



Developing a Peer Workforce for  
Eating Disorders

# Introductory Learning Resources for Peer Workers

A Trauma and Suicide Prevention Informed Approach

**Part C4**

## Developing a Peer Workforce Guide

“Developing a Peer Workforce for Eating Disorders” is a suite of evidence-informed practice guides designed to promote and facilitate evidence-based peer work in treatment and support services for people with eating disorders.

The Guide is presented in three parts:

### **Part A: Exploring the Evidence for Peer Work in Eating Disorder Settings**

Part A provides a brief outline of the evidence reviewed in the development of this Guide.

### **Part B: Understanding Peer Work**

Part B provides an introduction to peer work practices and the ways in which peer work can enhance outcomes for people with eating disorders.

### **Part C: Organisation Matters**

The four guides in Part C explore some of the organisational support strategies that have been found to assist in the development of safe and effective peer work initiatives. The documents in Part C may assist in the planning, implementation and evaluation of peer work initiatives. They may also provide useful content for training for peer workers and for clinicians.

#### **C1. Codeveloping a Peer Workforce**

#### **C2. Robust Recruitment**

#### **C3. Supporting Practice**

#### **C4. Introductory Training Resource**



This document

## Using this Resource

Some peer workers will come to their new role with qualifications or experience in mental health or peer work. Others may be starting peer work for the first time. The range of topics and skills included in the peer work competencies may seem daunting for those who are just starting out. Peer work should enable people to start work without unreasonable barriers such as months of training.

Orientation training provides a simple starting place that can be built on with additional external training over time. Introductory training can also provide a self-screening process, enabling people who are interested in peer work to identify for themselves whether they are ready for this type of work.

What each individual peer worker needs in their orientation will be different but the following list of core topics may provide a useful starting place for designing an induction/orientation program:

- Orientation to the organisation
- Understanding peer work approaches
- Safe story sharing
- Eating disorders information
- Suicide prevention and trauma informed care.

More information on how to plan for induction training and on external courses that may be suitable for peer workers can be found in part C3 of this guide.

The resources in part C4 (this document) provide a very brief and generalised introduction to key topics for eating disorders peer work. The resources may be used to compliment other training provided to assist workers to become familiar with their work roles and organisational policy and procedure requirements. The information is provided to assist learning. It is not a qualification and it should not be used as a substitute for professional health care advice or formal work-related training.

The introductory learning program outlined in this document is specifically designed for people:

- interested in finding out more about peer work
- starting peer work and require basic knowledge of specific concepts
- already employed as peer workers who want to refresh their understanding or prepare to help others understand peer work.

At the end of the learning module, participants will be able to confidently provide appropriate support to another person using trauma informed principles and, where required, seek professional assistance for someone who is experiencing a crisis or suicidal behaviour.

Learning outcomes include:

- Ability to explain eating disorders peer work to others
- Awareness of the value of own lived experience and how this can contribute to helping others
- Ability to purposefully and safely share from personal experience
- Confidence to advocate for self or others in peer work role
- Ability to recognise trauma and trauma informed care principles and apply this in day to day work
- Confidence to provide basic suicide prevention support
- Awareness of self-care, and an ability to create a self-care wellness plan
- Support and refer a person to professional assistance and further resources.

Each unit in this program has separate learning aims, objectives, and outcomes, activities and content linked to the Peer Work Guide to enhance understanding and maximise learning.

## Getting Started

The resources in Part C4 are suitable for use as:

- a self-paced, self-directed program that can be started and completed at your own pace
- a focus for group-based learning in peer work
- as part of the induction program for a specific work role.

## External Training Programs

The resources in Part C4 of this Guide are not intended to replace more intensive external training. They provide a place to get started before more intensive training or at a later stage as refresher training for people who have previously completed external training courses.

The following training programs are described in Part C3 of this Guide. They have been used successfully by individual eating disorder peer support programs for the training of peer workers.



**Intentional Peer Support (IPS)** <http://www.intentionalpeersupport.org>

**SafeTalk – awareness of suicide risk**  
<http://www.livingworks.com.au/programs/safetalk/>



**Mental Health First Aid Australia** <https://mhfa.com.au/>

**MIND Mental Health Peer Support training**  
<https://www.mindaustralia.org.au/about-mind/professional-training>

### **Certificate IV in Mental Health Peer Work**

Part C3 of this Guide also describes the Certificate IV in Mental Health Peer Work as a longer course of study that may be suitable for peer workers.

The nationally accredited Cert IV in Mental Health Peer Work provides core content that has been designed by people with a lived experience of a mental illness.

The six core units of the Certificate IV in Mental Health Peer Work cover:

- Applying peer work practices in the mental health sector
- Contributing to continuous improvement of mental health services
- Applying lived experience in mental health peer work
- Working effectively in trauma informed care
- Promoting and facilitating self-advocacy
- Contributing to work health and safety processes.

## Resource Overview

The resource is organised into six topic units:

1. **The Peer Work Approach** – an introduction to peer work and the way it contributes to recovery from an eating disorder.
2. **Sharing from Experience** – an introduction to safe story sharing for peer support and advocacy.
3. **Thinking about Eating Disorders** – an introduction to eating disorders and the most common treatment approaches to assist learners to be aware of the different experiences that other people may have.
4. **Staying Safe** – an introduction to self-care and wellness planning including thinking about boundaries as an essential factor in everyone's wellbeing.
5. **Trauma Informed Care** – an introduction to the principles of trauma informed approaches.
6. **Suicide Prevention** – an introduction to strategies to help someone feel calm and seek professional help when they are at risk of suicide or self-harm.

Each unit is a standalone topic and these may be used in any order.



## Self-directed Learning

Learning activities, questions and reflections have been included throughout each unit to help you reinforce learnings and apply them into your way of working and practice.

A suggestion in many instances will be to reflect on your current knowledge and understanding before you commence reading about the topic. Then after reading relevant sections in the Peer Guide, describe and discuss your viewpoints with any changes in your thinking and how you might approach your work differently.

We recommend you keep a study diary or journal to record your responses and ideas. Journaling, writing, drawing and doodling are well recognised self-care and self-expressive activities that you can do at any point in time.

You are encouraged to reflect on your learnings, do your activities and brainstorm through this approach. This may be a catalyst for new ideas, questions for discussion with colleagues, further learning or other things.

Express yourself however you wish, through sentences, poetry, stories, and/or drawings.

You may wish to consider developing this as a daily therapeutic activity (10 minutes) to relax and release some energy. This place can be used for personal venting, debriefing, self-nurturing or a combination of these.

Don't worry about grammar or punctuation, allow your hand and pen (or use your keyboard or another communication device) to freely express yourself. This is your private space. No one else needs to view or read your responses.

### **Self-care**

These modules include thinking and talking about some uncomfortable topics. Some content maybe triggering, eliciting stressful responses, emotions and memories of painful personal experiences. Whether you work through this resource on your own or in a group, self-care and self-compassion are vital.

Synonymous with the oxygen mask analogy, we need to "put the mask on ourselves first before we can help someone else."

Feel free to stop or pause working on these modules if you are finding anything distressing. Go outside, take a walk, have a cup of tea or glass of water, call a friend, write or draw in your journal. Choose an activity that feels comfortable and helps you to support yourself.

## Planning a Group Learning Program

What do you want to achieve for your group? What are your aims? Who will be invited to participate? What are they interested in? What are they likely to need?

How many sessions can you deliver and how long will they take? Writing and reflective learning take time to practice. As a general rule, a number of shorter sessions will be more successful than one long intensive workshop.

### Tips

- You don't need to do everything yourself. Invite guest speakers to address key topics such as suicide prevention.
- Invite experienced peer workers to share from their experience as part of each group session.
- Use practice scenarios based on your own service or program to confirm what people have learned through the topic.

### Session Format

A typical session format would include:

- Welcome and housekeeping
- Brief discussion of the content and purpose of the session
- An introductory discussion or 'ice breaker' activity
- Main activity/content
- Review and summary of key insights from the session
- Preparation and practice – the activities people will commit to doing before the next group session. These are likely to include reading one or more of the resources listed in each unit.

### Preparing to Facilitate a Group

- Read the module or selected sections of the module
- Note specific sections, quotations and activities you would like to highlight during the session
- Come up with half a dozen questions about the text to stimulate discussion
- Try one or more of the activities for yourself. Think about what you are willing to share from your own experience.
- Select a quote or brief section that you or someone else can read aloud. Hearing things can change the way we understand the words.
- Read ahead of the group so you can prepare a brief introductory outline of the next section for discussion.



### **Questions to start discussion**

- What did you expect from this section?
- How did you feel reading this section?
- Did anything from this section ring bells for you? How did it relate to your own experience?
- Was anything about this section challenging or difficult? How have you dealt with that?
- What would you change about the section?
- Has this section brought up new questions that you would like to find answers to?
- Has anything from this section inspired you? What would you like to do (or what have you done) in response to this section?

# Unit 1: The Peer Work Approach



## Unit 1: The Peer Work Approach

The impact of trauma and suicide are increasingly being recognised as factors in mental health. Eating disorders are associated with a high risk of suicide and with trauma, experienced before the eating disorder or during treatment.

We can all play a role in supporting each other during recovery by developing the awareness and skills needed to connect with, engage and create positive relationships with others. These basic behaviours can enhance our own wellbeing and contribute to prevention or compliment health care.

Connectedness is one of many factors that contribute to healing and recovery. Connectedness starts when our pain is acknowledged and validated by someone who is actively and compassionately listening to us without trying to fix our problems.

There is no one way to be a peer worker, or “to do recovery”. No one size fits all. The more we can understand, communicate and collaborate when supporting someone on their journey, the more we can provide a personalised approach to support.

When you have completed this unit, you will be:

- Able to explain eating disorders peer work to others
- Aware of the value of your own lived experience and how this can contribute to helping others.

### Module Resources

The key resource for this unit is the National Eating Disorders Collaboration resource **[‘Developing a Peer Workforce’ Part B: The Peer Work Approach.](#)**

Symbols used in the resource:



Suggests that you may like to make a note of a key point and compare this with your expectations and experience.



Links that you can look up online.



A reference used for the resource that you can look up if you would like to do more reading.

## Activity 1.1

### Reflection before you begin:



What does peer work mean to me? What do I expect to be doing in my peer work role?

Now start reading the resource. Use the reflective journal questions below to help you to think about how the information in each section compares with your expectations and experience.

## Activity 1.2

Read the section on [Defining Peer Work](#)



How would I describe peer work to someone else?

What does 'creating new ways of engaging with life through supportive relationships' mean to me?

Did anything in this section surprise me or make me uncomfortable? Who could I discuss this with?

## Activity 1.3

Read the section on [The Peer Workforce: Who can be a peer worker?](#)



Can peer workers have different experiences of illness to the people that they support?

How is my experience valuable to someone else with similar experiences?

How can I use my experience to help someone who has had a different experience?

## Activity 1.4

Read the section on [The Peer Work Approach: What makes peer work different?](#)



"Recovery means breaking free of illness to be myself and finding and liking who I am – not just my body but who I really am as a person."  
(Butterfly Foundation, 2016)

What does recovery mean to me?

What does 'discovering life' mean in my life?

What are the most important things I have learned through illness and recovery?

## Activity 1.5

Read the section on [A Skills Based Approach](#)



What other skills can I bring to this role apart from my lived experience of an eating disorder?

What sort of skills would I like to develop in my work?

How open am I to learning skills that are not particularly interesting to me?

## Activity 1.6

Read the section on **Building trusting relationships**



What do equality and trust feel like in a relationship? How do I know when a relationship is safe?

## Activity 1.7

Read the following reflection on being human.



Graphic from NEDC Stories from Experience Resource



Why is it important to feel connected?

How does the feeling of connectedness support recovery?

What helps people to feel connected?

### Activity 1.8

Read the section on [A collaborative approach – working through mutual help](#)

“Peer work requires a commitment from all participants to listen and learn from each other.”



How do I know I am learning from another person?

How do people know I am actively listening to them?

### Activity 1.9

Read the section on [Many Different Roles: What do peer workers do?](#)



What sort of role am I most interested in? Why?

What questions do I need to ask about the role I am interested in?

### Activity 1.10 - Optional

If you are a family member or carer or you have an interest in peer worker roles for families and carers, read the section on [Peer Support for Families and Carers](#).



What are the daily challenges for a family member or supporter of someone with an eating disorder?

What sort of information and support do family members or supporters need to help them work with the treatment team?

What do family members and supporters need to help them to take care of themselves?

### Review Activity

Write down and/or verbally explain to someone else:

- How peer workers make a difference to other people's experience of recovery
- What you have learned about the value of your own experience by working through this unit?

## Taking it Further

Recovery oriented practice and strengths-based practice are both useful approaches for peer workers and the health professionals they work with.

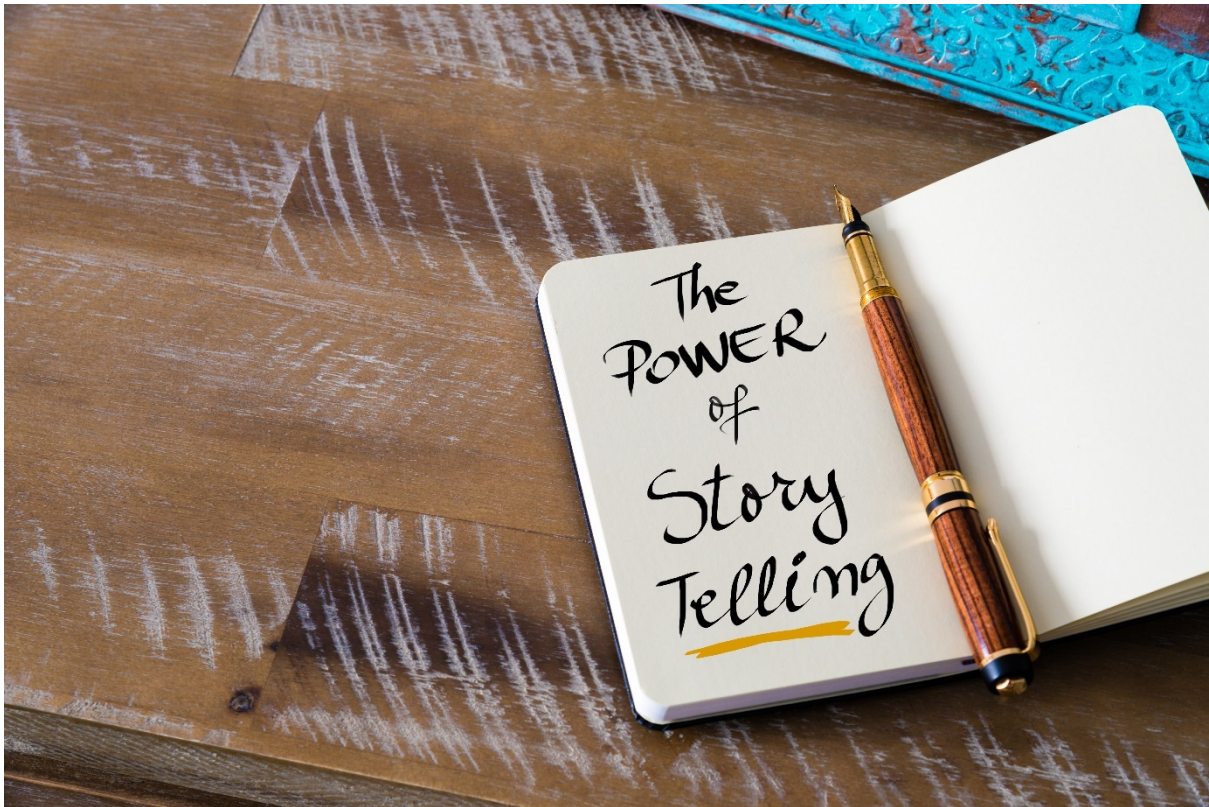
### **National Framework for Recovery-Orientated Mental Health Services**

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra>

### **Strengths Core Training Manual**

[https://recoverylibrary.unimelb.edu.au/\\_data/assets/pdf\\_file/0007/1391551/the\\_strengths\\_core\\_training\\_manual\\_june\\_2014.pdf](https://recoverylibrary.unimelb.edu.au/_data/assets/pdf_file/0007/1391551/the_strengths_core_training_manual_june_2014.pdf)

## Unit 2: Sharing from Experience





## Unit 2: Sharing from Experience

Sharing personal experiences is a powerful way of connecting with other people, helping them to think about topics they may not otherwise consider. The most important tool you have is your own story.

Telling stories of personal experience can feel empowering, helping you to build your self-esteem and confidence. On the other hand, sharing stories can also lead to stress, self-stigma and frustration. Learning how to share your story will make your message more powerful and help to keep you and the people you work with safe and well. Using writing to reflect on your experiences will help you to gain new insights into your own life.

This unit will explore some of the ways in which you can safely share from your experience to help others. It will also help you to use journaling as a way of continuing your learning from experience.

When you have completed this unit, you will feel more confident about your ability to purposefully and safely share from your personal experience.

### Module Resources

The key resource for this unit is the National Eating Disorders Collaboration online resource 'Stories from Experience' which you can access at [storiesfromexperience.com.au](http://storiesfromexperience.com.au).

You will need to register to use this resource. There are no costs or commitments involved in registering to use the resource.

For more information about the resource go to [www.nedc.com.au](http://www.nedc.com.au).

## Getting Started

### Activity 2.1 Sharing with Purpose

**Definition:** The reason for doing something; personal intention or objective.

People like to communicate. We chat, we email, we update our social media even when there is nothing much to say. We like to stay in touch and feel connected. Sharing with purpose is a little different. We set out with the hope of achieving something more than staying in touch. The more important the thing we want to achieve, the more preparation we need to make sure that what we say will be 'fit for purpose'.

Your purpose and the needs of the people you support will make a difference to what you share and how you share it. Work out why you want to share from your experience. What are you hoping to achieve? Having a clear purpose will help you to choose the right information to share in each situation. It will also help you monitor your own comfort as you share your story and decide to stop if you aren't achieving your purpose.



Why do I want to share from my experience?  
How will I know if I am achieving my purpose? What will I see happening?

**Tip:** When you think about your purpose, don't stop with your first thought e.g. "I want to make sure no one else has to go through this alone." Push a little deeper. Ask yourself 'why?' And then ask why again. Why do you want this?

## Activity 2.2 Introduction to writing

Read the following notes from [Stories from Experience](#):

Experiencing something different from your peers feels like it puts us on the outside looking in.

Research suggests that having unusual experiences, even when they are very positive, has a social cost, making it harder for us to share with friends and feel part of a peer group. On the other hand, having a shared experience of pain or difficulty can help to bond us with our peers which helps to explain the value of peer support.

The best preparation for sharing your experience with others is to write it down for yourself. Writing your story down gives you the chance to safely explore and understand your own experience.

Writing down your story can allow you to impose order, structure and meaning onto the events or experiences that have shaped your life. Writing involves organising our thoughts in a way that helps us to make sense of our experience. Writing not only gives meaning to our experience and allows us to reflect, but also helps us guide, shape and decide on our future actions.

Writing can be helpful if it:

- Helps you to step back and look at your experiences from a different perspective
- Gives you an opportunity to express your feelings
- Helps you to explore opportunities and solve problems
- Helps you to connect with other people
- Gives you an opportunity to express yourself creatively.

Writing can be less helpful if you use it to:

- Keep going over difficulties and dark times in your life or particular events or worries
- Substitute for talking to other people
- Try to write the perfect piece – there is no such thing!

Start by writing only for yourself. Create a private space in your writing where you can be honest with yourself. You can decide later whether to share your writing with others or not. Writing a little everyday can be very helpful. Try to set aside at least 15 minutes each day. Research has shown that writing down feelings for a short time

everyday can improve both physical and mental health. You can write in longhand or type your story on a computer, or use pictures or doodles – whatever works for you. An alternative to writing could be a video journal. Recording yourself as you recount your experience can be helpful preparation for sharing with other people.

Some of us are natural 'list makers' rather than story tellers. Writing lists can be a simple way to start writing about your life. If you think carefully about each list – maybe selecting your own top ten items – list writing can help you to organise your thoughts and give you something to refer back to on difficult days.

**Action:** If you have not already started to keep a journal as you work through this learning program, consider starting one now.

### Activity 2.3 Using the Stories Resource

Stories from Experience is a learning resource, available online or in hard copy, designed to help people with experience of eating disorders to:

- Reflect on their experience
- Make decisions about safely sharing their experience with others
- Practice writing and speaking about their experience
- Listen and respond appropriately to the experiences and needs of others
- Construct purposeful stories to achieve specific goals
- Share evidence-based information about eating disorders as well as personal experience
- Access information about recovery and consumer participation.

The underpinning premise of the Stories from Experience resource is that writing and strengthening connections with other people can be positive for personal mental health recovery if approached in a constructive, safe and supported way. The resource also explores the idea that sharing from lived experience may enhance motivation for recovery in others and contribute to positive community awareness of eating disorders. The resource is designed for adults who have experience of an eating disorder and of the personal journey of recovery who are motivated to share their story of experience with others.

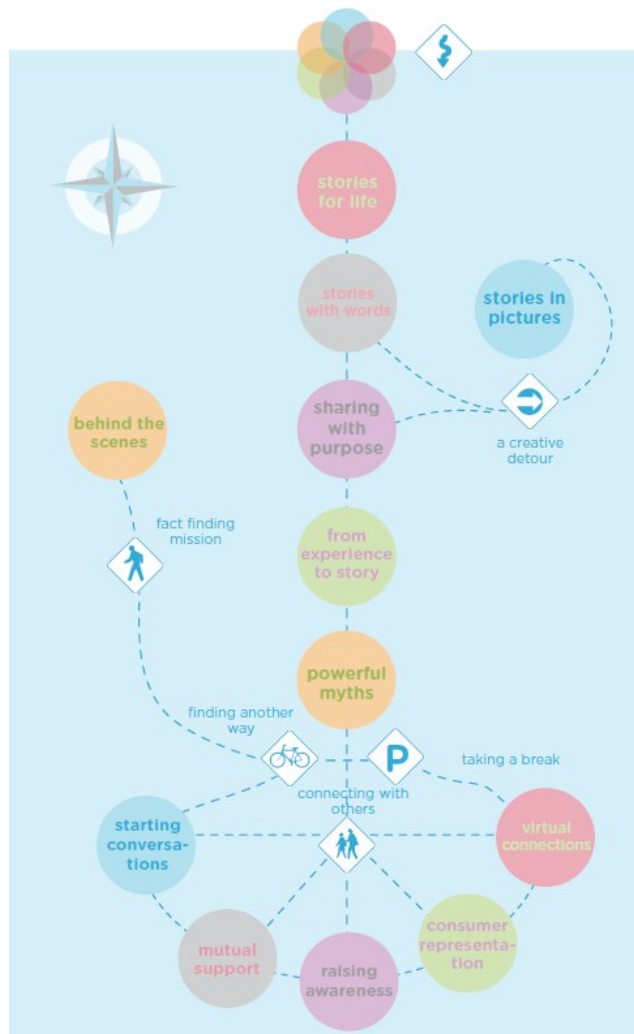
The resource provides a broad range of readings and activities that can be used individually or sequenced together for a longer learning program. The resource is intended to be used as an interactive resource with peer groups in either a face to face or online environment.

Stories from Experience is not meant to be read like a book from beginning to end. It is something to dip into to find the bits of information and the activities that are right for a particular person or group. You can choose topics to meet your needs or interests.

The recommended modules for people who are preparing for peer work roles are:

- **Sharing with Purpose**
- **From Experience to Story**
- **Mutual Support** – exploring approaches to peer to peer support
- **Powerful Myths**

**Action:** Select a module to start on and work your way through the activities that are of interest to you. If you are learning in a group, you may be asked to focus on specific activities in the resource.



## Activity 2.4 Meeting Hope

Read the following extract from **Stories from Experience**:

Hope is at the heart of recovery.

The kind of hope needed to recover from an eating disorder isn't wishful thinking. It isn't 'crossing your fingers and hoping.'

Hope is something much stronger, an anchor, a rope to hang onto, something that we choose to pursue in good times and in bad. Hope is not passive; it is the foundation of self-directed action. It grows through learning and discovery of what works and what does not.

Hope is the faith and knowledge that there is something better to work towards, despite any inherent challenges. Hope is the belief that you can make a difference in your own life and in the lives of others.

- **Motivates:** Hope sustains motivation and supports expectations of a personally satisfying life

- **Accepts:** Hope recognises present reality and works with it to create a better future reality
- **Questions:** Hope explores options and asks the question 'how can I make this work for my life?'
- **Strives** to overcome adversity, committing to the effort of change
- **Looks forward** rather than dwelling on the past
- **Celebrates** the small steps.

Hope is not the same as optimism. Hope and optimism go together but they have differences. Optimism expects the best. Hope drives us purposefully toward achievement of our goals.

## Reflection

One of the positive things that we can offer to other people when we share our story is hope.



What is my story of hope?

What was I hoping for when I started my journey of recovery and how has my hope changed?

What am I hoping for now?

What hope could my story hold for other people?

## Activity 2.5 Define your own safe boundaries

Read the following extract from **Stories from Experience**:

"The most difficult aspect of telling your own story is that it is about you. It is often painful to remember and sharing personal pain with others is not something that everyone can do."

There are risks in telling your story to another person:

- The experience may stir up negative feelings or make you feel stressed or frustrated
- Once other people remember your story, they can also use it for their own purposes and you can lose control of something that is very personal to you
- If people can identify you then you may lose your privacy
- Other people may not understand your story or respond to it in the way that you hoped
- Other people may be at risk if your story triggers difficult feelings for them.

The first step to telling your story is to make the decision that you can safely share your experience with someone else. Your safety and wellbeing are the most important things. It is up to you to weigh up the pros and cons of telling particular people specific information about your life.

In most situations, it is best to keep your story brief and to the point. You do not have to tell other people the details of your life unless you want to and it is safe for both of you. The less well you know people and the less familiar they are with you, the more carefully you need to select the information that you share in your story.

### **Define your own safe boundaries**

Some areas of life are too personal or painful to share. Others could put other people at risk. It is important to work out your boundaries for safe story telling from the beginning. It is a good idea to start with fairly strict boundaries about what you will and will not share with other people. You can always revisit and change your boundaries later if you need to; you cannot get information back once it has been shared.

The detail of the story is not as important as the learnings and lessons from the story; what did this mean for your recovery and how might it be important for the recovery journey of the person you are working with? Remember that peer work is not about you, but about how you can use your journey to support others. Think about how the person you are working with, will feel when hearing your story and how relevant it is to the place they are in right now. What is the message of the story for the other person?

Writing your story down before you share it is one way to make sure that you only use the information that you feel safe sharing with others. You may also find it helpful to write down a list of things which you definitely will not tell others as a personal reminder.

### **Reflection**



Are there some things that I really don't want to share with others right now?  
What can I do to politely avoid sharing this information?

### **Information that should not be included in personal stories**

Read the following extract from the NEDC guidelines on safe sharing:

Everyone's experience of eating disorders is different. Personal stories should not attempt to represent definite answers on what causes eating disorders or recommend one type of treatment over others as the right approach.

When you share from experience try to avoid including the following types of information:

### **Measurements and behaviours**

Stories about eating disorders should avoid the use of specific descriptions of behaviours and avoid measurements or other quantifiable details (e.g. weight, BMI, number of admissions to hospital, number of hours of exercise or number of repetitions of exercise, calorie intake, etc.). People who have eating disorders can experience competitive impulses and inclusion of this information may suggest targets for other people to try to achieve.

### **Identifying information**

The purpose of sharing is to inspire positive change. Specific criticism of individuals or organisations should not be included in personal stories.

Everyone has the right to tell their own story. If you know details of other people's experience these should not be a focus of your story. Stories should not include any information that would identify other people – this includes other people with experience of eating disorders and health professionals or other service providers.

### **Reflection**



Have I heard stories from experience that felt uncomfortable? What was it about those stories that did not seem right?

How easy is it to avoid these things when sharing from experience?

## Activity 2.6 Purposeful sharing

Read the following:

Self-disclosure is a part of human relationships; we all share information about ourselves directly or indirectly. The self-disclosure that is central to peer work is intentional, using personal information to help another person understand and respond to their own experience.

Purposeful story telling is a planned approach that can be practiced to increase skill and that reduces the risk of accidental disclosure or unintended harm. The aim of purposeful story telling is to ensure that information shared is carefully selected to support the other person's recovery process. The PACT acronym – pause, assess, connect, test - is one framework for working out what to purposefully share.

### **PAUSE**

#### **Wait for a moment before sharing**

- Listening may be more important to the other person than what you have to say.
- Reflect on your own experience and identify the parts of your experience that may help the other person understand their own situation.

### **ASSESS**

#### **Am I OK sharing this?**

- What is your intention? Why do you want to share?
- Is the story you want to share about the process of recovery or about illness? It can be helpful to empathise with the experience of illness, but purposeful sharing generally focusses on problem solving.
- Are you comfortable with the level of disclosure this story will involve?
- Are you sufficiently distanced from the original experience to feel in emotional control? Have you reflected on this enough to be able to understand your own experience from different perspectives?

### **CONNECT**

#### **Make the link between their need and your experience**

- How is the information you want to share useful to the other person?
- What links can you make between your information and what the other person has said?
- How can you share your information in a way that is meaningful to the other person?



### TEST

#### Start with a small amount of information

- Share briefly from your experience. Long narratives are usually not helpful when shared in conversation.
- Check for verbal and non-verbal cues as you share, especially any negative feedback
- Respond to questions

Adapted from Roberts, J. (2013). "Therapist Self-Disclosure" Psychotherapy Networker Symposium, 2013.

**Action:** Find a friend to work with and practice the PACT approach to sharing.

### Activity 2.7 Am I ready for purposeful sharing?

Think about the questions in the checklist below and write in your journal.

- Am I able to talk about my experience of eating difficulties and the struggles I have been through without being visibly distressed?
- Can I reflect on difficult times and still be available and present for other people?
- Have I learned from my experience of illness and am I able to speak about the process of recovery and why it was worth it?
- Am I comfortable with the fact that there is no 'one size fits all' way to recover from an eating disorder and that everyone needs to change at their own pace and in their own way? Can I avoid comparisons of ED experiences?

Adapted from Caswell & Logie, Reaching Out for Hope, republished in NEDC Stories from Experience Module 8, 2015

### Review Activity

Select a part of your experience of recovery that you think inspires hope and write it down and/or verbally share with someone you trust.

Reflect on how confident you feel sharing and what else you need to do to build confidence in purposeful sharing.

## Taking it Further



If you would like to explore the idea of keeping a journal or other writing activities for wellbeing here are some suggested readings:

Alexander, J. (2016). **Using Writing as a Therapy for Eating Disorders: The Diary Healer** (1<sup>st</sup> Ed). London, Routledge. Find information about this publication at <https://www.thediaryhealer.com/>

Dowrick, S. (2007). **Creative Journal Writing: the art and heart of reflection**. Crows Nest, Australia, Allen and Unwin.

DeSalvo, L.A. (2000). **Writing as a Way of Healing: How Telling Our Stories Transforms Our Lives**. Beacon Press.

Pennebaker, J.W. (2004). **Writing to Heal: A Guided Journal for Recovering from Trauma and Emotional Upheaval**. Oakland, CA, New Harbinger Press.

# Unit 3: Thinking about Eating Disorders



## Unit 3: Thinking about Eating Disorders

Everyone here has unique knowledge of eating disorders based on personal experience. We all know that the experience of an eating disorder is highly individual. Other people with eating disorders may not see things in quite the same way as us; their experiences may be different to ours. The perspective of health professionals may be different again depending on their experience.

The purpose of this session is to review some key clinical information about eating disorders from the perspective of lived experience. At the end of this session you will be able to:

1. Describe the most common types of treatment available for eating disorders and the reasons why these are used.
2. Explain the role of different professionals and family members in the treatment team.
3. Describe clinical and personal perspectives on recovery and person-centred care.
4. Apply lived experience to help people with eating disorders, families and health professionals to understand treatment from different perspectives.

### Module Resources

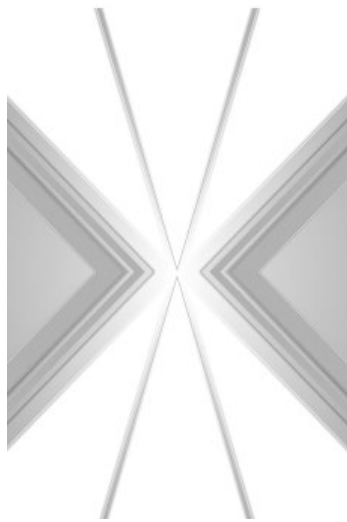
The full text of the workshop is included in this resource. For more evidence-based information go to [www.nedc.com.au](http://www.nedc.com.au).

**Note for group workshops:** the information in this unit is also available as a Power Point slide presentation.



## Getting Started

Read through the information below at your own pace. Reflective questions and suggested activities appear after some slides.



# Diagnosis

What is an eating disorder?

Let's start with the diagnosis. Getting a diagnosis can feel like having a label slapped on you or being put in a box. Or it can feel hopeful, even liberating, proving that this is really an important health issue and that something can be done about it.



For reflection or discussion: How do you feel about diagnoses?

A diagnosis does not define the person. A diagnosis simply helps the health professional to find the right starting place for treatment. It isn't intended to be a description of the whole person and it shouldn't restrict access to treatment. When used the right way, a diagnosis can be the key to the door that opens up treatment pathways.

## DSM-5

Characterised by frequency of food and weight related behaviours

- Anorexia nervosa – disturbed body image; intense fear of weight gain; restriction of energy intake relative to need.
- Bulimia nervosa – recurrent episodes binge eating; unhealthy compensatory behaviours to prevent weight gain.
- Binge eating disorder – recurrent episodes binge eating without compensatory behaviours.
- Atypical presentations (OSFED) e.g.
  - Atypical AN – weight within or above normal range
  - Subthreshold BN and BED – low frequency or limited duration
  - Purging disorder – recurrent purging without binge eating.

The most frequently used diagnostic criteria are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This is published by the American

Psychiatric Association but is developed through international consultation and consensus building with health professionals.

You are probably familiar with the main diagnostic descriptions. The common characteristic is food and weight related behaviours and beliefs. A diagnosis of one type of eating disorder is not any more or less serious than another eating disorder classification. All eating disorders are serious and life-threatening mental illnesses.



What about other presentations? Are you aware of any other forms of eating disorders?

**Note:** If you would like to know about each type of eating disorder in more detail go to [www.nedc.com.au](http://www.nedc.com.au)

## Transdiagnostic

All ED are complex mental illnesses with potential for severe presentations and medical complications.

- Shared core psychopathology. Clinical features maintained by similar processes
- Unhealthy and persistent eating or exercise behaviours
- Very low self-worth and intense psychological distress
- Cross-over between diagnoses over course of illness
- Associated with:
  - Significant physical and nutritional complications
  - Cardiac complications
  - Increased risk of suicide
  - Very poor mental health related quality of life

Eating disorders are clustered together in a group because they have more in common than they have differences.

As you may know from experience, diagnosis can change over time. All eating disorders have a serious and significant impact on people's health and quality of life.



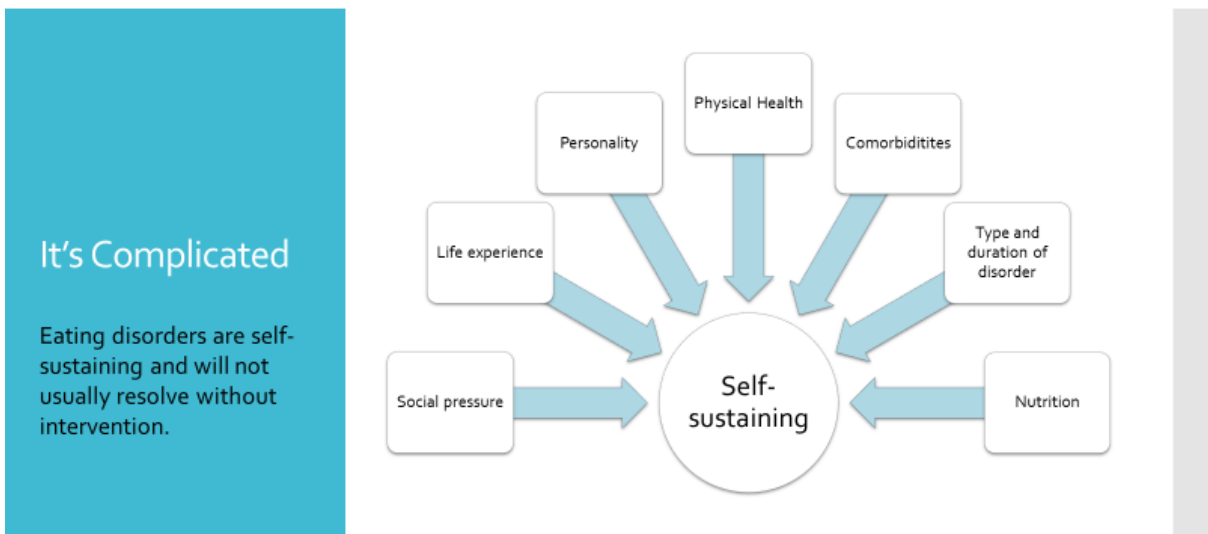
How would you describe the impact that an eating disorder has on health and quality of life?



People who have eating disorders are a diverse bunch! It is easy to lose sight of uniqueness when we wear a diagnostic label.



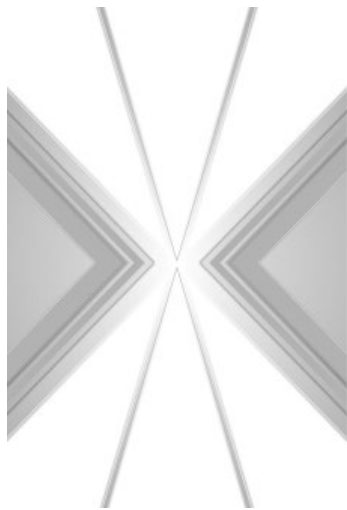
How does it help when people are recognised for all their characteristics rather than their diagnosis?



We talk about eating disorders as being complex. What this means is that there are many factors that contribute to the eating disorder. All of these interact which helps to keep the eating disorder going. This is why we say that eating disorders are self-sustaining and that some form of treatment intervention is most likely to be needed.

**Activity:** if you have a partner or are learning in a group, share from personal experience on how some of these factors worked to sustain illness. Were there other factors for you that are not listed on the screen?

If you are working through this module on your own, try writing in your journal about the factors that contributed to your experience of an eating disorder.

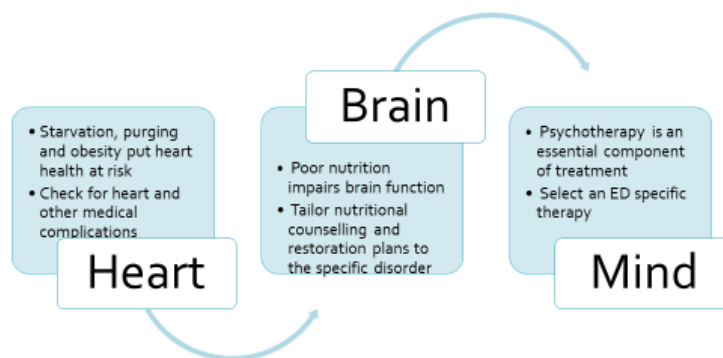
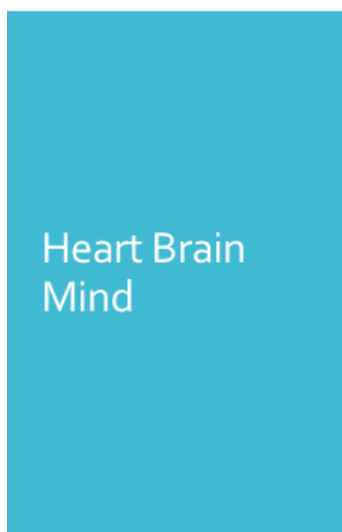


## First Steps to Treatment

Understanding medical assessment

In this section we are going to look at some of the common first steps and priorities in treatment.

As you read through this, remember that you or the people you work with may not have had these experiences in treatment.



This is a simple way of looking at the priorities of health professionals when they are treating someone with an eating disorder. Physical safety and medical stability are the first concern. Nutrition for good brain function is the second. Even though eating disorders are mental illnesses, psychological treatment may not be the first approach to treatment.



## Safety Standard

Safe treatment addresses all aspects of illness: medical, psychological and nutritional

“Safe treatment of eating disorders addresses all aspects of illness: physical, psychological, nutritional and functional” (National Standards Schema, NEDC, 2012)

- Consider team treatment:
  - GP or Paediatrician
  - Psychologist or other mental health professional
  - Dietitian

The standard to look for in any treatment for an eating disorder is a multi-disciplinary approach – a treatment team –that can take care of all the aspects of the eating disorder.

Multi-disciplinary team care is becoming more common but not everyone receives this – and not everyone wants it. Some people choose to receive their treatment from one health professional or only have access to one health professional in their community.

**Activity:** If you have a partner or are learning in a group, share from your experience of team care and discuss ways in which you can support someone to maintain their physical and nutritional health.

If you are working through this module on your own, try writing in your journal about the different ways in which people can do something about all the aspects of their eating disorder.

## Clinical Practice Guidelines RANZCP

Recovery oriented practice that emphasis person-centred care and choice.

- Person-centred informed decision-making
- Involving family and significant others as partners in the assessment and treatment process
- Recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues
- Maximises choice, self-determination and self-management of mental health and wellbeing; supports positive risk-taking
- Assists families to understand the challenges and opportunities arising from their family members' experiences
- Provides evidence-informed treatment, therapy rehabilitation and psychosocial support that helps people to achieve the best outcome for their mental health, physical health and wellbeing
- Works in partnership with consumer organisations and a broad cross-section of services and community groups; Embraces and supports the development of new models of peer-run programs and services
- Promotes safety while taking into consideration the dignity of risk

Adapted from: The Royal Australian and New Zealand College of Psychiatrists **Clinical Practice Guidelines for the Treatment of Eating Disorders** (Hay et al., 2014).

The information on this slide comes from the Royal Australian and New Zealand College of Psychiatrists guidelines on the treatment of eating disorders. Read through the list and think about what each standard means for you.



What stands out for you about this list of recovery-oriented practice standards?

How could you use knowledge of these standards to help someone else with an eating disorder?

How could you use this knowledge to help health professionals develop their recovery-oriented practice?

## Medical Assessment

- Medical assessment includes:
  - Specific signs and symptoms of eating disorder
  - Evidence of malnutrition, laxative use or excessive exercise
  - Weight, BMI and weight history
  - Seated and standing blood pressure and pulse
- Consider potential compromise in cardiovascular, gastrointestinal, endocrine, hematological, skeletal and central nervous system
- Investigations include:
  - Full blood count
  - Electrolytes
  - Hydration
  - Liver function
  - Cardiac function

It may be a while since you have gone through medical assessment. The medical assessments for an eating disorder can be extensive. The doctor must take into consideration the potential for compromise to every organ in the body. Blood and other tests need to be repeated on a regular basis to make sure that the person's physical health is stable and to alert the treatment team to the need for hospitalisation.

While a peer worker is not responsible for medical assessment you can play an important role in supporting and motivating the person to undergo medical reviews. Some people with eating disorders may have negative fears about doctors, being weighed and having invasive tests. A peer worker may work with the individual to help allay these fears and support the person to maintain regular medical monitoring.



What could be helpful for someone who is being regularly medically assessed?

How can you support someone to see their GP if they are reluctant to do this?

Measuring weight is a vital part of assessment, partly because weight loss or gain may be an indicator of physical health but because learning to feel comfortable about weight and food is part of the recovery journey.



What could be helpful for someone who struggles with being weighed or thinking about weight?

## Family feelings

Family members are the frontline in identification of ED and support for ED treatment.

*"You need an intentional social support team. It doesn't have to be immediate family; it can be friends or peers. You need someone there with you for the long term. You can't get over an ED by yourself".  
(Butterfly Foundation, 2016)*

- Families need help to understand ED
- Include in treatment for children and young people
- Ideally included in treatment team for anyone with a complex presentation and expected longer course of treatment
- Assist families to reduce stress, anxiety and self-blame

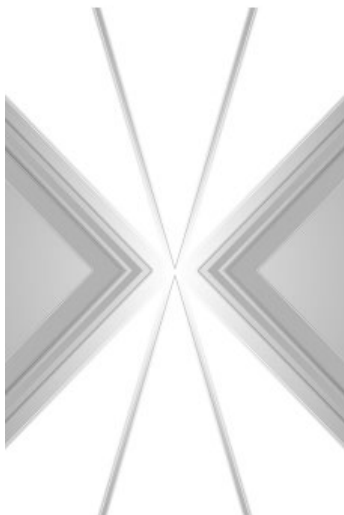
The standard for good care for someone with an eating disorder is to involve the family as much as possible. This could mean a parent, sibling, partner or perhaps a 'family of choice,' i.e. people who the person chooses to have involved in their care.



How do you feel about having family or friends involved in treatment? What is challenging about having family or friends involved in treatment?

What might help to reduce stress for the person and their family?

Take it further: Read the section on family and carers as peer workers in [Part B of Developing A Peer Workforce](#).



## First Line Treatments

What are the options?

The people you support may receive different treatments to those you are familiar with. Even if they have the same type of treatment, they may experience it differently. The relationship with the treatment team makes a big difference to how people think about their treatment.

Reflection or group discussion: what really makes the difference in treatment?

## First Line Treatments

- Guided Self Help CBT
- Cognitive Behavioural Therapy Enhanced CBT-E
- Family Based Treatment FBT
- Specialist Supportive Clinical Management

A small number of therapeutic approaches have been developed specifically for the treatment of eating disorders. No single treatment approach has been shown to be effective for every person with an eating disorder, so the selection of approaches must always take into consideration the individual, their family and social context, the diagnosis, the stage and longevity of illness, and comorbid conditions.

People may need several episodes of treatment during their illness and different treatment approaches may be required at different stages of illness.

### **CBT Guided Self Help (GSH)**

For people with bulimia nervosa or binge eating disorder, treatment may start at the least intensive level with guided self-help. This is a cognitive behavioural (CBT) approach in which the person makes self-directed progress through a program while receiving support through regular sessions of professional guidance. This is a safe way to start treatment and can be effective for around 20% of people with these disorders (Wilson and Zandberg, 2013; Perkins, Murphy et al., 2006). It is not recommended for people with anorexia nervosa or with eating disorders characterised by severe restriction.

### **Cognitive Behavioural Therapy – Enhanced (CBT-E)**

CBT-E was developed as a treatment for all types of eating disorder.

It is the leading treatment for bulimia nervosa and for binge eating disorder and seems to work effectively for around 40–60% of individuals (Hay and Touyz, 2012). CBT-E is usually delivered for twenty 50-minute sessions for people with bulimia nervosa and binge eating disorder and forty sessions for people with anorexia nervosa.

### **Family Based Treatment (FBT) (also called Maudsley method)**

FBT is an intensive community-based treatment, in which parents take on the role of delivering the treatment in the home, with support from a professional health care team. This treatment has three phases which occur over a period of 6-12 months, and which involve the entire family in weekly to monthly sessions for parents and

siblings. Sessions periodically entail family meals under the guidance of a health professional.

FBT is the first line treatment for children and adolescents with anorexia nervosa (NICE, 2017) who have had the disorder for less than three years (Le Grange et al., 2010). A typical course of FBT is twenty sessions of treatment (Lock, Le Grange et al., 2010; Le Grange, Crosby et al., 2007; Couturier, Isserlin and Lock, 2010; Treasure and Russell, 2011). However, the course of treatment may require additional sessions for children and adolescents with complex issues and those who have not responded to the first twenty sessions.

FBT was specifically developed as a therapy for the treatment of anorexia nervosa. The treatment has since been adapted to treat bulimia nervosa (FBT-BN) and to provide treatment for adults.

Family based therapy has been adapted for delivery to parents or caregivers. This parent focussed approach is just as effective as the more traditional approach (Le Grange, Hughes et al., 2016). Multi-family therapy approaches which bring families together in groups are also effective (Eisler, Simic et al., 2016).

### **Specialist Supportive Clinical Management (SSCM)**

SSCM combines clinical management to alleviate symptoms with a supportive therapeutic style to provide community-based treatment for adults with anorexia nervosa. The primary goals of SSCM are resumption of normal eating and restoration of healthy weight achieved through a positive relationship with the therapist (Jordan, McIntosh, and Bulik, 2015).

There are many other therapies that can be helpful for eating disorders. Some of the common ones that people may experience include:

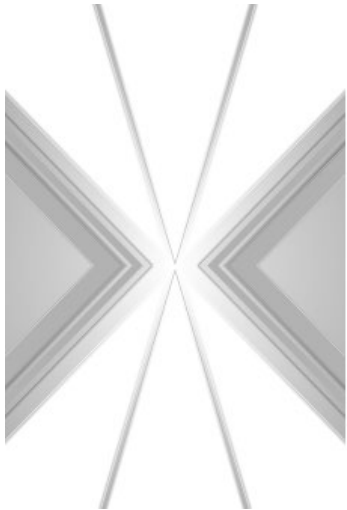
- Dialectic Behavioural Therapy (DBT)
- Motivational Interviewing
- Acceptance Commitment Therapy (ACT)
- Narrative Therapy



If you would like to know more about treatment for eating disorders go to [www.nedc.com.au](http://www.nedc.com.au)

Two new therapies that you may come across are self-compassion and temperament based treatment:

- Self Compassion for Eating Disorders - [https://self-compassion.org/wp-content/uploads/2016/06/Braun\\_2016.pdf](https://self-compassion.org/wp-content/uploads/2016/06/Braun_2016.pdf)
- Temperament Based treatment for Eating Disorders <https://www.nedc.com.au/professional-development/event/67/temperament-based-therapy-with-supports-tbt-s>



## Perspectives on Recovery

One word – many journeys

The most widely used definition of personal recovery was written by Anthony (1993):

“...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. Personal recovery is the process of change through which people improve their health and wellbeing and their quality of life.”

The journey of personal recovery is a unique and individual process of change as the person works towards living what they define as a satisfying and meaningful life (Glover, 2010). Recovery “means different things to different people. But most people agree that a person in recovery is working to take back control of his or her life and achieving her or his own goals and dreams” (Copeland, 2006).

The National Standards for Mental Health Services (Department of Health, 2010) acknowledge “that each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them.”

There is no single solution that suits every person with an eating disorder and it is therefore vital to consider and apply the perspectives of the individual, as they are the ones who decide how they engage in treatment and work towards recovery (Yu, Agras & Bryson 2013).

(Text extracted from Insights in Recovery, The Butterfly Foundation, 2016)

## Recovery Criteria

- **Diagnosis** – no longer meeting diagnostic criteria
- **Behaviour** – no longer engaging in eating disorder behaviours
- **Physical health** – weight within healthy BMI range and/or improved general health measures
- **Psychological** – positive attitudes to one's self, food, the body, expression of emotions and social interaction
- **Practical** – quality of life including capacity for engagement in work or education, and leisure

(Bardone-Cone, et al., 2010)

Most people who have recovered think that recovery is not just about diagnostic criteria, but about self-acceptance, having a social life, having a relaxed attitude to food and being able to express emotions (Björk & Ahlström, 2008). Personal recovery means building a better future, founded on the person's present circumstances. Every experience of recovery starts from a different place and leads to a different, personally-defined concept of recovery (Dawson, Rhodes & Touyz, 2014); there is no standard or universal goal to be achieved.



Reflection or Discussion: What does recovery mean to you?

## No straight lines

Realistic expectations of  
recovery

- Recovery is possible for everyone and is the goal of treatment BUT...
- Unrealistic expectations of recovery may trigger increased ED symptoms, anxiety, depression or self-harm
- Set-backs and relapse are an expected part of the learning process in recovery

Recovery has been described as a 'long journey' and a 'non-linear' experience. It can sometimes feel as if you are going around in circles or some people talk about a roller coaster ride of ups and downs.

Support during the highs and lows of recovery can make a real difference to sustained recovery.



Reflection or Discussion: how do you balance hope for recovery and the realities of the recovery process?

## Insights from Recovery

When you are struggling to understand and accept your self you need others to help you to feel safe.

- **Help me...** the whole person in the context of my family and friends, my life and dreams
- **To feel...** to deal with my thoughts and feelings in a positive way
- **Safe...** to feel understood, less afraid and more hopeful in my journey through recovery

(Insights in Recovery, Butterfly Foundation, 2016)

What people seem to want most from their treatment team is a feeling of safety.



Reflection or Discussion: What helps people to feel safe?

## Review Activity



What have I learned about eating disorders from this unit?

- What do the different eating disorders have in common?
- What are the common types of eating disorder treatment?
- Why is a multi-disciplinary team approach recommended for treatment?
- What is the role of family or other supporters during treatment?

What are the limits of my knowledge? When is it important to get professional advice?

How would I describe recovery?



Write and/or verbally share how you can explain to a health professional or family member how treatment may be understood by the person receiving treatment.

Reflect on your own comfort with difference and difficulty:

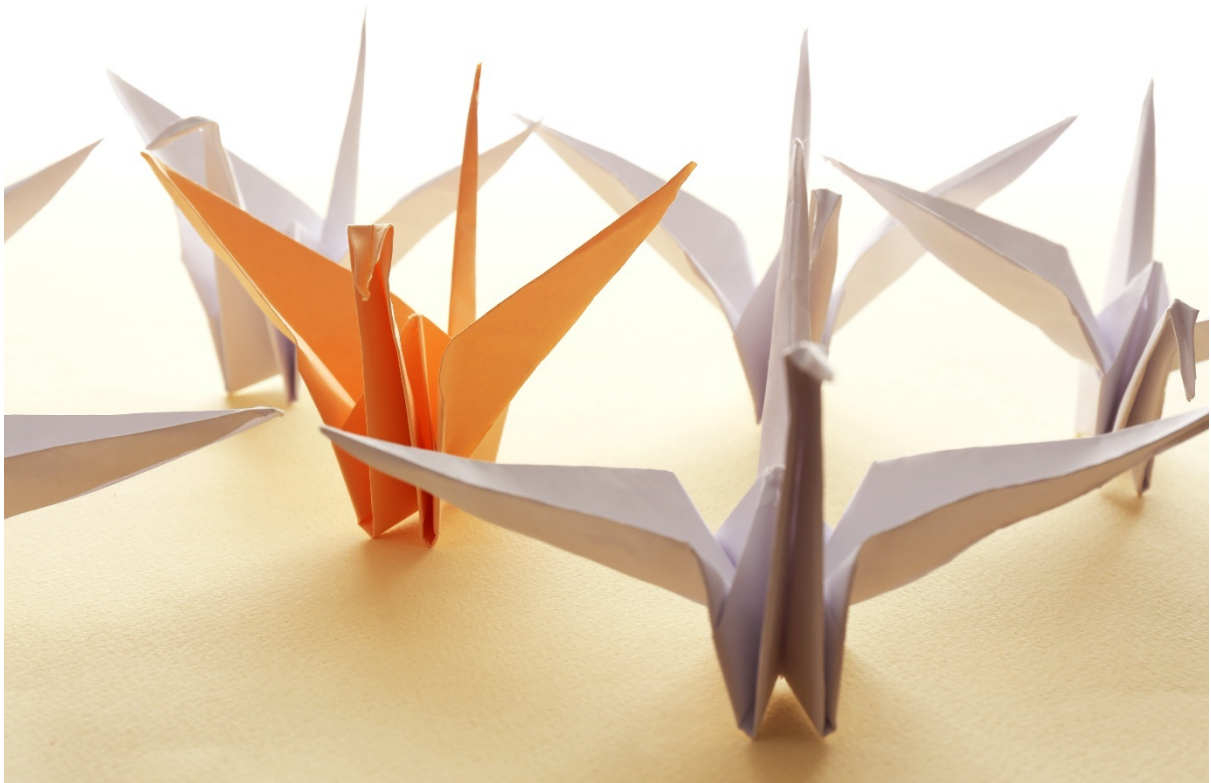
- Am I comfortable with the fact that there is no 'one size fits all' way to recover from an eating disorder and that everyone needs to change at their own pace and in their own way?
- Am I comfortable with the idea that recovery is always possible while still acknowledging that the process is often difficult and distressing?



## Case Study

**Note for training organisers:** We suggest introducing one or more case studies from your work context for learners to practice application of their own experience to other people's situations.

## Unit 4: Staying Safe



## Unit 4: Staying Safe

### Overview

Peer work involves emotional labour. That means it involves using and managing personal feelings as an essential part of the work role (Mancini and Lawson, 2009).

“Sharing from lived experience requires courage. We are sharing from the most vulnerable and often hidden parts of our lives to help others. Dipping into what is often some of our darkest experience and relating it to a new situation can take time, reflection and sheer hard work.” (Cook, 2016).

Working on our personal safety and wellbeing is so important for peer work that it is part of the competency standards for peer workers in eating disorder services.

If we are expected to model recovery for others, we also need to be practicing self-care strategies and need to know how to recognise when we are at risk and ask for the help we need. This unit will help you to plan and develop strategies to exercise self-care and take charge of your health and wellness.

At the end of this unit, you should be able to:

- Recognise “The Wellbeing Thermometer” and the moving spectrum of wellness
- Identify the signs, symptoms and potential triggers of unwellness
- Describe and discuss what is self-care
- Create and develop a personal wellness action plan
- Establishing boundaries for self-care (Refer to unit 1 on the Peer Work Approach).

### Activity 4.1 What makes peer work challenging?

Some of the things that add to the stress of eating disorder peer work roles include:

**Caring** – we know that being a family member or carer of someone with an eating disorder can be very stressful. Peer workers can take on some of this stress when they provide support. Setting firm boundaries helps but even with these in place we hear and hold onto some very difficult stories from the people we work with and this affects our own wellbeing.

**Remembering** – listening to the experience of others can bring back difficult memories of our own illness and treatment. Sometimes this takes us by surprise; we may be reminded of an event that we had been avoiding thinking about, or we may start to understand our experience differently when we see what happens to other people. Peer supervision, mentoring and having access to our own mental health professional can all help when difficult memories are triggered by our work.

**Miscommunication** – when other people do not seem to understand what you are doing or trying to achieve through your work this can increase your experience of stress or fatigue. Being strong in recovery often means educating those around us about the peer work role and what it is really like to work in this way, advocating for peer work and for mentally healthy workplaces.

**Comparison** – we all compare ourselves with other people around us from time to time. One of the risk areas for those of us with experience of eating disorders is body comparison. Most people feel some dissatisfaction with their body. It has become normal in our society to compare our bodies with those of other people and want to lose a little weight or tone up our muscles. If you have had an eating disorder these activities are potentially quite dangerous.

Warning signs to be aware of include:

- Being tempted to buy diet products
- Joining bootcamp or extreme exercise programs
- Cutting back on meals or food groups
- Noticing that something has become 'fattening' that was previously fine
- Finding it difficult to get dressed for work
- Commencing hateful or critical self-talk
- Resuming weighing
- Becoming overly involved with Instagram or other social media platforms
- Being interested in self-harm or wishing to be an inpatient
- Over-eating, drinking or medicating to deal with emotional overload.

If you feel tempted to compete with other people around body image issues, then consider using a body image self-evaluation tool to monitor your own thoughts and help you to role model body satisfaction for the people you support.

**Activity:** Try using the Confident Body Confident Child body image self-assessment tool <http://www.confidentbody.net/activity-1-what-is-your-body-image.html>

### **Feeling Guilty**

When everyone around you seems to be working long hours and coping well, it is easy to feel guilty when you need time out for self-care. Recognising the signs in our own life that things aren't quite right and asking for help are really signs that we are self-aware and modelling recovery.

### **Perfectionism**

There is a relationship between perfectionism and the development and maintenance of an eating disorder (Bardone-Cone et al., 2010). Perfectionism is a way of understanding the world that involves setting unrealistically high standards and then judging our worth based on our ability to achieve these standards. People

with eating disorders may undervalue themselves and work extra hard to prove themselves when this is not necessary.

**Activity:** Read some of the resources on perfectionism available from the Centre for Clinical Interventions:

<https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Perfectionism>



How can I manage my tendency to set unrealistic standards for myself?

## Activity 4.2 Using the Wellness Thermometer

Mental health is a state of wellbeing and refers to our emotional, psychological and spiritual health and how we feel about ourselves and the world around us. Mental health helps us to realise our own potential, cope with the normal stresses of life, work productively and positively contribute to our community.

We all experience bad days where our motivation may not be at its peak; we may feel stress by deadlines, work obligations or family pressures. Problems occur when feelings of anger, frustration, grief and sadness remain with us for too long and affect our ability to live and function.

Mental health problems can cause changes in our thinking, behaviour and emotions, and can manifest into physical symptoms. These in turn impact on our ability to work and maintain healthy and positive relationships. These health problems or illnesses can be complex and confronting.

Appropriate and timely guidance, information, support and understanding can make a real difference to someone developing a mental health problem or any health issue. The “Being Human - Our Wellbeing Thermometer” (see image on the next page) is a simple self-help concept to help us see where we may be at a point in time in our health and wellbeing. This is a useful indicator of when health is slipping. The signs and symptoms reflect declining health.

Where we find ourselves on this continuum may change at different times, moving from the green end of the spectrum towards the middle end and back again with the normal challenges and peaks and troughs of life. Many of us may be able to relate to being in the yellow zone at times.

Some people, though, may not recognise when they are slipping down the thermometer. For example, not eating or sleeping well, gaining or losing weight, getting many colds, headaches, stomach aches, or reaching for an extra glass of wine or beer. These are all common things that most people can relate to. It is when these signs accumulate over time, say two weeks and more, that our bodies are giving us warning signs that all is not well.

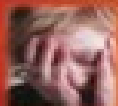
This is where we have a choice. We can listen or ignore our body's inner warning system. If we act early for self-care, we can help ourselves from deteriorating to something worse.

## Being Human - The Wellbeing & Resilience Thermometer

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Acknowledgements: Dr Lynn McAtamney - Telstra and Ingrid Ozols - mh@work®

**Urgent!**  
Don't go under



**Get help!**

**Warning!**  
Wellness alert!



**Action needed!**

**Thriving!**  
Support others



**Build on it!**

**Stop**

I often feel anxious, irritable, nervous, teary, tired, steamrollered or plain worn out for no reason or reasons with no control. I struggle to concentrate or make decisions. I am relying on caffeine, alcohol, drugs, pain killers or smoking too much. My health is deteriorating and I see no way out.

**Think**

I am having ... difficulty sleeping, diarrhoea, constipation tense neck, shoulder, jaw, frequent headaches pounding heart, heartburn, wind, bloating or indigestion a cold or bug that lingers outbursts, loss of patience, no time for me/people saying I am working too hard I am slipping into using drugs, gambling, alcohol or smoking to get through the week

**Go**

I feel great, alive, full of life. I am on top of life's challenges and pressures. I have good systems in place to pace myself. My life is pretty balanced through a daily exercise program, eating healthily, weight under control, not smoking and having a few drinks on the weekend only.

## Reflection



What does wellness and potential unwellness look and feel like for you?

What are your most likely triggers and warning signs?

Where are you currently on the wellness thermometer?

What do you think is behind being in this space or zone?

What action would be needed if you were feeling yourself in the yellow zone?

What would you do to help yourself? Have you experienced these situations previously? How have you responded? What was the outcome?

## Activity 4.3 Dimensions of Wellness

If you have travelled on a plane, you are probably familiar with the instruction for using an oxygen mask: "it is important to place the mask on yourself first before placing it on someone else." Why?

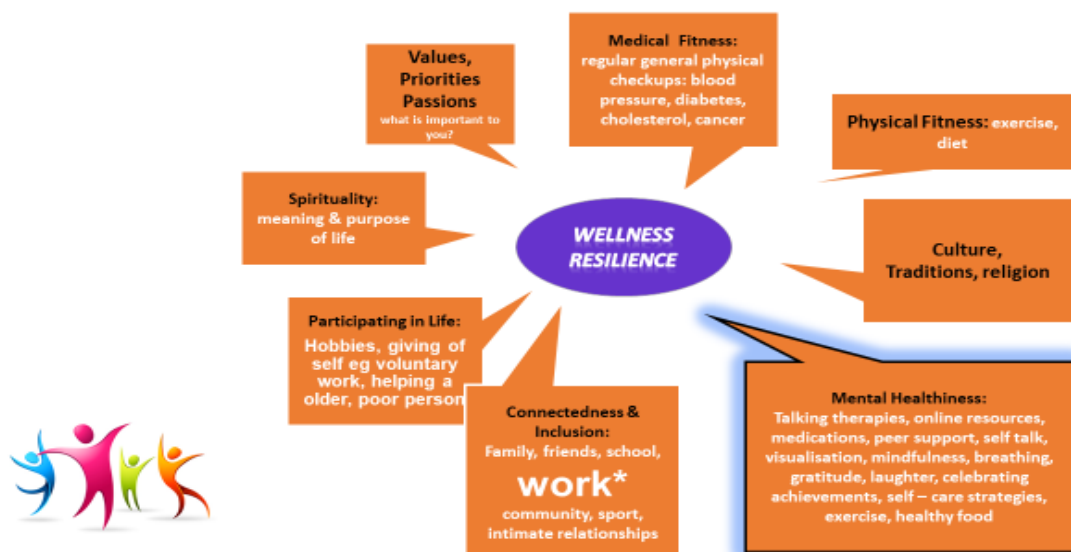
Many of us have been raised to believe that self-care and self-love is selfish. That we should place others' wellbeing and happiness ahead of ourselves. The reality is this doesn't work. We are of no use to anyone else if we are unwell.

By being aware of our wellbeing, and how we are travelling through life, we can better help ourselves build up wellness and resilience, to be able to face life's ups and downs. This encompasses our body, mind and spirit. This can also be likened to having fuel in the tank. Where is your fuel level in your tank?

Only we can do the work of self-care. No else can force us to want or do this. Self-care is up to us.

### Self-care Dimensions towards wellness

(I. Ozols, 2016)



## Reflection

Consider the **Self Care Dimensions** on the previous page. In your journal, write what each dimension means to you. Each dimension may prompt other things and ideas that may be of value to you. Include these.

Then reflect on where you are on each dimension today, ranking out of 10, where 1 is the area where you least give yourself attention and 10 is the most, e.g. where do you believe is your level of physical wellness currently? Great, perfect, at 10? Or poor, an area where you don't believe or feel your level is at its optimum?

Next to these scores, write where and what score you would like to "be" for each dimension. Do these scores align? Are you surprised? Why? Why not?

## Activity 4.4 Self-Care Planning

Having some time away from thinking about eating disorders is very important when you have already lived through this yourself. Take time out to enjoy activities that make you feel good and spend time with supportive family or friends. Many people find writing in a journal helpful.



**Activity:** These tools may help you to think about your own wellbeing:

Wellness Recovery Action Plan (WRAP)

<http://mentalhealthrecovery.com/wrap-is/>

Life Values Inventory

<https://www.lifevaluesinventory.org/theprocess.html>

Make time to talk things through with your supervisor or mentor. If things are getting too much for you, talk to your therapist.

Read the following list of tips for improving wellness.

### Tips for wellness

Take "me time" time for yourself, to rest, to talk to a friend, to read, to walk.

Relax by doing something you enjoy, listening to music, meditating. Find what suits you.

Sleep – it is important to have a good night's sleep.

Increase positive feelings, do something that will help you to feel good.

Spend time with people you feel safe and comfortable with. Family, friends, colleagues...

Keep a journal about your feelings and activities.

Hug an animal!



If you are worrying about something, try to understand what is causing these thoughts. Write the problems down, the positives and the negatives. Brainstorm different ways to solve each. Perhaps talk to someone else about your concerns.

Learn to speak kindly and with compassion to yourself. Would the way you self-talk at the moment be the same as how you would speak to someone else?

Set realistic goals.

Take slow deep breaths when feeling stressed. Breathe in and out slowly. Repeat this several times.

Take a break, change the activity you are doing, move to a different position or place.

Reduce caffeine and alcohol intake.

## Reflection



What do I find helpful in stressful situations?

What strategies do I or could I use to help manage triggers?

Who do I need to support me and what type of support do I need?

Are there other tips, ideas or activities from my experience that need to be added to this list?

## Activity 4.5 Further Self-Care Planning

Look at your dimensions of wellness scores from Activity 4.2. Consider your top three most valued dimensions (try to pick the ones that are for this moment), brainstorm ideas as to what you could do for each.

Using the responses to the thermometer questions (Activity 4.1), your scores with the dimensions of wellness, and the top three chosen areas you wish to work on, plus your preferred tips for wellness, you can create and prepare a simple self-care plan with what you need to help support you to achieve your goals and objectives.

S.M.A.R.T objectives can be a simple way to help achieve realistic goals for your short term and long-term actions for keeping yourself well. Ask yourself "is your goal S.M.A.R.T?"

S = What exactly do you want to achieve

M = How will you know when you have achieved it?

A = Is it something you have control over?

R = Why is this applicable/real to you?

T = When do you wish to achieve your goal?



You may wish to write your responses into a table using one of the templates below and on the following pages. Feel free to create your own action plan format. Be creative, colourful, or whatever will help you. Keep this visible and close by for self-monitoring and review as you develop your goals.

### Reflection





Are there any barriers or challenges that might prevent me from putting my plan into action. What can I do to get around these?

**\_\_\_\_\_’s Self-Care Plan!**

<b>MIND</b>	<b>BODY</b>	<b>I WANT TO ACCOMPLISH</b>
<b>SUPPORTIVE PEOPLE IN MY LIFE</b>	<b>SPIRIT</b>	

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<b>Wellness dimension</b>	<b>Current score out of /10</b>	<b>Your ideal score out of /10</b>
<b>Values/Priorities - specify</b>		
<b>Medical Fitness</b>		
<b>Physical Fitness</b>		
<b>Mental Healthiness &amp; Resilience</b>		
<b>Social Connectedness</b>		
<b>Participation in Life</b>		
<b>Spirituality</b>		

**Wellness Plan – USING SMART GOALS**

<b>Wellness dimension</b>	<b>Specific</b> goal & action.	<b>Measurement</b> of goal (how will you know you have achieved it?)	How is this <b>attainable</b> ? What do you need to support you on this journey?	How, why is this <b>realistic/real</b> to you?	Date/ <b>time</b> frame for goal achievement
Short term ( 3-6 months)  <b>1</b>  <b>2</b>  <b>3</b>					
Long term (6-12months)  <b>1</b>  <b>2</b>  <b>3</b>					

## Activity 4.6 Supporting someone else to write a self-care plan

Think about how you might support someone else to develop a wellness plan. Do they already have one? What do they think of it? What further support could you offer in your role as a peer worker to help them through this journey?



Write your responses and reflections in your journal.

## Activity 4.7 Managing Boundaries

### What is too much caring? Where are your boundaries?

If you have worked through Unit 1, you will have already thought about the importance of boundaries. If not, then try reading and doing activity 2.5 in this resource.

There may be times in our work or life when we are not able to support a vulnerable person as much as they may ask. That's ok. This work can be emotive and exhausting, especially as a peer worker when we are on a recovery journey. This doesn't mean that we are not at risk. In fact, we need to be extra vigilant with our self-care if things become overwhelming for us.

Caring, whether through our "work" or as a family member, doesn't always have clear boundaries. But we need to set them in order to keep ourselves well and to be able to help those that are in our care.

How do we manage boundaries?

Trust your inner warning signs. Your body will tell you very quickly that you may be going down a path that causes you concern, distress or anxiety. This is important to listen to. Consider where you are on the wellbeing thermometer. If you are not doing well yourself, it is ok to let the other person know that you are unable to assist further. Have someone or somewhere else you can refer them to. It may be that you are feeling on call constantly, or that the person is relying on you too much.

It is important to recognise and be honest about this to yourself and to share your feelings with the person. This can feel uncomfortable; you may feel selfish or guilty. As a peer worker or other support person, this is a normal reaction in such a situation.

Establishing boundaries early is important for peer workers. Let the person know that you will give them your best attention when you are together, but voice some realities that may prevent this from happening. Share your realistic availability. Do you really wish to be contacted at 2.00am? Have other referrals ready.



**Activity:** Reflect on some approaches you have used, or consider ones you could use? Jot down your ideas and thoughts. What would you say? What would you not say? Why?

**Note:** Come back to this when you are working through the units on Trauma Informed Care and Suicide Prevention to add further ideas and strategies.

## Sharing Distress

People working in health care who are directly exposed to hearing of other people's trauma first-hand can be impacted by repeated, prolonged exposure to such stories. This can culminate in wide-ranging and long-term consequences. This is referred to as **vicarious trauma**.

**Compassion Fatigue** occurs with prolonged exposure from listening to other people's trauma (Carter, S.B. 2013).

**Burnout** is a state of chronic stress that has developed over time and impacts one's ability to function personally or professionally.

## Review Activity

We set out in this unit to:

- Reflect on what wellness looks like and communicate general signs and symptoms of potential unwellness
- Apply self-care strategies at work and in life
- Review and evaluate personal wellness action plans
- Manage boundaries – what is too much caring?

Please reflect on each of these aims by writing in your journal what you have learned from this unit and describing how you will change your approach.



How can I apply this when I am helping someone else?

### Reflection: Am I ready?

Think about the questions in the checklist below.

- Do I have a support network and self-care strategies in place?
- Do I know my own indicators of risk?
- Am I able to ask for help or withdraw from the group when I am at risk?
- Am I committed to taking care of myself?

Adapted from Caswell & Logie, *Reaching Out for Hope*, republished in NEDC Stories from Experience Module 8, 2015.

## Unit 5: Trauma Informed Care



## Unit 5: Trauma Informed Care

Trauma affects us all directly and indirectly. Many people live with the ongoing effects of past and present overwhelming stress (trauma). Despite large numbers of people experiencing trauma, many of us don't think of the possibility that someone we meet, speak with or support may have experienced it. Being aware and able to recognise the signs and symptoms of trauma can help us be more sensitive to other people's vulnerabilities and be more respectful and understanding.

Eating disorders and some aspects of treatment are inherently traumatic, and people may have trauma from other life events before they developed their eating disorder.

As a peer worker, your understanding of trauma and trauma informed care will provide you with an opportunity to support someone walking through their journey.

At the end of this unit, you will be able to:

- Explain what trauma is and how it differs from complex trauma
- Identify the signs, symptoms and potential triggers of trauma
- Describe and discuss trauma informed care and understand the principles underpinning this concept
- Apply trauma informed care principles in real life practice.

### Activity 5.1 Personal Reflection



Think about trauma – what does it mean to you?

Using your own experience and journey, reflect on what trauma meant to you.

How did or didn't others help or support you appropriately? What worked, what didn't work? What would you have preferred?

### Activity 5.2 Trauma and Eating Disorders

The experiences we have in life change the way we understand and react to new events. It is normal for our past experiences to affect the way we feel and the choices we make.

When we talk about events being traumatic in everyday conversation, we usually mean an experience that was deeply distressing or gave us an emotional shock. These events are things we find difficult to forget.

There are many definitions of trauma. They commonly refer to a traumatic event as a single incident that someone is exposed to, that is outside of normal life experience and that impacts them physically, mentally, emotionally, spiritually and socially, with long lasting adverse effects (SAMHSA, 2011).



Trauma can also be used to describe a diagnosable mental illness. In this context, trauma refers to personal experiences that involve a real or threatened risk of death or serious injury that makes the person feel frightened, helpless or horrified. This could include many different sorts of events including being involved in an accident or disaster, sexual or physical abuse, family violence, physical assault, or being involved in war. Traumatic events also include some medical procedures, persistent victimization such as emotional abuse, teasing and bullying. Complex trauma is exposure of multiple, cumulative or prolonged traumatic events in a person's life.

Someone may be diagnosed with Post Traumatic Stress Disorder (PTSD) if a traumatic event continues to dominate their life. They may experience symptoms like nightmares, negative thoughts about the event, avoidance of reminders of the event, difficulty sleeping or concentrating, and constant anxiety. These symptoms make a difference to the person's ability to function in daily life, their willingness to engage with treatment, and their ability to recover.

Exposure to trauma has been identified as a significant public health issue with traumatic experiences in childhood found to be key risk factors for poor health in adulthood (Beckett et al, 2017). Blue Knot Foundation reports approximately 5 million Australian adults have unresolved childhood trauma including abuse (complex trauma) that is associated with substantial physical and mental health issues. Individuals affected by trauma can often find it difficult to regulate their levels of arousal, emotions and behaviours.

### **Trauma and eating disorders**

There is a relationship between experiencing trauma and developing an eating disorder (Brewerton, 2007). Risk factors for eating disorders include trauma that involves harmful experiences in relationships such as sexual abuse, emotional abuse, child neglect, teasing and bullying.

One study found that "the vast majority of women and men with anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) reported a history of interpersonal trauma" (Mitchell et al. 2012).

This does not mean that everyone who has an eating disorder has experienced trauma. It does mean that more people with eating disorders also have experience of trauma than you would expect in the general population.

Studies (Mitchell et al, 2012) show the following rates of PTSD in people with eating disorders:

- Bulimia nervosa: 40% of women and 66% of men
- Binge eating disorder: 25% of women and 24% of men
- Anorexia nervosa: 16% of women.

Rates of PTSD have been found to be highest in people with eating disorder symptoms of bingeing and purging (Mitchell et al. 2012). The traumatic event usually happens before the eating disorder develops (Reyes-Rodriguez, Von Holle, et al., 2011).

## Trauma and eating disorders treatment

Some people experience health care as traumatic. Intense or distressing medical procedures can lead to the development of PTSD with lasting impact on the person's life (Hall and Hall, 2013). Some of the factors that make it more likely that a person will experience medical trauma include:

- A pre-existing mental health condition such as anxiety, depression (Levenson, 2007) or a previous experience of trauma (NCTSN)
- Medical treatments that are invasive, painful or frightening
- The physical environment where treatment is delivered, especially if the person does not feel safe (Hall and Hall, 2013)
- Feeling powerless and unable to influence one's own treatment (Jones et al., 2007) or the treatment of a family member
- Emergency admissions and treatment in acute care units (Hall & Hall, 2013; Tulloch, Greenman, & Tassé, 2015).

The National Child Traumatic Stress Network (NCTSN) identifies that up to 80% of children who experience hospital treatment for life-threatening illness or who experience painful medical procedures will have some sort of stress reaction. Between 20 and 30% of parents and up to 25% of children and their siblings will continue to have traumatic stress reactions that affect their daily life.

Using this general evidence as a guide, eating disorders treatments could be experienced as traumatic if the person needs medical intervention or needs to be refed. They may also be experienced as traumatic if the person is frightened, feels unsafe or powerless or if they receive care that feels as if it is punishing or bullying. People who have received intensive treatment for an eating disorder do talk about some of their experiences as being highly stressful and distressing.



What can be experienced as traumatising in eating disorders treatment?

## Peer work and trauma

Someone who has experienced trauma may find it difficult to trust other people. If the trauma involved medical treatment, they may have difficulty trusting their treatment team.

Treatment may be more complicated or take longer when a person has multiple mental health issues to deal with. The health professionals providing treatment for an eating disorder need to know about any trauma that the person has experienced so that they can plan the best approach to treatment and avoid the risk of triggering more traumatic responses.

Peer workers can help to prevent trauma or reduce the impact of trauma on the person's life by developing trusting relationships and providing support and information to relieve fears. Lived experience workers may also be able to identify the risk of trauma in treatment situations and help health professionals to modify

distressing procedures or explain these procedures to the person and their family to reduce fear.



What is the role of a peer worker in supporting someone who has experienced trauma?



### **Taking it Further: Suggested Reading**

If you are interested in learning more about trauma and eating disorders or childhood trauma the following references may be helpful:

Brewerton T.D. (2007) Eating Disorders, Trauma, and Comorbidity: Focus on PTSD. *Eating Disorders*, 15:4, 285-04, DOI: [10.1080/10640260701454311](https://doi.org/10.1080/10640260701454311)  
<https://www.tandfonline.com/doi/abs/10.1080/10640260701454311>

Corstorphine, E., Waller, G., Lawson, R., & Ganis, C. (2007). Trauma and multi-impulsivity in the eating disorders. *Eating behaviors*, 8(1), 23-30.  
<https://www.sciencedirect.com/science/article/pii/S1471015304000625>

Kong, S., & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of Clinical Nursing*, 18(13), 1897-1907.  
<https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2702.2008.02740.x>

Reyes-Rodríguez, M. L., Von Holle, A., Ulman, T. F., Thornton, L. M., Klump, K. L., Brandt, H., Crawford, S., Fichter, M. M., Halmi, K. A., Huber, T., Johnson, C., Jones, I., Kaplan, A. S., Mitchell, J. E., Strober, M., Treasure, J., Woodside, D. B., Berrettini, W. H., Kaye, W. H., ... Bulik, C. M. (2011). Posttraumatic stress disorder in anorexia nervosa. *Psychosomatic medicine*, 73(6), 491-7.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3132652/>

The National Child Traumatic Stress Network (NCTSN), USA.  
<https://www.nctsn.org/>

## Activity 5.3 Signs and Symptoms of Trauma

Trauma can lead to long lasting, adverse effects which may appear immediately or as a delayed response later. In some situations, the duration of the effects can be short to long term feelings of intense fear emotional, physical reactions, (perspiring profusely, heart racing), feelings of panic, helplessness, horror and not feeling safe.

Acute Stress Disorder (ASD) is a temporary response to a traumatic event. Symptoms may begin during or shortly after the event and can include an initial state of haziness, being on edge, experiencing heightened anxiety, being in an arousal state, "wound-up", alert, constantly aware, easily startled, always looking for potential danger, withdrawn, numb, detached/disconnected, heightened sensory levels, disorientation, flashbacks, upsetting memories, reliving of the event, sadness via unwelcome recurring memories or vivid nightmares, and having sleep problems.

People who have experienced a traumatic event may find it hard to cope on an ongoing basis with what has happened to them. It may take some time for the person to come to terms with what they have experienced. This can lead to avoiding reminders such as places, people and activities that may trigger memories of the trauma.

If these signs and symptoms do not resolve, continue for more than one month and impact on a person's ability to function, impairing work, performing day to day activities and relationships with family, friends and colleagues, they may have developed Post Traumatic Stress Disorder (PTSD).

PTSD is also commonly associated with significant co-morbidity, especially alcoholism and other substance abuse, major depression and anxiety disorders. These may develop directly in response to the traumatic event or following PTSD.

Emerging research has shown relationships among those exposed to traumatic events with impaired neurodevelopmental and immune system responses, and subsequent health and behavioural risks resulting in chronic physical or behavioural health disorders (SAMHSA, 2017).

Leaving trauma and PTSD untreated can lead to a chronic and debilitating condition, carrying a higher suicide risk than any other anxiety disorder.

## Signs & Symptoms of Trauma

	Signs	Symptoms
<b>Vicarious Trauma</b>	Anxiety Sadness Confusion Apathy Intrusive imagery Loss of control, trust & independence Somatic complaints	Physical Psychological distress Cognitive changes Relationship problems
<b>Burnout</b>	Fatigue Anger Frustration Negative reactions towards others Cynicism Negativity Withdrawal	Physical Psychological Cognitive changes Relationships problems
<b>Compassion Fatigue</b>	Sadness & grief Avoidance or dread of working with some patients Reduced ability to feel empathy towards patients Somatic complaints Addictions Nightmares Frequent use of sick days Increased psychological arousal Changes in thinking Detachment Decreased intimacy Poor self-care	Headaches Digestive problems Muscle tension Fatigue Psychological distress Poor concentration, focus and judgement

### Risk & protective factors

Protective (positive) factors are elements or a set of conditions that can help a person, families, friends and communities manage life's challenges more effectively. Risk (negative) factors have the reverse, negative effect. Their impact is highlighted in the diagram on the next page.

Having as many protective factors in place as possible, along with a low number of risk factors, might help 'buffer' a person to some extent from developing negative or

more severe responses to a traumatic experience. People with more protective factors in place recover more positively than those who are without them.

Protective factors, as illustrated in the image below, commence from childhood (and in utero) to individual, family, community, society attachments, and can be influenced by a combination of environmental, biological, psychological, genetic and historical elements. Dependable, supportive and stable relationships and environments are important protective factors for an individual's health and wellbeing and hold them in solid stead for life's more challenging and stressful times (Brown, 2017).

Poverty, homelessness, severe mental illness, family history of abuse, and trauma are some risk factors towards predisposing a vulnerable individual to further distress (Fallot & Harris, 2009). Even with all the protective factors in place, we are all vulnerable and can be profoundly impacted by a trauma.



How would you recognise the signs and symptoms of trauma?

### Activity 5. 3 Coping and Comfort Zones

Think about the following two diagrams:

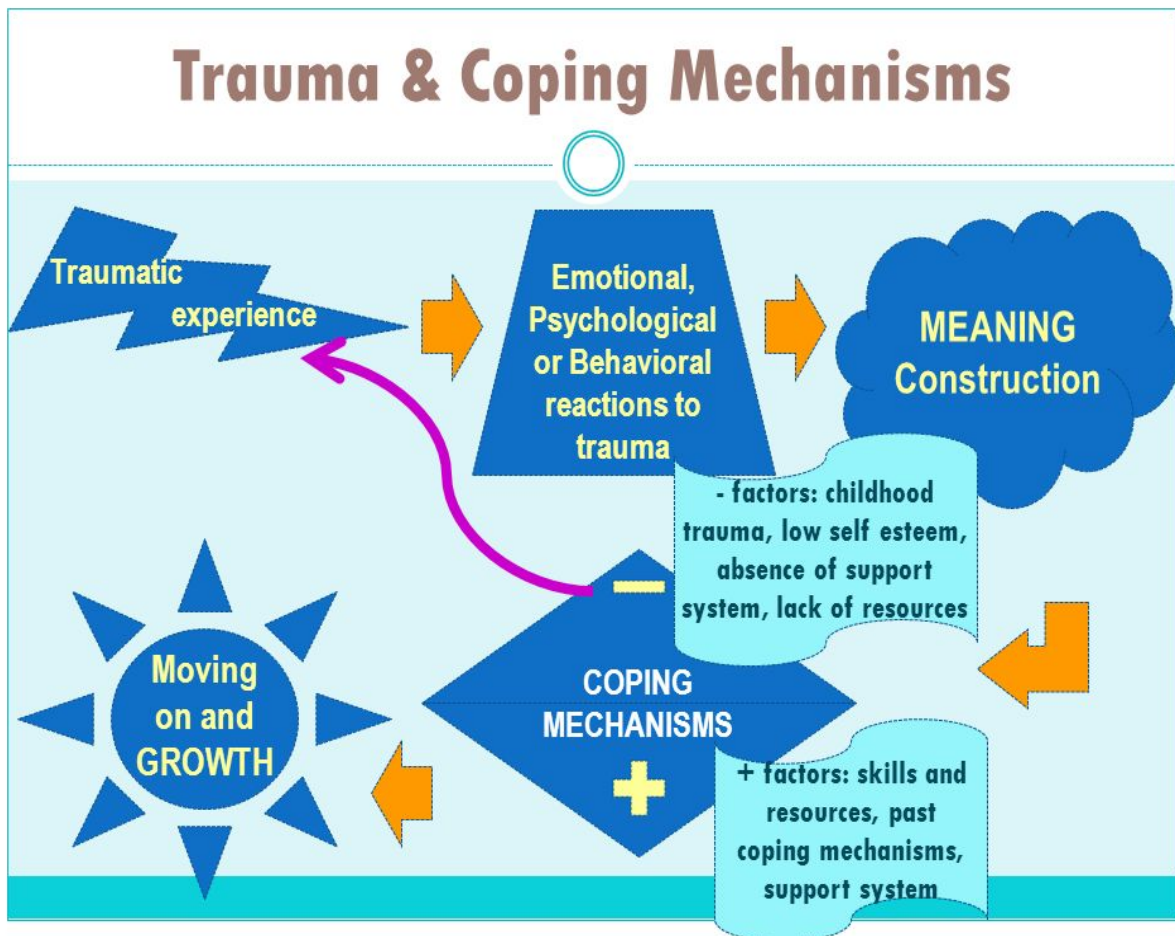
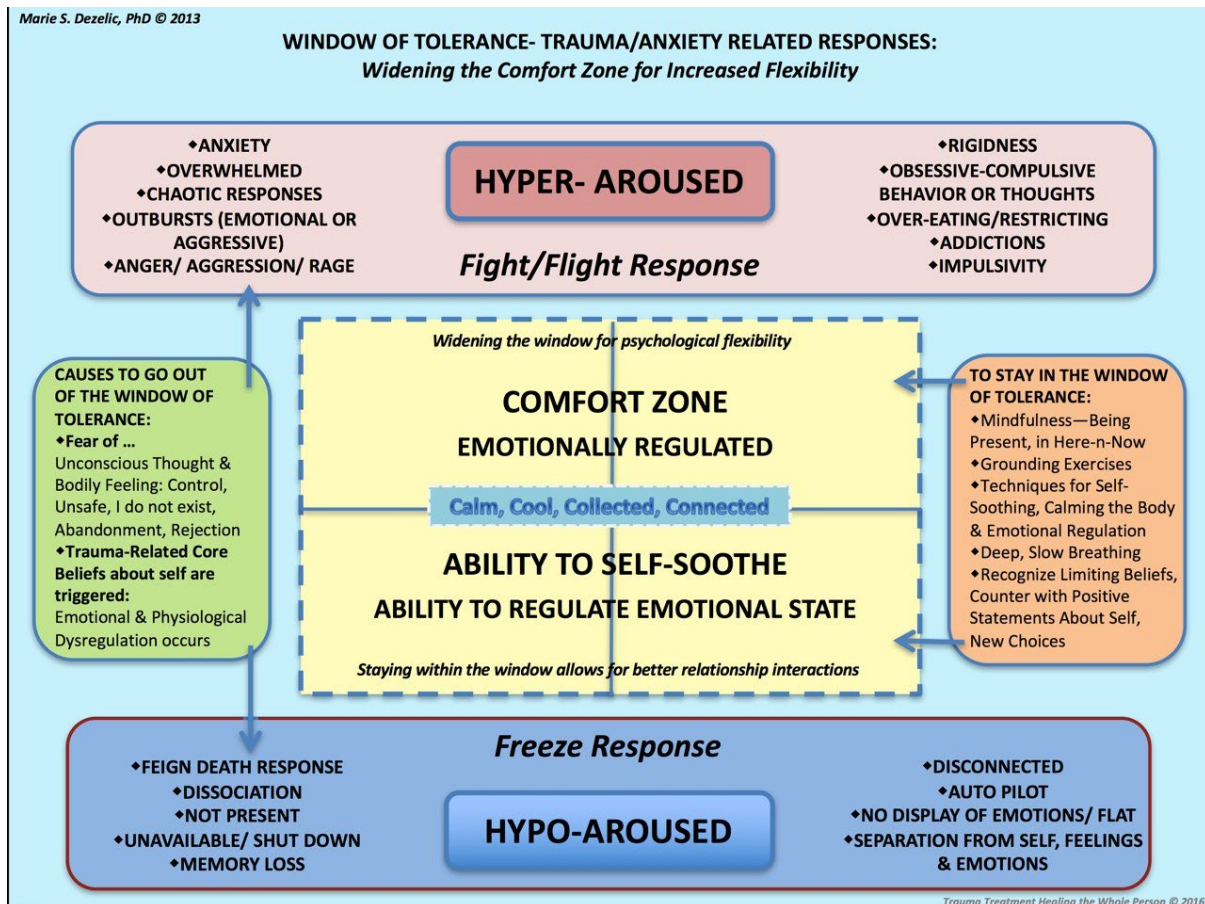


Diagram: Trauma & Coping Mechanisms



**Diagram: Window of Tolerance – Trauma/Anxiety Related responses**

**The Window of Tolerance or Optimal Arousal** is the zone in which a traumatized person feels they can tolerate their pain. Support and therapy should always help the client to stay within this “optimal arousal zone”.

The diagram illustrates that the therapeutic or support relationship stops being helpful and can become re-traumatizing if the person receiving support becomes hyper-aroused (visibly agitated) or hypo-aroused (dissociated, “spaced out” or emotionally shutdown). A vulnerable person in either state is overwhelmed and at the limits of their capacity to cope.

In both cases they should be assisted to return to the “window of tolerance” via appropriate self-regulatory, self-soothing skills, e.g. grounding/distraction exercises.

### Reflection



What does the “The Window of Tolerance” mean to you? How can you relate to this?

How would you know if someone was not in their comfort zone? How could you respond to help the person feel safe?

## **Activity 5.4 What are Trauma Informed Care and Trauma Informed Practice?**

With awareness of the prevalence and impact of trauma and complex trauma increasing over the last 20 years, development of trauma informed care and trauma informed practice aims to provide services to people in a way that stops emotional pain from increasing, avoids re-traumatisation and supports healing.

Trauma Informed Care acknowledges the need to understand a person's life experience to be able to deliver effective care and improve outcomes (Menscher & Maul, 2016).

It has been developed around new knowledge, involving "attachment," "development," "working with the body," "memory" and "understanding of self."

Treatments are changing from purely biomedical, psychological and psychiatric to bio-psycho-social, trauma informed, recovery-oriented models complementing the strengths-based approach.

Promoting the importance of collaborative, empowering, informed and supportive therapeutic relationships, trauma informed care is grounded in an understanding of responsiveness to the impact of trauma.

Trauma Informed care and practice emphasise physical, psychological and emotional safety and their impact on the social wellbeing of people and communities, providing opportunities for survivors to rebuild a sense of control and empowerment (Blue Knot Foundation, 2018).

### **What are the Principles of Trauma informed Care?**

The key principles of Trauma Informed Care are:

- 1/ Choice
- 2/ Collaboration
- 3/ Trustworthiness
- 4/ Safety
- 5/ Empowerment

Patients/consumers have a need to feel connected, valued, informed and hopeful of recovery. The importance of the therapeutic alliance with clinician and patient, and engagement with staff cannot be underestimated. These need to be mindful and empowering, promoting and protecting of safety, choice and autonomy

These principles underlie Trauma informed Care and Practice, facilitating these to minimize re-traumatisation whilst promoting self and community wellness and connectedness within a recovery focused person-centred approach.

Trauma Informed Care and Practice acknowledges, validates and attempts to understand and explain unhealthy coping mechanisms and skills, and how that



might impact situations that may be frightening and stressful for the patient or consumer who has experienced trauma (Beckett et al, 2017).

### **Providing Trauma Informed Care in Services**

There is growing evidence that trauma is the single most significant predictor that a person will need support from mental health services.

Australian mental health services have a poor record in recognizing the relationship between trauma and the development of mental health disorders, and responding appropriately (MHCC, 2013). They are slow to provide approaches to care and treatment that address trauma directly. Embedding trauma informed care from the acute inpatient ward throughout the whole organization and patient journey can lead to improved and more professional practice.

Inpatient mental health wards and other clinical environments are meant to provide safe care and treatment for people with mental illness, and yet can be and often are trauma-inducing (SAMHSA, 2017). A paradigm and culture shift by mental health services benefiting services users in a number of areas is urgently needed in all health service providers.

Ideally, any such service and organizational changes addressing trauma include a multi-pronged, multi-disciplinary public health approach with awareness, education, prevention, early identification, trauma specific assessment and treatment and are embraced by the whole organization, its policies and procedures and are embedded in leadership and organizational values.

A trauma informed service has the following features:

- Is attuned to possibility of trauma in all clients
- Commits to and act on the core principles of Trauma Informed Care: safety, trustworthiness, choice, collaboration and empowerment
- Adapts systems and processes to incorporate principles, accommodating vulnerabilities of trauma survivors
- Enables, develops, delivers and promotes services that minimise risk of re-traumatisation
- Emphasises physical and emotional safety for all (clients, practitioners, service providers, etc)
- Recognises signs and symptoms as adaptive versus pathological
- Collaborates with clients and affirms strengths and resources
- Recognises the importance of respect, information, hope and possibilities for connection
- Embeds trauma informed practice as a philosophy in which services are offered, the whole context in which care is provided, 'a natural way of doing business.'

There are positive fundamental practice changes that mental health service providers could identify from changing paradigms (Beckett, et al 2017). The positive impact of such practice changes has shown to improve therapeutic relationships and engagement, along with:

- 1/ Decreasing use of seclusion and restraint
- 2/ Increasing staff confidence by improving skills in trauma informed care and practice, de-escalation and physical safety training
- 3/ Ensuring best-practice for pharmacological interventions
- 4/ Introducing strengths-based philosophy, policies and practices
- 5/ Providing sexual safety training and awareness
- 6/ Improving access to therapeutic activities on the ward.

If trauma informed care and practice is to be embedded and infiltrated throughout a service organisation, everyone in contact with the service can practice this philosophy naturally, encouraging compassion and sensitivity to staff and patients. Providing an atmosphere and space that is comfortable, relaxing and safe, and doesn't "feel" or "look" punitive or enforcing, goes a long way towards helping a patient feel a little less distressed.

**Traditional practice versus Trauma Informed Care Approach**

Often Trauma Informed Care was thought to be needed only after the traumatic event, but Trauma Informed Care is a model and process that continues throughout the treatment and recovery journey. It involves decreasing clinical jargon and negative descriptions of consumers, focussing on strengths and resources during clinical discussions and handover. Greater awareness of childhood and adulthood adversity is encouraged to improve understanding, compassion and respect for the consumer.

<b>Traditional Paradigm</b>	<b>Trauma Informed Care and Practice</b>
Clients are "sick or ill"	Clients are hurt and suffering
What's "wrong?"	"What happened?"
Clients' behaviours are immoral/manipulative	Clients' behaviours are survival skills developed to live through trauma but may be maladaptive in normal society
Clients can change and stop immoral and destructive behaviour if they only had the motivation	Clients need support, trust and safety to reduce and change their behaviours
Manage and dominate individual's behaviours	Provide opportunity to heal from the trauma
Staff should work at their best and perform to expectations	Leaders need to create a strong organisational culture to combat (re)

	traumatisation, stress and burnout from working with traumatised clients
System care should be created to minimise and contain short term behaviour	Invest in healing and support over the long term
“Do to patient” – paternalistic, controlling approach	Commit and act on the core principles of Trauma Informed Care: Safety, Trustworthiness, Choice – striving for self-determination and autonomy; Collaboration – Collective holistic approach; Empowerment.

**Reflective activity:** summarize what you have learned about trauma informed care. Think about how you might explain this approach to someone else.



Read more about trauma informed practice at:  
<https://mhaustralia.org/general/trauma-informed-practice>

## Activity 5.5 Using Trauma Informed Care Principles as a Peer Worker

As peer workers, we need to be able to:

**Recognize** signs and symptoms of trauma

**Respond** with the principles in mind to keep the person safe

**Refer** the individual appropriately to improve their health and wellbeing outcomes

It is important to understand and remember that positive experiences in our relationships can help us heal. Negative experiences make our emotional and psychological problems worse.

Positive interactions are soothing and validating for trauma and general health and wellbeing. Support is crucial to recovery. As peer workers, we can offer and support a vulnerable person in this way.

Being aware of appropriate choice of language, tone, behaviour and body language towards everyone, and holding the assumption that everyone you are working with has experienced some form of trauma, is key to developing your own practice in this model of care.

- Create a safe environment for a traumatised person
- Reassure and help the person accept that being upset and frightened by the event is a normal reaction
- Provide practical and emotional support that is tailored to the person's needs
- Encourage return to routine, work and life activities
- Support the person to seek professional help. Research strongly reinforces that trauma-focused psychological interventions are effective.
- Encourage the person to be with people
- Encourage the person to talk about what happened, but do not push them if they do not wish to discuss it, try other topics. If the person doesn't wish to talk at all that's ok, they still may value your company
- Listen actively and compassionately without judging
- Remind the person the event is in the past and they will be ok
- Help the person to balance time spent alone and time spent with people, encourage company for part of each day
- Encourage the person to avoid drugs, alcohol and sedatives
- Ask the person to drive extra carefully (offer other transport options if the person is distressed)
- Actions speak louder than words. Within the scope of your peer work role, help with practical activities if you can.

## How to Support Someone Who Has Experienced Trauma



### Questions to ask

- “What happened?”
- “Would it help you to talk about what happened?”
- “You have had a rough time, how are you going?”
- “Is there anything that will help you to feel better?”

### Reflective activity

Reflect on the principles of Trauma Informed Care – How do they resonate with you? Are these realistic? Is anything missing? What do you think are the benefits of embedding this as an approach for dealing with people who have experienced trauma?

Summarize what you have learned about peer worker roles in trauma informed care. Write a list of five ‘top tips’ for yourself.

What are the barriers and challenges you might face in working from a trauma informed perspective? How you could handle these?

## Activity 5.6 Treatment

Read the following section on treatment for trauma, keeping in mind that the treatments referred to are delivered by a clinician and are not part of the peer worker's role. This section provides background information.

If left unresolved or unprocessed, trauma impedes a wide range of functioning. The person maybe unable to process and “move on,” remaining in high alert and easily triggered by seemingly minor stress.

Traumatic experiences complicate how we make sense of our lives and create meaningful consistent relationships (SAMHSA, 2011). Childhood coping mechanisms become adult symptoms of ill health if overwhelming stress experienced in childhood in not treated. Many people can be re-traumatized by health professionals, the process and/or system if there is inadequate knowledge of trauma.

Treatments for trauma are changing from purely biomedical, psychological and psychiatric to bio-psycho-social, trauma informed, recovery-oriented models of care, complementing the strengths-based approach, emphasizing a “whole of life” journey, including physical activities, exercise, nutrition, social connectedness, inclusion, housing, employment, financial security, etc.

The trauma informed care and practice treatment process maybe more easily understood if broken down into phases. These are not linear as safety needs to be established time and time again (Blue Knot Foundation, 2018).

**Phase #1** - Primary focus on safety and stabilisation of emotional distress, restoration or acquisition of self-regulatory skills. This is most important and may require frequent revisiting.

**Phase #2** - Trauma processing – this focuses on the whole body, e.g. emotional, cognitive approaches to assessment, resource building and trauma processing

**Phase #3** - Integration of the person's trauma into their life story, engaging activity in their daily life and strengthening their sense of self.

During treatment for people who have experienced childhood trauma, they will gain understanding to build their strengths, their reactions, ways of coping better, identifying strategies for positive change.

[This fact sheet was developed by mentalhealth@work.]

## Review Activity

Think about your own experiences and your reflections on trauma in this unit. What would you do as a peer worker when supporting someone in this situation? Would you do anything differently after reading this section, would your approach change? Why?



What is Trauma?

What is Trauma Informed Care?

What two key things I have learned, and how will I apply them in practice?

What would I say, ask or do to help someone vulnerable?

Do I know where to go to for further assistance, or information on this? Who? Where?

### For more information:

[www.blueknot.org.au](http://www.blueknot.org.au)

[www.eMHPrac.org.au](http://www.eMHPrac.org.au)

[www.headtohealth.org.au](http://www.headtohealth.org.au)

[www.mhcc.org.au](http://www.mhcc.org.au)

[www.mindhealthconnect.org.au](http://www.mindhealthconnect.org.au)

## Unit 6: Suicide Prevention



## Unit 6: Suicide Prevention

Suicide prevention is included in recovery support strategies for people with eating disorders because suicide is the leading cause of death for people with an eating disorder (Pompili et al., 2006).

As peer workers with the lived experience of eating disorders, we can offer support and human connectedness with empathy and compassion to support a person experiencing suicidal ideation or behaviours.

We don't have to be medically qualified to offer kindness and support to someone vulnerable who is in crisis. The greatest gifts we can give another person are our time and full active attention. This is when they need it!

The key is to help the person feel calmer and, if required, supporting them to seek professional assistance, e.g. their GP, local community health, emergency department at the local hospital, Lifeline 13 11 14 or 000.

This unit aims to help you increase confidence and ability for situations where you are supporting someone at risk of suicide whilst seeking health professional assistance.

When you have completed this unit, you will:

- Understand suicide prevention
- Recognise some of the signs and symptoms of suicidal behaviour
- Learn the triggers and causes of suicidal behaviour
- Understand the difference between risk factors and protective factors
- Learn how to support someone in a crisis, knowing what to say and do, versus what not to say and do
- Understand the types of treatments available
- Support someone to seek professional help.

### Self-care Reminder

In this unit, we cover some challenging and uncomfortable topics. Some content maybe triggering, eliciting stressful responses, emotions and memories of painful personal experiences.

### Self-care and self-compassion are vital.

We need to "put the oxygen mask on ourselves first before we can help someone else." Feel free to stop or pause working on this module if you are finding anything distressing. Go outside, take a walk, have a cup of tea or glass of water, call a friend, write or draw in your journal. Whatever helps you to support yourself and feel comfortable.

Please be aware of additional supports available to you:

- Your GP or health professional
- Lifeline 13 11 14
- The resources made available through your workplace.



## Activity 6.1 Personal Reflection

Before you start this unit, think about suicide, stigma and suicide prevention – what comes to mind? What are your attitudes and thoughts about this? Why?



What do you think is helpful or not helpful when supporting someone at risk?

### Self-care

“Having an eating disorder is like being in a personal hell, where no matter what you do or don’t do, everything is wrong. It involved a lonely isolated world of shame, guilt and a feeling of utter failure.” (Butterfly Foundation, Insights in Recovery, 2016)

Many people who have lived through an eating disorder have thought about suicide at times. It seems that the critical ‘ED voice’ brings this up as part of the punishing regime. People may experience thoughts such as “you don’t deserve to live” or “no one cares about you.”

Sometimes, this message stays with us after recovery as a kind of broken old record, so it’s particularly important to pay attention to any familiar negative thoughts that come up and to put your wellness plan into immediate action.

**Activity:** If you have a wellness plan, keep it handy as you work through this unit. If you haven’t made a wellness plan yet, think about completing the unit on self-care before you go ahead with this unit.

## Activity 6.2 Recognising Risk

The topic of suicidal behaviour and death is confronting. For some people, this is an uncomfortable, morbid topic. But if we are being brave in facing mental health issues, eating disorders and breaking down the stigma around human fragility, then we need to extend that courage a little further. In reaching out compassionately, we may help to save a life.

Some of the people most at risk of suicide are those who:

- Have attempted suicide in the past
- Are struggling to manage a mental illness, such as an eating disorder, drug or alcohol problem, mood disorder, anxiety, PTSD, or psychotic condition
- Have experience of a traumatic event such as a death; a significant loss (parent, family member, friend); conflict; family, domestic or other violence
- Have experienced childhood trauma, abuse, or loss
- Have a family history of suicide or suicidal behaviours
- Are socially or geographically isolated
- Are experiencing pain, disability or distress because of a physical health condition or injury
- Feel a sense of hopelessness, helplessness and worthlessness.

Vulnerable, fragile people don't want to burden or hurt someone close. They fear not being understood, or worse, being rejected. Suicidal behaviour is about indescribable pain. Most people experiencing suicidal thinking do not wish to die, they want to end the pain and don't know how. They cannot see any other way out of their situation and taking their life seems the only option in their view.

Often mistaken for "wanting attention" as if this is a negative, suicidal behaviour is complex, a combination of feeling hopelessness, helplessness and worthlessness from a mixture of biological, psychological and environmental risk factors. It does require compassionate and urgent attention. As humans, we are social beings. Showing someone that we care and value them by being "present" in the moment and giving them "attention" is part of being human, a more positive life experience and vitally important for our wellbeing.

**So how can we, as peers, help a vulnerable person?** Learn to recognize signs and symptoms, changes in a person's manner and behaviours. Warning signs of suicidal thinking can help us to recognize a person at risk.

Behaviours that may indicate imminent risk of suicide may include:

- Threatening to hurt or kill themselves
- Planning ways to kill themselves and/or trying to access means to kill themselves
- Talking or writing about death, dying or suicide
- Expressing feelings of hopelessness, helplessness and worthlessness
- Talking or writing about being a burden to others
- Engaging in reckless or risky behaviours without concern for their safety
- Poor impulse control
- Increased alcohol consumption compared to their usual pattern
- Withdrawing from friends and family
- Withdrawing from social events
- Noticeable changes in mood, including increased levels of anger or agitation
- Not caring about their appearance, not washing or appearing disheveled
- Giving away possessions
- Saying goodbye to loved ones.

It is not uncommon for someone to display one or more of these behaviours at various times, especially if in distress. It is better to act safely and talk to the person as soon as possible about what is going on for them and whether they are experiencing thoughts of suicide.

Creating a supportive environment where a person feels safe to let out their 'toxins' will help enormously. It has been a common misconception that talking about suicide will give the person ideas and may lead them to attempt suicide. Research tells us this is not the case. In fact, we can do more harm by not talking about it. So please, don't be afraid of this uncomfortable topic, don't ignore it hoping it will go away by itself. It won't.

A person with a mental health disorder may already feel isolated, untrusting, and perhaps paranoid of others. At this point, they may also be feeling bad about themselves, not valuing who they are, not caring about themselves or life or

anything. They build a big, seemingly impenetrable wall around themselves to not let people in. They may even tell you everything is ok. Yet on the inside they desperately want someone to notice, reach out and perhaps hug them, take their hand or gently touch their arm – ask first.

Acknowledging and accepting that suicide is an uncomfortable and anxiety provoking topic for most people, including clinicians and health professionals, is an important step towards approaching and reaching out to someone in crisis.

- Treat the person respectfully, like you would someone with any other health condition
- Create a safe, supportive environment where the person can share their feelings openly
- Listen compassionately and actively without passing judgment, leaving your opinions to one side and not sharing them. This will only close the person down
- If you don't feel that you have developed a rapport with the person, or are not in a good space yourself, ask or find someone to help
- Have a conversation, talk to the person, ask open-ended questions, explore what is going on in the person's life, share a little of your own vulnerability to encourage and give the other person permission to share
- Let them know you care and that they are valued as a person – be genuine.

Reassure the person that we all experience challenging times, it is normal for us to drop the ball now and again.

### Reflective Activity



What are some of the potential risk factors for suicidal behaviours?

How would you recognise the signs and symptoms of someone at risk of suicide?

## Activity 6.3 Responding to Imminent Risk

If you are concerned that a person may be having suicidal thoughts or is planning to take their life, take this seriously and **act immediately. Ask directly if they are thinking about suicide or killing themselves, and if they have a plan.** This WILL NOT “put thoughts into their head” and is vitally important to assess their level of risk of suicide. It will help the person to open up.

**Do NOT keep this a secret** and let the person know that you need to seek urgent professional help for them.

**Stay with the person** – or arrange for someone else to stay. Do not leave them alone until they can be seen and assessed.

**Contact a nominated support person**, a parent or a partner, a friend or peer they are comfortable with.

**Remove access to methods** of self-harm/suicide such as medications, sharp objects, drugs and alcohol, car keys.

**Contact** the local mental health service, call 000 or take them person to the emergency department or their GP.

**Activity:** What help is available in your organisation, community and state for people who are at risk of suicide?

Look at some of the following national resources and any local resources you can identify.

*LIFELINE; 131114*

[www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)

[www.thebutterflyfoundation.org.au](http://www.thebutterflyfoundation.org.au)

[www.headtohealth.gov.au](http://www.headtohealth.gov.au)

[www.emhprac.org.au](http://www.emhprac.org.au)

## Activity 6.4 Knowing what not to say

Knowing what not to say in this situation is important. Here are some examples.

- “Others are in a far worse situation.”
- “What do you have to be depressed about?”
- “Think positive!”
- “You are talking yourself into it.”
- “Cheer up.”
- “Chin up... get on with it.”
- “Stop feeling sorry for yourself.”
- “Yes, I was exactly in the same situation...” – talking about your own problems
- “I know exactly how you feel.”
- “Stop being paranoid.”
- “You're smart, clever, why can't you just ask for help?”
- “You are testing our love and patience.”
- “Think of your family and how selfish you are being.”
- “You have everything you need, what do you have to be depressed about?”
- “Stop being so weak.”
- “You need to toughen up.”
- “You're being supersensitive.”
- “You are hopeless, no good.”

Don't use guilt, tough love or “reverse psychology”. This can be more harmful to an unwell and fragile mind. If someone with a mental health disorder could do any of these things to change their (at times) nightmarish health condition, they would. This is not something one chooses to have or do. As with a broken arm, recovery takes time, effort and courage. Do not give advice if you are not qualified to do so.

“Fixing” other people's problems is not our role.

Better approaches involve building rapport and asking directly if the person is alright.

### Questions for building rapport

- “How are you?” — be prepared to really listen actively and compassionately
- “How is work, the job, the team going?”
- “How is life generally treating you?”
- “How is the family?”
- “What have you been doing at home?”
- “What did you do on the weekend?”
- “What did you do in your spare time?”

### More direct questions

- “I have noticed some changes in you. Are you struggling to cope?”
- “You don't seem to be yourself. Is everything OK?”
- “Are you able to work?”
- “How is what you are feeling impacting on your work?”
- “How long have you been feeling like this?”

“Have you considered seeing your GP?”

“Are you aware we have an Employee Assistance Program (EAP)?”

“How can I help you?”

“What would help you to feel better?”

“Can we temporarily adjust your workload until you feel more able to manage?”

“Would you like me to help with making an appointment with your GP or EAP?”

## Reflective Activity

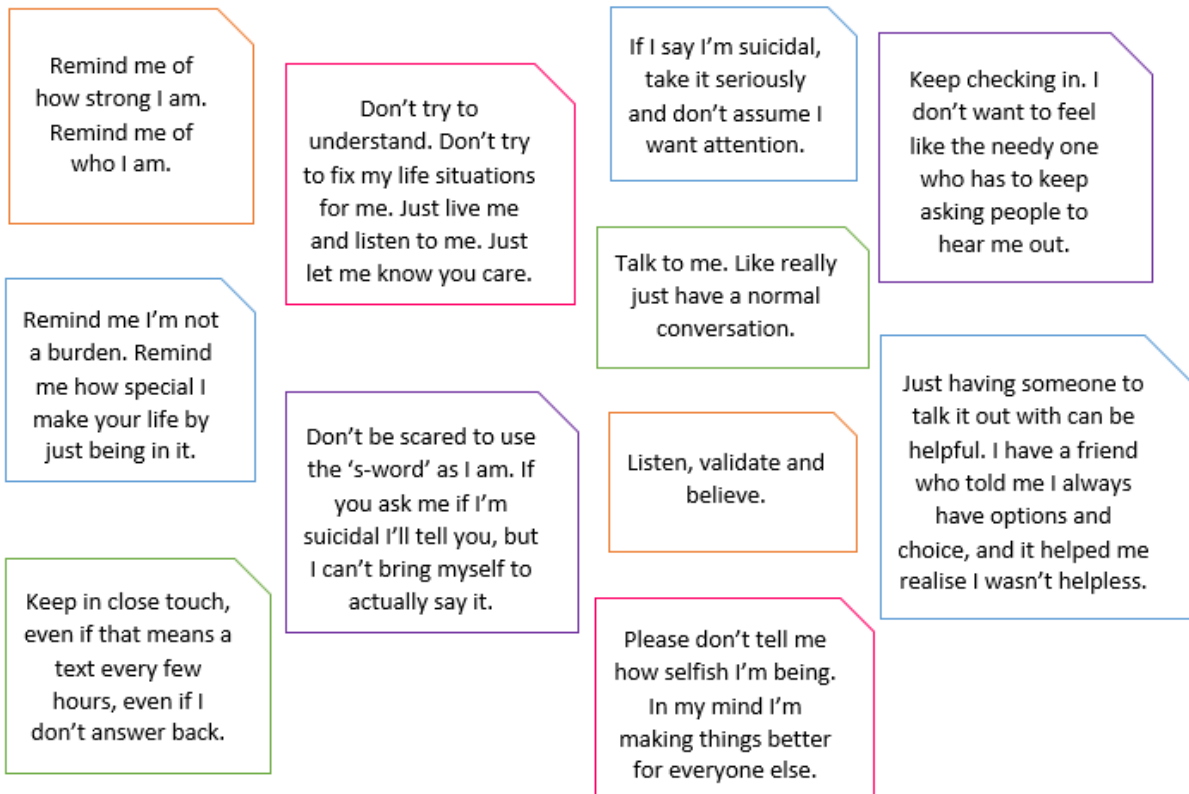


What is suicidal behaviour?

What is suicide prevention?

What would I feel comfortable saying if I thought someone may be suicidal?

## How to help someone who is feeling suicidal – suggestions from lived experience



**Activity:** For more information and resources visit these websites:

[www.blueknot.org.au](http://www.blueknot.org.au)

[www.headtohealth.org.au](http://www.headtohealth.org.au)

[www.mindhealthconnect.org.au](http://www.mindhealthconnect.org.au)

[www.eMHPprac.org.au](http://www.eMHPprac.org.au)

## Review Activity

**Reflection:** You are never alone

**YOU** You are never alone. You are not responsible for anyone who chooses to take their own life. As friends, family and loved ones, all you can do is listen, support and assist the person in getting the help they need.

**CONNECT** the person to resources and to a supportive, trusted adult.

**ACCEPT** and listen to the person's feelings and take them seriously.

**RESPOND** if a person has a plan to attempt suicide and tell someone you trust.

**EMPOWER** the person to get help and to call The Trevor Lifeline (866-488-7386).

**Because...** suicide is the third leading cause of death among 15 to 24-year-olds.

**Because...** LGB youth are up to 4 times more likely to attempt suicide than their straight peers

**Because...** depression is treatable and suicide is preventable

**Because...** when You CARE, you can help save a life!

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When you have finished the readings in this unit, think about your own experiences and your responses to the questions. Would you do anything differently after reading this section, would your approach change?



Why are people with eating disorders vulnerable to suicidal thoughts?

What would you do as a peer worker supporting someone in this situation?

Using a flowchart, map out the different conversational approaches you could try. How would you start a conversation? What if the person said everything was fine, but your instinct indicated otherwise? What if they said they were feeling unsafe?



### Taking it Further

Consider participating in formal suicide prevention training, e.g. ASSIST <http://www.livingworks.com.au/programs/assist/> safeTALK <http://www.livingworks.com.au/programs/safetalk>

## Module Review Activity

If you have completed all the units in this learning program, you may find it helpful to reflect on the following questions:



Why is connectedness important in peer work?

How would I go about developing a supportive relationship with someone I am working with? How would I manage boundaries?

How would I describe the overlap between trauma informed care, suicide prevention and peer work?



## References

This document is a part of the **Developing a Peer Workforce in Eating Disorder Service Settings** suite of resources. A full list of references for this document may be found in Part A: Exploring the Evidence.



### **The National Eating Disorders Collaboration**

Email: [info@nedc.com.au](mailto:info@nedc.com.au)

For a downloadable copy of this resource visit:  
[www.nedc.com.au](http://www.nedc.com.au)

The National Eating Disorders Collaboration (NEDC) is an initiative of the Australian Government Department of Health.