Introduction to Mental Health, Learning Disability and Eating Disorders

Pre-Course Reading Eating Disorders
1.0 Introduction

Eating disorders are illnesses that manifest themselves in concerns about food, eating and weight and shape. These eating problems are a way of patients coping with other emotions and problems. The eating disorder is a (maladapted) solution to underlying problems, and it a way of expressing emotional distress through behaviours. The behaviours help the person to deal with difficult emotions and anxiety. For most eating disorder patients a multidisciplinary approach is best. The NICE (2004) Eating Disorder Guidelines recommended that Dietitian’s should not be the sole therapist who works with Anorexia Nervosa patients.

However Dietitians have a strong role within the multidisciplinary team working with all types of eating disorder patients. The QIS Eating Disorders Guidelines in Scotland recommend that Dietitians are one of the core professions involved with eating disorder patients. Dietitians can work with patients on all their eating attitudes and behaviours. This allows other health professional to work with them on the underlying issues for their eating disorder.

The BDA/MHG professional consensus statement for dietitians working in eating disorders is key to all Dietitians working in eating disorders and is included in the pack.

2.0 Diagnosis

There are four main eating disorder diagnoses. There is an explanation of these four below. There are various different diagnostic criteria used but the IDC10 and DSMV are the most commonly used.

2.1 Anorexia Nervosa

- Extreme overvaluation of weight/shape.
- Extreme weight control measures (dieting, vomiting, laxatives, exercise, drugs).
- Low weight (15% below that expected, or for adults BMI = < 17.5).
- Endocrine dysfunction (menstruation ceases in females or puberty delayed and there are signs of reduced testosterone in males).

Subtypes:
- “Restrictive” (starvation & exercise used to control weight).
- “Purging” (vomiting and purging as well as starvation used to maintain low weight).

2.1.1 Common Symptoms/Behaviours of Anorexia Nervosa

- A fear of fatness.
- An intense drive to be thin.
- Seeing yourself as fat when everyone else sees you as very thin.
• Doing things to make yourself thin:
  ° Restricting what you eat and avoiding certain foods.
  ° Exercising excessively.
  ° Making yourself sick.
  ° Taking laxatives, diuretics or ‘diet’ pills.
• Feeling down and lacking drive.
• Feeling anxious, tense or panicky.
• Eating disorders turn other people into mere obstacles to the eating disorder.
• Normally honest people are sometimes forced to lie and cheat.
• Sufferers withdraw from friendships and generally loose interest in “normal” activities.
• Interpersonal life is disrupted/ especially during adolescence.
• Education suffers.
• Family relationships become strained and fraught with worry.

2.1.2 Onset and Incidence
This is the least common of all eating disorders, but the one we hear most about. Age of onset on average is 15 years. Duration is average of 7 years. Highest mortality of any psychiatric disorder. Around 1/3 recover, 1/3 relapse and 1/3 become severe and enduring in their illness.

2.2 Bulimia Nervosa
• Over concern with weight and shape.
• Extreme weight control measures.
• Powerful and intractable urges to binge - and then compensatory behaviours to get rid of the food.
• A binge is where an unusually large amount of food is consumed over a specified period of time and the person feels a sense of being out of control.
• Binges and purges occur at least twice weekly for 3 months.
• Not underweight necessarily.

2.2.1 Common/Behaviours Symptoms of Bulimia Nervosa
• Feeling of guilt/ repulsion/anxiety/failure or emotionally numb.
• Feeling out of control.
• Secretive eating.
• Social/Family life affected.
• Unrealistic dietary weight loss planning.
• Fear of weight gain.

2.2.2 Onset and Incidence
Presentation to services is usually in early 20’s. Unlike AN it is culturally bound and so increasing in westernised countries (3-5% incidence).
Early treatment most effective.
80% make a full recovery. 20% do not recover and become severe and enduring.

Patients mostly present to services from their early 20’s onwards however this is thought to be mostly related to younger patients not reporting to services. Although a larger group in treatment than anorexia nervosa there are far more people still that are not in treatment. People whose weight is normal are able to hide their eating disorder for years.
2.3 Atypical or EDNOS (eating disorder otherwise not specified)

This group of patients still have significant problems with an eating disorder, but they do not quite fit into either AN or BN.

For example:
- A patient is severely under weight and restricting their diet as in anorexia nervosa, but they do not have significant body image distortion.
- A patient's life is affected by binging and purging but it is not frequent or persistent enough to meet BN criteria.
- All of the criteria for anorexia nervosa are met except that, despite significant weight loss, the individual's weight is within the normal range.
- All of the criteria for anorexia nervosa are met except there is no endocrine dysfunction.

Binge Eating disorder- is classified within EDNOS.

2.3.1 Common symptoms and Behaviours

Recurrent episodes of binge eating, where some of the following occur:
- Eating much more rapidly than normal.
- Eating until feeling uncomfortably full.
- Eating large amounts of food when not feeling physically hungry.
- Eating alone because of being embarrassed by how much one is eating.
- Feeling disgusted with oneself, depressed or very guilty after overeating.

There is marked distress regarding binge eating is present.

The binge eating is not associated with the regular use of inappropriate compensatory or purging behaviours.

There is a link with Polycystic Ovary Syndrome.

It is more common than Anorexia and Bulimia. Rates of recovery are good >80%.

2.3.2 Incidence of all EDNOS

The majority of eating disorder patients seen by Dietitians will fit into this category as it is the most common area (60% of all ED's).

3.0 Men and Boys with Eating Disorders

Males do suffer from eating disorders but in significantly less numbers than females. It is estimated that 1 in 10 of all of eating disorders are men. There have been many theories as to why this is for example less culture pressure for thinness, less males presenting themselves for treatment. It is important to remember males do have eating disorders and not to miss the symptoms in this gender group.

The main differences are more emphasis on fitness and muscle tone, commitment to fitness related occupations, gender conflict, substance and alcohol abuse, and a history of being bullied in childhood and teased about weight.
4.0 Pharmacology and Psychological Treatment

4.1 Anorexia Nervosa

4.1.1 Pharmacology

There is no evidence that any medication is beneficial in the treatment of AN.

4.1.2 Psychological Treatment

Supportive psychological work is of benefit. There is little evidence in favour of one type of treatment - can probably say that a defined treatment (Cognitive Behavioural Therapy CBT, Cognitive Analytical Therapy CAT, Interpersonal Psychotherapy Dialectical Behaviour Therapy IBD) are better than routine out patient treatment. The nature of AN makes research difficult to conduct.

For adolescents the above is the same but there is the best evidence base of all Anorexia Treatments for family therapy for adolescence (12-18). Therefore all young people should be getting family work as part of their treatment, it is ideal if this is with a family therapist.

4.2 Bulimia Nervosa

4.2.1 Pharmacology

Fluoxetine 60 mg most useful in decreasing binges.

4.2.2 Psychological

Self guided CBT delivered by experienced clinician is effective (also for adolescents).

4.3 Atypical Eating Disorder

Little evidence for this group, hard to do research in such a diverse group of symptoms. Follow treatment of eating problem that most closely resembles eating disorder diagnosis. Rapid response to treatment predicts out come.

4.4 Binge Eating Disorder

4.4.1 Pharmacology

Antidepresents/orlistat/sibutramine. 
Psychological CBT treatment of choice.

5.0 Barriers to Change

Some of the barriers for people suffering from all eating disorders are as follows:
- Long established behaviours.
- Lack of motivation - they get a lot out of their eating disorder.
- Lack of psychological input/support.
- Lack skills in problem solving and challenging thinking.
Lack insight into own psychological understanding of behaviour and own emotional state.
Personality disorders.
Social / environmental situation may remain the same making change difficult.

5.1 Barriers specifically to Anorexia Nervosa

- Ambivalence - anorexia nervosa is often seen by patients as a solution to problems.
- Effects of starvation can create barriers to change (see below).

6.0 Consequences of Dietary Restriction and Weight loss

6.1 Physical
The diagram below shows the effect of starvation on your Body.

**Hair** – hair loss/dry hair on head.
**Skin** – dry, cracked or red skin. Pressure Sores, poor healing and easy bruising may become evident.
**Temperature** – you may feel cold when others are not nor have blue hands and/or feet. At its most extreme this can lead to Hypothermia which can be fatal.
**Bones** – thinning of bones (Osteopenia) and a lack of bone building in adolescents, result in an increased risk of broken bones and osteoporosis.
**Blood** - Low blood glucose levels lead to light-headedness, dizziness, irritability, lack of energy. If left untreated, low blood glucose levels can result in coma and death. Anaemia causing dizziness and tiredness. Low blood pressure can cause fainting, poor circulation (cold hands).
6.2 Psychological/behavioural effects of starvation
- Food is on the mind most of the day.
- Food is obsessed about - collecting cook books, reading diet articles.
- Thinking about food and planning what to eat takes up a large proportion of thoughts in the day.
- Anxiety increases. It is difficult to relax, and sleeping can be affected.
- Mood is lowered. Humour diminishes and irritability increase.
- Restlessness and a need to always be doing things.
- Social withdrawal and isolation.
- It is difficult to make decisions, even small ones.

7.0 Awareness of Refeeding Syndrome and 7.1 Patients at risk

MARSIPAN Guidelines- see attached

Note that for children under 18, use BMI Centile Charts.

8.0 Consequences of the Binge Purge Cycle

See diagram below

Vomiting can cause physical and chemical changes in your body. These changes affect many parts of the body and may be fatal. Examples of these are: dry skin, dry hair, bad breath, sore throat, bleeding of the throat, hoarseness, irregular periods, kidney stones, kidney failure, numbness of fingers and toes, swollen feet and ankles caused by a shortage of protein, cuts, blisters and scabs on the back of hands or knuckles from using hands to vomit, low blood glucose (sugar), cardiac complications, dental problems, etc.
8.1 How to break the cycle?

Encourage 3 regular meals, that is, breakfast, midday lunch and an evening meal and 3 snacks in between these meals. Never leave more than 3 hours without eating. This will reduce the risk of bingeing. Do not rely on the patients feeling of hunger to determine when to eat. If the patients eating have been erratic for some time then it might be difficult for them to recognise feelings of hunger and fullness. Get the patient to work with you to get them onto a food plan that they can trust.

8.2 Vomiting

There are serious medical consequences of vomiting. It is important that the Doctor working with the patient is aware of the amount that the patient is vomiting so that they can do appropriate medical checks. The Dietitian has a role in informing the doctor and other professionals about how often a patient is vomiting, and give patient advice regarding dental care, and risks.

8.3 Binge Eating

Over-eating patterns can form cycles. A patient will decide to try to diet, try to diet often too rigidly and not be able to keep to it resulting in over eating/bingeing. This will produce greater feelings of guilt and reduced self esteem and failure. The cycle continues as the patient then feels they will cope better if thinner and resolve to diet and so it goes on. The current Dietetic treatment is to encourage the patient to stop dieting. A major step in overcoming over-eating is to STOP DIETING. It is important to reassure patients that no foods are “banned”. For example when out for a meal it is better to have a dessert along with everyone else than to not have one and to go home and over-eat in secret. Eating regularly as with BN is the basis of Dietetic treatment. As the Dietitian you can tailor advice to help overcome episodes of over-eating.

9.0 When to refer on

9.1 Anorexia Nervosa

Advice for most Dietitians working in general Dietetics for Anorexia nervosa is to refer onto a mental health/specialist service. This is of particular importance for adolescence due to the risks associated with developmental delay and reduced recovery rates with longer treatment. NICE clearly states that Dietitians should not be working alone with AN patient, i.e. they need also to be being seen by other professionals whom the Dietitians is able to communicate about the patient regularly. If there is no eating disorder/mental health Dietetic specialist working in your area and you do decide to start work with an AN patient keep treatment goals clear and review them regularly. If treatment goals are not being met it is often better to stop treating the patient until they are ready to change or to find a specialist Dietitian to re assess them.

9.2 Bulimia Nervosa

For BN patients, along with Dietetic input, patients should be getting CBT for BN and assessed for medication. Again if patients are not meeting their treatment goals refer on.
9.3 Binge Eating Disorder

BED as for BN except that CBT related to BED.

9.4 Atypical/EDNOS

This group is the largest group and their symptoms and risks can be as great as any of the other groups. Match treatments to nearest eating disorder and look for psychological involvement. If your Dietetic treatment is not meeting its goals look to refer on.

Refer on all patients with significant social problems or co-morbidities (such as very low mood, self harm, personality disorders, etc), they should be seen my specialist eating disorders Dietitians or Mental Health Dietitians.

In general eating disorders are complex in nature and are best managed by a multidisciplinary team. ED patients can also be very treatment resistant so Dietitians working alone should not feel that they have failed if they have to refer on, it is the nature of the illness.

10.0 References and Useful Websites


Beating Eating Disorders - www.b-eat.co.uk

Eating Disorders in south east Scotland - http://ednse.com
Free info /diet sheets designed by dietetics/ ED teams Scotland

BDA Specialist Mental Health Group - http://www.dietitiansmentalhealthgroup.org.uk

Healthcare Improvement Scotland - www.nhshealthquality.org
Includes an Appendix (4) on the Role of the Dietitian in the treatment of eating disorders.