient's treatment team. • Some of the symptoms of an ED include secrecy, ambivalence, impaired judgment, and denial about the seriousness of the illness. These factors can interfere with the patient's ability to make informed decisions about their health and to make progress in treatment.	• "Have your parents shown any concerns about your weight loss and how you're eating? What did that look like?" • "From what you've just said, you are afraid of telling your parents what's going on because you don't want them monitoring you?" • "What would it look like if your parents were more involved with your eating and exercise behaviours?" • "What do you know about the health risks of an ED?" For more information on mature minor status, please refer to: • Your manager. • Health Law at 1-888-943-0904 or email: legal.clinical@ahs.ca.
What if the patient has no doctor or refuses to see a doctor?	
• Encourage the patient to find a physician/nurse practitioner as soon as possible. • Suggest a walk-in clinic if one is available. • Explore the patient's reasons for reluctance or refusal to see a doctor. • Provide education about the potential medical risks of the patient's condition based on their needs. • Encourage a visit to the emergency for any urgent symptoms. • Document all actions.	• "Could you tell me your thoughts about seeing a doctor?" • "I feel it's important for you to know about the medical risks associated with [examples might include vomiting, excessive exercise, laxative overuse] so you can make informed decisions about your health. Regular medical monitoring can help to safeguard your health while you work on recovery." • "We've noticed your chest pain, faintness, weakness, and fatigue. It is important for us to continue our conversation, but right now it's more important to see a doctor right away. You'll have to go to emergency, and then we'll talk. Are we in agreement?"

Questions	Sample Dialogue
What if the patient refuses to see a mental health provider?	
• Describe the limitations of your professional role. • Maintain your scope of practice and be mindful of topic boundaries between them and mental health. • Maintain good contact with the patient's primary care provider so you are not working in isolation. • Refer any known or potential mental health concerns to the physician (e.g. depressive symptoms, severe anxiety, self-harm, sleep problems). • Document all actions.	• "I can see you are struggling with some issues in your relationship that are affecting eating behaviours. Although I can listen and empathize, I don't have the training and skills to help you work through them." • "Could you tell me your thoughts about seeing a mental health care provider?" • "How would it be to see your doctor to discuss low moods, anxiety and sleeping problems?"
What if I can't find a mental health provider to refer my patient to?	
• Explore all possible options with the patient (e.g., Employee Assistance Programs, community agencies, or private practitioners). • Recommend for the patient to call the AHS Mental Health Help Line for support with finding a mental health provider (1-877-303-2642 or 811). • Refer any known or potential mental health concerns to the physician (e.g. depressive symptoms, severe anxiety, self-harm, sleep problems, suicidal ideation). • Document all actions.	• "Do you have any access to counselling services through a work employee assistance program?" • "I think it would be a good idea to see your doctor to discuss anxiety and mood concerns. How does this sound?" • "I can listen while you share your concerns that your husband is sabotaging your recovery, but I'm not qualified to help you address relationship difficulties." • "Since we can't find a mental health practitioner to support your needs, may I suggest you contact the Mental Health Help Line to see what they suggest?"
What if my patient appears to be at risk of suicide?	
• Act while the patient is still in your office. • Escort the patient to the emergency. • If there is no emergency department, contact the AHS Mental Health Help Line and put the call on speakerphone so the patient can answer their questions (1-877-303-2642 or 811). • Local crisis services may also be available in individual zones/ communities and can be an alternative option if you are familiar with them. • If the patient has called you from their home and needs immediate help (e.g. is holding a gun, has taken an overdose or ingested a toxic substance), call 911. • Be prepared to provide the exact location of the patient. • Document all actions, including conversations with the Help or Distress Line.	• "Thank you for telling me what's going on and what you are planning to do. I really would like to help. I am wondering if we can walk to the emergency department together so you can get some immediate help. Would that be okay?" • "Thank you for telling me how you're feeling. It is so brave of you to let me know this. I would like to help; can we call a helpline together and put them on speakerphone so we both figure out our next steps?" • "I am so thankful that you told me this. I am really worried about you. I'm calling 911 on a different phone for assistance; please stay on this line with me. I will stay with you until help arrives."

Questions	Sample Dialogue
What are the indications my patient is at high risk and may need urgent treatment?	
• Medical instability (e.g. unusually low blood pressure, cardiac arrhythmias, chest pain, severe and sudden onset of abdominal pain, seizures due to low blood sugar levels, severe dehydration, acute malnutrition, uncontrolled vomiting, refeeding complications). • Psychiatric emergencies such as suicide risk. • The patient has a medical emergency while in your office. • The threshold for intervention is lower in children because they are at a higher risk.	• "I'm really concerned about the symptoms you've described. I would like you to go immediately to the emergency department for a medical examination." • "I'm calling for an ambulance. In the meantime, I've asked a nurse from the department next door to stay with you."
When should I consider referral to a specialized treatment program?	
• High level of patient acuity (see indications for urgent treatment). • The patient is not making progress or symptoms are worsening. • The family situation cannot support family-based treatment (e.g. household has other serious mental health issues, addictions, and abuse).	• "I can see how hard you are struggling to eat and the challenges you face for recovery. Would you be open to a referral to a specialized treatment program? They can work with you in a more effective way." • Visit www.ahs.ca/pathways for specific program and referral information in Alberta
What are the indications for hospitalization?	
• Very low body weight; weight at or near a point when medical destabilization occurred in the past. • Acute food refusal, especially with decreasing/low body weight. • Medical instability (e.g. abnormal heart rate, blood pressure, glucose, electrolytes, dehydration, organ compromise, poorly controlled diabetes). • Low motivation to recover. • Severe symptoms of BN not responding to outpatient treatment. • Additional stressors interfering with the ability to eat (e.g. severe family dysfunction). • Suicide risk or severe concurrent psychiatric conditions.	Example of a call to the family doctor: • "Hello [Dr.X,] my name is [X] and I'm the [insert your role] who has been working with one of your patients, [X]. [X] is currently sitting in my office and I'm concerned about their health. They presented today describing uncontrollable vomiting, being too weak to climb the stairs, and fainting several times. Their weight is down an additional 3 kg since your referral. I don't see how we can manage the severity of the situation on an outpatient basis. What are your thoughts about how we should proceed?"