Eating Disorders

GLOUCESTERSHIRE HEALTH AUTHORITY

Guidance on clinical management in primary health care

This leaflet offers guidance, to help staff in primary health care identify and deal with people with eating disorders more effectively.

- Anorexia Nervosa, Bulimia Nervosa and atypical eating disorders affect 2 - 6% of young women.
- Men, children and older women can also have an eating disorder.
- An eating disorder can be caused and maintained by many different factors, but it usually starts with dieting.
- People who have low self esteem, and tend to be perfectionist, are particularly vulnerable.
- People with an eating disorder become over concerned with body shape and weight, but have underlying problems of very low self esteem and difficulties relating with people.
- They rarely see themselves as ill and try to avoid discovery of their secret behaviour.
- Weight loss is seen as the only way to feel better and "in control" of life, so people with an eating disorder generally don't seek help.
- Eating Disorders cause physical, psychological and social suffering, and can also have a damaging effect on the lives of carers, who are often the first to identify the problem.
- Eating disorders usually last several years and don't tend to improve without help.

For further training or information on eating disorders, the local EDA support group or services available in Gloucestershire, contact:

Sam Clark-Stone, Eating Disorders Project, 01452-891142

What is an Eating Disorder?

The person with **Anorexia Nervosa (AN)** diets (and often exercises excessively), reducing their body weight to at least 15% below their average expected weight.

- A resulting hormonal disorder leads to loss of menstrual periods in women.
- The person with AN has an intense fear of becoming fat, which is sometimes denied.
- They feel fat even though under-weight, and have very low self esteem, which is unduly influenced by body shape or weight.
- They might also binge eat, vomit or misuse laxatives.

The person with **Bulimia Nervosa (BN)** experiences episodes of binge eating (a large amount of food in a short space of time), during which they cannot control how much they eat.

- To prevent weight gain, they self induce vomiting, misuse laxatives, fast, or excessively exercise.
- They have low self esteem which is unduly influenced by body shape or weight.

The person with an **Atypical Eating Disorder** will not quite meet the diagnostic criteria for AN or BN, but could:

- Self induce vomiting after eating small amounts of food,
- repeatedly chew and spit out food,
- or binge eat, but not prevent weight gain (Binge Eating Disorder).

What are the effects of an eating disorder?

The physical consequences can affect almost every part of the body, and are potentially fatal if there is severe weight loss, vomiting or laxative abuse.

Physical effects can include:

- Circulatory problems
- Electrolyte imbalance
- Epileptic fits
- Gastric problems
- Bowel damage
- Stunted growth
- Infertility
- Kidney failure
- Heart failure
- Osteoporosis
- Dental enamel erosion

The psychological consequences often include:

- Depression
- Anxiety
- Obsessional behaviour
- Drug abuse
- Self harm

Social effects can include:

- Erratic behaviour
- Social withdrawal
- Debt
- Shoplifting
- Damage to relationships (including feeding and growth problems in the children of mothers with an eating disorder)

Identifying the person with an Eating Disorder

Eating Disorders can cause severe and chronic physical and psychiatric morbidity and occasionally death. Intervention in the early stages of the illness is more likely to be successful.

The person with an Eating Disorder usually keeps the behaviour secret and may deny the problem if confronted. However, eventually someone notices or the person realises they need help. This might take months or years. They often remain ambivalent regarding receiving help and changing their behaviour, because the disorder becomes a way of coping with stress.

People often visit their GP several times before gaining the courage to discuss the real problem. They can present with various symptoms including:

Gynaecological problems

- Amenorrhoea, delayed menarche, infertility
- Pre-menstrual syndrome, irregular periods

Digestive problems

- Abdominal bloating and pain
- Indigestion, diarrhoea, nausea
- Constipation (including requests for laxatives)

Other Problems

- Psycho-sexual or mental health problems
- Fluid retention
- Sore throat (as a result of vomiting)
- Difficulties sleeping or concentrating
- Weight loss or failure to thrive in children
- Generally feeling unwell, weak and tired, anaemia
- Wanting to lose weight when normal or under weight
- Food allergies

Assessment in Primary Health Care

Enquiring about eating habits and worries about weight gives the person the opportunity to "come out" and can take very little time to rule out an eating disorder (bearing in mind the possibility of denial).

People with Eating Disorders are extremely sensitive and can easily be put off pursuing help. However, careful assessment and respect for the views of the patient and their carers makes change possible.

Ask questions about:

- Eating pattern (diet, regularity, amount)
- Amount and frequency of purging behaviour (vomiting, laxatives, diuretics, exercise)
- Attitude and aims regarding weight (including previous variation)
- Menstrual history (the contraceptive pill can mask amenorrhoea)
- Substance use (alcohol, amphetamines, diet pills, cannabis, caffeine)
- Mental state (depression, self harm, anxiety, obsessional behaviour)

Weigh and measure and calculate Body Mass Index (weight in Kgs ÷ height in metres^2) or percentile on Tanner scales for a child.

- BMI normal range = 20 - 25 (< 13.5 = danger level)
- Calculate rate of weight loss if significant or rapid

Carry out a full physical examination and appropriate investigations:

- FBC (haemoglobin)
- U&E (including magnesium, calcium and phosphate if AN)
- ECG (if low weight or chest pain)
- Dental examination (if vomiting)
- Amenorrhoea > 6 months: Refer to Osteoporosis Clinic

and also for Anorexia Nervosa:

- TFT and blood glucose
- LFT and protein
- Arrange assessment by a paediatrician for children below age 14

Initial Treatment in Primary Health Care

- Acknowledge with the person that their eating disorder has psychological origins and encourage them to try to identify what its benefits might be.
- Provide information about the effects of eating disorders. This can increase motivation to change behaviour, especially in the early stages. Don't try to shock, but use your knowledge of the body to explain things in a matter of fact way (e.g. energy balance, the effects of starvation, vomiting and laxative abuse, the risk of osteoporosis).
- Encourage them to buy and read a self help book (research shows that some people with Bulimia Nervosa recover simply by following the advice contained in the book).

e.g. for **Bulimia Nervosa:**

- "Getting Better Bit(e) By Bit(e)" by Ulrike Schmidt and Janet Treasure. Psychology Press.
- "Overcoming Binge Eating" by Christopher Fairburn. The Guilford Press.
- "Bulimia Nervosa - A Guide to Recovery" by Peter Cooper. Robinson Publishing.

e.g. for **Anorexia Nervosa:**

- "Anorexia Nervosa - The Wish To Change" by A. Crisp, N. Joughin, C. Halek and C. Bowyer. Psychology Press.
- "Anorexia Nervosa - A Survival Guide for Families, Friends and Sufferers" by Janet Treasure. Psychology Press.

- Provide advice regarding adequate nutrition and the dangers and ineffectiveness of dieting.
- Rather than focusing on immediate weight gain, encourage the person to stabilise their weight and discuss their emotional and relationship problems.
- Suggest they monitor their eating, behaviour, emotions and thoughts by keeping a diary.

- Encourage the patient and their carers to contact the Eating Disorders Association (EDA) and attend the local support group.
- See the person regularly, monitoring their weight and reviewing their progress (don't praise weight gain, ask how they feel).

EDA 01603 621414 (Youth helpline 01603 765050 4pm - 6pm) 1st Floor, Wensum House, 103 Prince of Wales Road, Norwich, NR1 1DW.

The Gloucestershire EDA support group meets the 1st Tuesday of each month 7.30pm - 9 pm, at the Brownhill Centre, Old St Paul's Hospital site, Swindon Road, Cheltenham.

Eating Disorders Project Helpline 01452 891142

When to refer to your local Mental Health Service

Clinical management within primary health care, plus the use of a self help manual might be sufficient help for many people with less severe eating disorders. However, **early referral is advisable for patients who do not respond rapidly to help in primary health care**.

People with moderate to severe eating disorders (e.g. bingeing or purging once per day or more, or BMI <18) will usually require prompt referral to mental health services for multi-dimensional assessment and treatment.

- Refer to your local mental health team, but continue physical monitoring and support within the practice.
- Referral to a dietitian for nutritional assessment and advice is often indicated after a full mental health assessment has taken place.

On-going Management in Secondary Mental Health Care

There is evidence for the effectiveness of:

- Cognitive Behaviour Therapy (CBT) and some focal psychotherapies for Bulimia Nervosa.
- Family Therapy for younger people with Anorexia Nervosa.
- Otherwise, a consistent psychotherapeutic relationship with a therapist who has knowledge and experience of treating eating disorders seems important, and occasionally hospital admission is required.
- Family support, education and advice can help to reduce anxiety, guilt and well intentioned, but unhelpful interventions from carers.
- Medication plays little role in the treatment of the Eating Disorder itself. Treatment of uncomplicated BN by anti-depressant alone reduces bingeing, but relapse rates are very high.
- Physical investigations will need to be repeated every 3 months or more often if indicated, whilst the person remains significantly under weight or engages in frequent purging behaviours.
- It can sometimes take several attempts to change before recovery occurs. About 20% of patients will remain severely chronically ill despite offers of effective treatment.
- At very low weights, people with AN might appear rational, but be severely impaired by the effects of starvation and their intense morbid fear of weight gain. They will typically be unable to fulfil commitments they agree to. It is important to establish clear boundaries of safety and to insist on intervention if safety cannot be maintained. Occasionally, use of section three of the Mental Health Act might be appropriate.

References: Eating Disorders: A guide for primary care. (Eating Disorders Association) (Dr Chris Freeman, Cullen Centre, Royal Edinburgh Hospital)

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