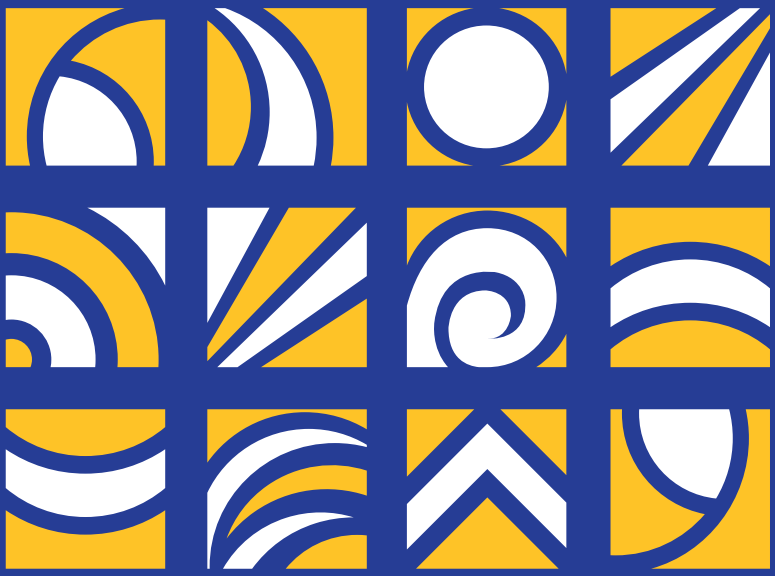
BODYWHYS
The Eating Disorders Association of Ireland

Eating Disorders
A Resource for General Practitioners



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Eating Disorders A Resource for General Practitioners

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While every effort has been made to ensure that the information contained in ***Eating Disorders* A Resource for General Practitioners** is accurate, no legal responsibility is accepted by the authors or Bodywhys for any errors or omissions.

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LIFE SOMETIMES GETS COMPLICATED

Introduction

This guide has been developed to assist general practitioners (GPs) in the identification, assessment and management of patients with eating disorders. The typical image that comes to mind when we think of a person with an eating disorder, is the severely emaciated frame of a young woman, and while this is one way a person with an eating disorder may present, there are also many other ways in which eating disorders can present that are not so obvious. Eating disorders are extremely complex and when a patient is entrenched in the disorder, the complexity can increase and make the diagnosis and management more difficult.

GPs are uniquely placed to the early detection and management of eating disorders, offer intervention and help co-ordinate and monitor treatment. Early detection and management may contribute to better outcomes.[1] However, existing medical literature suggests that eating disorders may in fact go undetected in general practice, despite the high rate of associated medical problems.[2] Research also suggests that people with eating disorders consult their GP more frequently than other people in the five years prior to being diagnosed.[3] However, it is common for a patient to present to the GP and not identify eating disorders as a problem. GPs are therefore uniquely placed to identify and assess those patients with disordered eating prior to these behaviours and psychological distortions becoming entrenched.

In their guidelines for the management of eating disorders, the National Institute for Health & Clinical Excellence (NICE, 2004) states that the majority of eating disorder patients can be managed in primary care or by local services with access to specialist multi-disciplinary advice and support.

This resource will give GPs a practical tool to use to identify those who need treatment and support for an eating disorder. Each section begins and ends with 'key points' which are elaborated on within each section to ensure GPs are fully informed and feel adequately equipped when presented with a patient with an eating disorder.

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1 Morgan, JF, Reid, F and Lacey JH. *The SCOFF Questionnaire; assessment of a new screening tool for eating disorders.* BMJ 1999; 319 (7223): 1467-8.

2 Treasure J, Schmidt U, Hugo P; *Mind the gap: service transition and interface problems for patients with eating disorders.* Br J Psych 2005; 187: 398-400.

3 Ogg, E., Miller, H., Pusztai, E., Thom, A. (1997), 'General practice consultation patterns preceding diagnosis of eating disorders', International Journal of Eating Disorders, 22, 89-93.

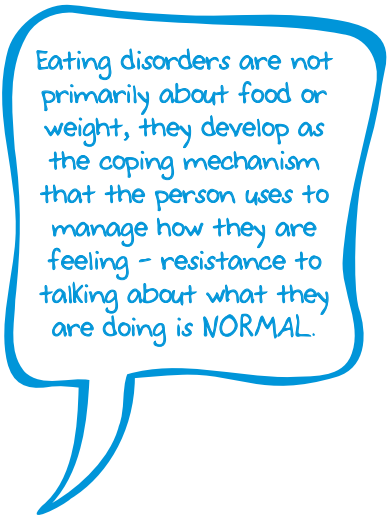
1. Basic understanding of Eating Disorders

KEY POINTS

- Eating disorders are complex mental health conditions and should always be taken seriously
- Understanding an eating disorder as a coping mechanism should inform your initial approach
- The SCOFF Questionnaire[4] can be used as a screening tool

Eating disorders are complex serious expressions of emotional distress with physical, mental and family consequences. With early intervention, eating disorder patients respond well to treatment. The main eating disorders are: *(detailed in a later section)*

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED) and
- Other Specified Eating Disorders that do not fully meet the criteria for either AN, BN or BED.



Creating trust and a sense of safety

Keep in mind - **We all cope with life in different ways. If you were asked to suddenly stop coping in the way you do, how would you feel? Anxious, panicky, frightened? As a first communication the most important step you can take as a GP is to make the person feel safe and that they can trust you.**

[4] *Morgan et al. (1999)*

How to create trust:

- **Communicate concern:** Be clear as to why you are concerned and are making an assessment of an eating disorder
- **Empathise:** Ask them how they feel about what they are doing, rather than telling them to stop
- **Collaborate:** Make a plan with the person by combining what they think would help them, and what you can advise

Most common presentation for GPs

Eating disorders may be difficult to detect in primary care settings. Patients may be reluctant to disclose to their GP, and also GPs may not consider an eating disorder. Adults with eating disorders appear to consult their general practitioner more frequently than controls, presenting particularly with psychological, gastrointestinal and gynaecological problems (Ogg *et al.*, 1997). Consultations of this nature present an opportunity to screen for eating disorders.

Top Tips for Screening

- Consider the possibility of an eating disorder
- Gently inquire in a non-judgmental way
- Establish trust by communicating concern, empathising, and collaborating

The patient's history is paramount and special investigations are not normally required to make a diagnosis.

Who should be screened?[5]

Target groups for screening should include:

- Young women with low body mass index (BMI) compared with age norms
- Patients consulting with weight concerns who are not overweight
- Adolescents consulting with weight concerns
- Women with menstrual disturbances or amenorrhoea
- People with gastrointestinal symptoms
- Patients with physical signs of starvation or repeated vomiting
- Children with poor growth

[5] *Eating Disorders Resource for Health Professionals*, The Victorian Centre of Excellence in Eating Disorders

When to consider if there is an underlying eating disorder[6]:

- Amenorrhoea, infertility, pre-menstrual syndrome, irregular periods
- Constipation, abdominal bloating and pain, indigestion, diarrhoea, nausea, vomiting
- Psycho-sexual or mental health problems
- Sore throat
- Difficulties sleeping, or concentrating
- Weight loss
- Generally feeling unwell
- Weak, dizziness or tired
- Wanting to lose weight when normal or underweight
- Headaches

Common mis-diagnoses[6]:

- Lactose intolerance or IBS
- Abdominal pain
- Hypoglycaemia
- Premenstrual syndrome
- Systemic candidiasis
- Food allergies
- Chronic Fatigue Syndrome

Be aware - A patient with an underlying eating disorder can also present with depression, anxiety and suicidal ideation. Ask the appropriate questions, in an appropriate way, to get a better and more complete picture.

Be concerned - If time is an issue on an initial consultation, make another appointment and leave more time to explore the many options for what might be going on.

Remember - An eating disorder is the person's coping mechanism – they will resist talking about it because they will feel frightened and ashamed. You can help them to talk to you if you ask around the issue, and communicate an understanding that letting it go, and change, is difficult.

[6] *Eating Disorders Resource for Health Professionals*, The Victorian Centre of Excellence in Eating Disorders

PRESENTING SIGNS AND SYMPTOMS

General

- Marked weight loss, gain or fluctuations
- Weight loss, weight maintenance or failure to gain expected weight in a child and adolescent who is still growing and developing
- Intolerance to cold
- Weakness
- Fatigue or lethargy
- Dizziness
- Syncope
- Hot flashes, sweating episodes

Oral and Dental

- Oral trauma or lacerations
- Dental erosion
- Perimolysis
- Parotoid enlargement

Cardiorespiratory

- Chest pain
- Heart palpitations
- Arrhythmias
- Shortness of breath
- Oedema

Gastrointestinal

- Epigastric discomfort
- Early satiety, delayed gastric emptying
- Gastroesophageal reflux
- Hematemesis
- Hemorrhoids and rectal prolapsed
- Constipation

Endocrine

- Amenorrhea or irregular menses
- Loss of libido
- Low bone mineral density and increased risk for bone fractures and osteoporosis
- Infertility

Neuropsychiatric

- Seizures
- Memory loss / poor concentration
- Insomnia
- Depression / anxiety / obsessive behaviour
- Self-harm
- Suicidal ideation / suicide attempt

Dermatologic

- Lanugo hair
- Hair loss
- Yellowish discolouration of skin
- Callus or scars on the dorsum of the hand (Russell's sign)
- Poor healing

Source: AED Academy for Eating Disorders (2012)

Summary of important SIGNS and SYMPTOMS for early recognition of an eating disorder:

1. Substantial weight fluctuations
2. Failure to gain expected weight in a child or adolescent who is still growing and developing
3. Electrolyte abnormalities especially hypokalemia, hypochloremia, or elevated CO^2. High normal CO^2 in the presence of low chloride and/or urine pH of 8.0 – 8.5 can indicate recurrent vomiting. Hypoglycemia may accompany such electrolyte changes.
4. Bradycardia
5. Amenorrhea or menstrual irregularities
6. Unexplained infertility
7. Excessive exercise or extreme physical training
8. Constipation in the setting of other inappropriate dieting and/or weight loss promoting behaviours
9. Type 1 diabetes mellitus and unexplained weight loss and/or poor metabolic control or diabetic ketoacidosis (DKA). These patients are at increased risk of developing sub-threshold and full syndrome eating disorders. Intentionally changing insulin doses will lead to weight loss, poor glycemic control, hypoglycemia/hyperglycemia, DKA, and acceleration of diabetic complications.
10. A history of using one or more compensatory behaviours to influence weight after eating, or perceived overeating or binge eating e.g. self induced vomiting, excessive exercise, fasting.
11. A history of using/abusing appetite suppressants, excessive caffeine, diuretics, laxatives, enemas.

Assessment Tool: **SCOFF Questionnaire**[7]

Can you ask? What should you ask?

If you are presented with an individual with some of the signs or symptoms as listed, and you wish to get a clearer understanding of how the person is behaving around food, eating, and their attitude towards their weight, it can be helpful to get into the habit of routinely enquiring into this by using the SCOFF Questionnaire.

S *Do you make yourself **Sick** because you feel uncomfortably full?*
C *Do you worry you have lost **Control** over how much you eat?*
O *Have you recently lost more than **One** stone (6.35kg) in a three-month period?*
F *Do you believe yourself to be **Fat** when others say you are too thin?*
F *Would you say **Food** dominates your life?*

One point is assigned for every 'yes'. A score greater than two should raise the index of suspicion.

You may also ask the following two questions for indications of bulimia nervosa:

1. *Are you satisfied with your eating patterns?*
2. *Do you ever eat in secret?*

When screening for eating disorders a range of other questions can be asked:

- Do you think you have an eating problem?
- Do you worry excessively about your weight?
- What do you eat in an average day?
- Which foods feel 'safe' and what do you avoid?
- Do you ever vomit, exercise, abuse laxatives and/or diuretics? If so how much and when?
- How often do you weigh yourself?

Remember - Resistance to answering or giving a full picture is NORMAL.

General practitioners must be prepared to align themselves with the patient against the eating disorder, using a collaborative approach. Think of the eating disorder as an entity in and of itself. 'It' does not want the person to talk openly about it. 'It' wants to be kept secret, and the person will struggle to tell this secret.

[7] *Morgan et al. (1999)*

Barriers to GPs considering the possibility of an eating disorder - MYTHS

Myth No. 1 - Eating disorders are a female issue. *FALSE.* Eating disorders can occur in men and women, boys and girls. It is estimated that one in every 10 cases of an eating disorder is male, while for Binge Eating Disorder it is 1 in every 2 cases.

Myth No. 2 - Eating disorders are a teenage issue. *FALSE.* An eating disorder can occur at any age from under 10 to over 70. The average age of onset is 15-24, and when you think about the life changes that happen during these years you can understand why this might be the average age of onset. But, at any age, for some reason, some people turn to controlling their body and food intake as a way of coping.

Myth No. 3 - An eating disorder is a faddy diet. *FALSE.* An eating disorder is not a type of diet that somebody uses to lose weight. An eating disorder is a serious mental illness that has the **highest mortality rates of all psychiatric disorders**. It is a mistake to think that eating disorders are only about food and weight. They are about the person's sense of themselves, their self-esteem and self-worth.

Myth No. 4 - An eating disorder is a lifestyle choice. *FALSE.* A person does not 'choose' to have an eating disorder, and certainly living with an eating disorder is not about emanating a certain type of lifestyle. A person becomes trapped in an eating disorder, and in a similar way to an addiction, feels compelled to continue engaging in the disordered eating behaviour in order to feel safe and secure. This compulsion replaces the conscious choice a person has, and they need help and support to be able to choose a different way of coping and living.

Myth No. 5 - An eating disorder is a phase. *FALSE.* An eating disorder is not just a phase, it is not something that a person 'will grow out of'.It is much more serious than that and should be taken as such by all medical and treatment practitioners involved.

What are common presentations to look out for?

Anorexia Nervosa

The first contact with a GP is often made by a concerned family member, rather than the patient. Concerns expressed may be related to weight loss, food-related behaviours such as skipping meals, hiding food or adopting a restrictive diet. There may be a change in mood, sleep patterns and increased activity.

Typical psychopathological features:

- Fear of gaining weight or becoming fat despite being underweight;
- Disturbance in evaluating or experiencing body weight or shape;
- Undue influence of eating or changes in body weight on self-evaluation; and
- Preoccupation with shape or weight-related matters.

These features may not all be present, easy to elicit or they may be denied. Denial of the seriousness of the weight loss or consequences, both physical and psychological is not unusual.

Established anorexia nervosa with signs of emaciation is usually obvious. However, patients may present initially in primary care with non-specific physical symptoms such as abdominal pain, bloating, constipation, cold intolerance, light headedness, hair, nail or skin changes. Amenorrhoea, combined with unexplained weight loss, in the population at risk should always prompt further enquiry.

Apparent food allergy/intolerance and chronic fatigue syndrome sometimes precede the development of an eating disorder and may cause diagnostic confusion. In children, growth failure may be a presenting feature. In practice, typical cases should cause little difficulty when the time is taken to explore the history including corroborative information and the patient's attitude to the weight loss.

Indeed, diagnosis is often delayed when doctors inadvertently collude by over investigating and referring to other specialties rather than confronting the possibility of an eating disorder.

In anorexia nervosa, although weight and body mass index (BMI) are important indicators of physical risk they should not be considered the sole indicators (as on their own they are unreliable in adults and especially in children)[8].

[8] *Eating Disorders Resource for Health Professionals*, The Victorian Centre of Excellence in Eating Disorders

"In assessing whether a person has anorexia nervosa, attention should be paid to the overall clinical assessment (repeated over time), including rate of weight loss, growth rates in children, objective physical signs and appropriate laboratory tests." [9]

The effective management of anorexia nervosa depends on a full assessment of physical status, psychological features, risk and capacity to consent to treatment.

Young people are typically brought to the attention of the GP by concerned parents because of the extent of their weight loss. Other presenting features may include:

- Altered eating or dietary behaviour
- Excessive exercise
- Amenorrhoea
- Depressed mood and/or social withdrawal
- Self-harm
- Suicidal ideation

The young person may also present with physical complaints related to undernutrition including dizziness, fatigue and headache, or abdominal symptoms such as nausea or bloating, unexplained vomiting, lack of appetite and constipation. The young person may deny any problem and offer assurances for concerns.

Bulimia Nervosa

The patient with bulimia nervosa is more likely to be older and to consult alone than a patient with anorexia nervosa. There may be a history of previous anorexia nervosa or of unhappiness with previous weight and attempts to diet. Appropriate questioning (see screening section) may reveal patterns of restriction, binge eating and purging and psychopathology that make the diagnosis clear.

Not infrequently, physical symptoms are presented which may be related to or consequences of purging or laxative use. These are parotid enlargement, Russell's sign (callus formation on the dorsum of the hand) and dental enamel erosion. Also common are electrolyte abnormalities, so urea and electrolytes should be routinely obtained. These symptoms, particularly in a young woman should be a 'red flag' in prompting the GP to consider further enquiry.

[9] National Collaborating Centre for Mental Health, (2004), p.64

Where the patient does not disclose bulimia nervosa, a range of symptoms may present which should raise the index of suspicion. These include requests for help with weight loss, menstrual disturbance and the physical consequences of vomiting and laxative and diuretic use. Non-specific symptoms may include fatigue and lethargy. Gastrointestinal disorders may be present including bloating, fullness, abdominal pain, irritable bowel syndrome type symptoms, constipation, diarrhoea and rectal prolapse as well as oesophagitis and gastrointestinal bleeding. Oropharyngeal symptoms may include a sore throat, parotid swelling and dental enamel erosion.

Binge Eating Disorder

A person with Binge Eating Disorder will most commonly present with a weight issue (overweight or obese), and associated problems that occur with being in the overweight / obese category. The person affected by Binge Eating Disorder (BED) may diet frequently, however, they will not engage in purging behaviour after a binge. Over time this can, but may not always, result in significant weight gain. Binges almost always occur in secret, and an appearance of 'normal' eating is often maintained. The food that is eaten is usually filling and high in calories. It tends to be food that people regard as fattening, and which they are attempting to exclude from their diet. The food is usually consumed very quickly, and is seldom tasted or enjoyed. While in Binge Eating Disorder there is no purging, there may be sporadic fasts or repetitive diets, and often feelings of shame or self-hatred surface after a binge. A person affected by Binge Eating Disorder may find themselves trapped in a cycle of dieting, binging, self-recrimination and self-loathing. They can feel particularly isolated which can contribute to the prolonging of their experience.

KEY POINTS

- **Eating disorders are complex serious mental health conditions. Understanding an eating disorder as a coping mechanism should inform your initial approach.**
- **A patient may not present with an eating problem initially. Be cautious of patients presenting with weight issues, abdominal or digestive issues, menstrual issues, fatigue and lack of energy.**
- **You can screen initially by asking 5 questions: SCOFF Questionnaire**
- **Don't let common myths cloud your judgement.**
- **Remember – resistance to talking about the real issue is NORMAL. Communicate concern, empathise, and collaborate on a plan.**

2. Assessment

KEY POINTS

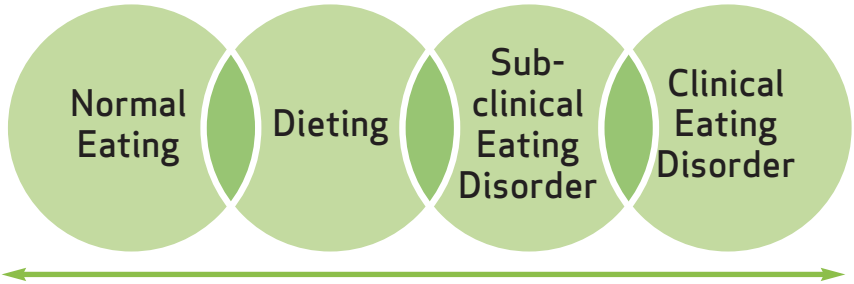
- Use the 'Thinking Tool' Spectrum of disordered eating
- Use the checklist for assessment
- Review assessment with your patient
- Review your diagnosis with your patient
- Collaborate with your patient on a plan of action

Keep in mind - We all cope with life in different ways. If you were asked to suddenly stop coping in the way you do, how would you feel? Anxious, panicky, frightened? As a first communication the most important step you can take as a GP is to make the person feel safe and that they can trust you.

> Eating disorders are not primarily about food or weight, they develop as the coping mechanism that the person uses to manage how they are feeling – resistance to talking about what they are doing is NORMAL.

If a person raises alarm bells for you alerting you to the **POSSIBILITY** that they may have an eating disorder, a quick and simple tool can help you to place them at a point of risk in your own decision making, and help you to determine the assessment you will do.

TOOL - Think of assessment in terms of a SPECTRUM of disordered eating[10]:



[10] *Eating Disorders Resource for Health Professionals*, The Victorian Centre of Excellence in Eating Disorders

Here you will see:

- All circles overlap as they move away from normal eating towards disordered eating
- Where you overlap into 'eating disorder territory' is where COMPULSION comes into play, i.e. where the person feels compelled to continue with the disordered eating behaviour in order to cope and to alleviate anxiety and panic. At this point, it is no longer a 'choice' as the person feels compelled to continue with the disordered eating behaviour in order to maintain a sense of calm and control.
- *See Appendix 1 for features of each segment of the spectrum*

Checklist for Assessment

QUESTION
"I have a concern for a patient, what should I do next?"

ANSWER
ASSESSMENT

1. Physical assessment of weight (BMI)
2. Nutritional status of patient
3. Is the patient engaging in weight controlling behaviours?
4. Menstrual history
5. Personal and family history of food issues, obesity, mood disorders, anxiety disorders, substance abuse issues
6. Assess other physical aspects
7. Conduct initial laboratory examination
8. Bone density tests
9. ECG

Remember - Talk to your patient while doing the assessment to get a full picture. See possible helpful questions to ask when weighing.

Initially, a GP will be making a physical assessment of the patient. There are several assessments that need to be made, either before, or alongside the 'conversation' about the bigger picture of what is happening to the person.

1. A GP will need to weigh and measure the patient to be able to calculate BMI. This will serve a number of purposes including:

a. Providing a base line for future monitoring of trends in weight fluctuations

b. Being able to plot a child or adolescent's weight on the centile charts for age

c. Allowing the GP to plot the highs and lows of the patient's weight, the preferred weight, and the range that the patient will accept. This will give an indication of the patient's attitude towards their current weight and whether they have a (distorted) wish to be a different weight.

Helpful questions when weighing:

- Has the patient lost (gained) weight, and when did this start?
- Has the patient noticed this weight loss (gain) and why do they think it has happened?
- Has the patient been trying to lose weight? When did this start and why?
- Does the patient feel that they need to lose more weight?
- How do they feel knowing they are under / over weight?
- Do they feel that they are preoccupied by their weight?
- Have they ever spoken to anyone about their weight and how it makes them feel?

The GP is trying to get a picture of the extent to which the person is preoccupied by weight, the value it holds for them in their life, and whether the patient is experiencing an extreme dissatisfaction with their weight, or a fear of fatness. (See Appendix 1 and 2 for why this is important for diagnosis.)

2. Assess nutritional status of patient.

Assess the patient's diet, daily food intake including patterns of exercise and disordered eating behaviours such as purging behaviours.

Try to get information on the types of disordered eating behaviours that the person is engaging in. If the person is a very low weight, with a BMI under 14, or where the patient is losing more than 1kg per week, there is a greater risk of mortality if they are engaging in purging behaviours, or if there is co-morbid substance abuse. These patients should be immediately referred to specialist care and may need urgent medical admission.

Warning signs in emaciated patients are:

- **Weakness, unable to climb stairs or rise from a squat**
- **Chest pain**
- **Cognitive slowing**

These patients should be admitted for rest, rehydration and medical monitoring.

Helpful questions for assessing nutritional status:

- I need to get an idea of what you are eating at the moment. Can you tell me what you have had today?
- Would you eat that every day?
- Would you do the same amount of exercise every day?
- How do you feel when you eat?
- Do you plan what you will eat?
- Do you cook for yourself?
- What foods do you like? Do you eat foods you like?
- Do you eat the same all week or are there days or times when you eat more / less? What are these times?

3. Assess if the person is engaging in weight controlling behaviours.

These range from actively dieting, to exercise regimes, to more disordered behaviours such as purging behaviours and abuse of laxatives.

The aim of these three initial assessments is to build up a picture in your mind of what the person is doing (eating), what food and eating means to them (e.g. are they trying not to eat, do they feel stressed or anxious when they eat, or when they don't exercise), and what is happening in their day-to-day life. This conversation, if conducted in a sensitive, inquiring and sympathetic way, will create a mutual space where the patient is more likely to trust the GP to be able to hear their issue and not dismiss their concern as purely a physical and nutritional concern.

4. Assess menstrual history in female patients.

This will give you an idea of the level of nutrition the person is actually receiving and whether what they are saying is in keeping with what you are observing.

5. Conduct an initial laboratory examination of the following:

Laboratory Studies	Potential abnormal findings when a person has an eating disorder
Complete Blood count	Leukopenia, anaemia, or thrombocytopenia
Comprehensive Serum metabolic profile, other electrolytes and enzymes	• Low glucose (poor nutrition) • Elevated glucose (insulin omission) • Low potassium (vomiting, laxatives, diuretics, refeeding) • Low chloride (vomiting) • Elevated chloride (laxatives) • Elevated blood bicarbonate (vomiting) • Low blood bicarbonate (laxatives) • Elevated blood urea nitrogen (dehydration) • Elevated creatinine (dehydration, renal dysfunction, poor muscle mass) • Slightly low calcium (poor nutrition at the expense of bone) • Low phosphate (poor nutrition or refeeding) • Low magnesium (poor nutrition, laxatives, refeeding) • Elevated protein / albumin (in early mal-nutrition at the expense of body mass) • Low protein / albumin (in later malnutrition) • Elevated total bilirubin (liver dysfunction) • Low total bilirubin (poor RBC mass) • Elevated aspartate aminotransaminase (AST), alanine aminotransaminase (AST) (liver dysfunction) • Elevated amylase (vomiting, pancreatitis) • Elevated lipase (pancreatitis)
Thyroid Function Tests	Low to normal thyrotropin (TSH), normal or slightly low thyroxine (T4) (sick euthyroid syndrome)
Gonadotropins and sex steroids	Low luteinizing hormone (LH) and follicle-stimulating hormone (FSH). Low estradiol in females, low testosterone in males
Pregnancy test of women in childbearing years	Low weight females can ovulate and are therefore at risk for becoming pregnant if sexually active
Lipid panel	This is not recommended as an initial laboratory test since cholesterol may be elevated in early malnutrition or low in advanced malnutrition

Source: AED Academy for Eating Disorders (2012)

6. Assess and explore personal and family history of:

- Food issues
- Obesity
- Mood disorders
- Anxiety disorders
- Substance abuse issues

7. Assess other physical aspects such as:

- Supine and standing heart rate and blood pressure
- Respiratory rate
- Oral temperature

8. Bone density tests.

Patients with eating disorders are at risk of low bone density (DXA scans are recommended for patients with amenorrhea for 6 months or longer). There is no evidence that hormone replacement therapy improves this. Treatments of choice are nutritional rehabilitation, weight recovery and normalisation of endogenous sex steroid production.

Source: AED Academy for Eating Disorders (2012)

9. ECG.

A patient with an eating disorder may present with bradycardia or other arrhythmias, low-voltage changes, prolonged QTc Interval, T-wave inversions and occasional ST – segment depression.

Source: AED Academy for Eating Disorders (2012)

Reviewing the information

Following a full physical assessment, and using the ***bigger picture*** the GP has built up from the gentle open questions about eating behaviours and feelings about weight and self, a GP should have an idea of the diagnosis to make. ***See Appendix 1 and 2 for diagnostic criteria for eating disorders.***

At this stage it is very important for the GP to do the following:

1. Explore the patient's attitude to their food and eating habits further.
2. **Discuss a collaborative action plan** where there is an **acknowledgement on the part of the patient that there is an issue and they need some help and support** to begin to think about changes. There also needs to be **an acknowledgment on the part of the GP that they have an understanding that the person cannot change immediately**, and that the issues go beyond being physical and simply about diet and weight normalisation.
3. Discuss what options are available to the patient and talk through what the patient feels they can manage as a first step.
4. **Agree a follow up appointment** to give the patient time to think about what they feel they want to do and what they feel they can manage.

NOTE: The GP must remember that eating disorder patients can be very defensive, and quite often **it can be pointless to try to force an action plan on the individual straight away**. There is a much better chance of the person engaging with the GP and any other form of treatment if plans are taken very slowly and where the person feels that they remain in control of what is happening to them. This can be frustrating for a GP, and it can feel like they are doing nothing, but in the long run it will foster a trusting relationship with the patient which will serve them into the future.

KEY POINTS

- ☐ **Use the 'Thinking Tool' Spectrum of disordered eating**
- ☐ **Use the checklist for assessment**
- ☐ **Review assessment and diagnosis with your patient**
- ☐ **Collaborate with your patient on a plan of action**

NOTES

3. What next?

KEY POINTS

- **Allow the next step of the process to be 'patient-led'**
- **Understand the goals of treatment – physical, psychological, behavioural, emotional**
- **Present options – talk them through – help your patient decide**
- **Remember there is NO 'one size fits all' when it comes to treatment**

Having made a diagnosis, which can be a very difficult and challenging step for both the GP and the patient, the next step is to move towards treatment and recovery.

GPs need to be sensitive that this will provoke a high level of anxiety and fear in the patient so the initial discussion of this step needs to be 'patient-led'.

'Patient -led' in this context means that the GP needs to present the patient with the various options and talk through how the patient feels about exploring these options.

TYPES OF QUESTIONS TO ASK:

1. I am concerned for you, and it seems that there is an issue here that needs thinking about, what do you feel would be helpful right now?
2. Who would you feel comfortable talking to?
3. I think you need some help to address this - can we talk through the options?

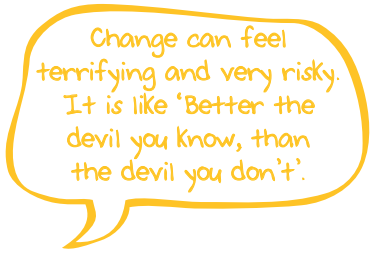
The GP also needs to focus on the patient's support network and provide a clear picture of what this support network is for the patient. Support options, for example, could include family, partner, friend. Include BODYWHYS, as an option, for information and support.

From the GP's perspective, it is important to have in mind the goals of treatment, and to understand that treatment and reaching these goals can be a long process and will take a considerable amount of time and effort on both the part of the patient and the GP who is ideally positioned to be a core support for the patient. It will ultimately be the patient's choice as to the extent to which the GP plays a part in the patient's recovery process, but the GP's communication of understanding and willingness to be a part of the process can influence this greatly.

What are the goals of treatment?

An eating disorder is comprised of different aspects: physical, psychological, behavioural and emotional. While treatment and recovery will address these different aspects, these aspects do not always change at the same rate. Overall, the goals of treatment need to include:

- Stabilisation of the medical and physical consequences of the eating disorder
- A strengthening of a sense of self, due to working on increasing low self-esteem, minimising clinical perfectionism, appropriate processing and dealing with emotions, and/or dealing with underlying trauma in some cases
- Cessation of the cognitive distortions and ideation around body image and eating behaviours
- Normalisation of eating habits / behaviours and restoration of nutritional wellness
- In females the resumption of regular menses
- Normalisation of weight
- Re-engagement in a full social life including family life



It is crucial to understand that **an eating disorder is not a choice** that a person makes. As the disordered eating patterns increase, the person's sense of self outside of this diminishes, and they become imprisoned by the need to maintain the eating disorder. **The person feels compelled to continue with it due to a fear of not being able to cope without it.** This is why recovery can take a prolonged period of time and different aspects of the disorder change at different rates during the recovery process.

Remember - ***There is no 'one size fits all' when it comes to treatment. In order to engage the patient in treatment, they must feel that they have a voice in the decision making process.***

Although this is not as straight forward with people aged under 18, where parents / guardians must make the decisions about care, trying to incorporate the idea of a collaborative approach early on will serve the patient as they embark on the treatment pathway.

Helpful hints for parents/family:

- There is no one single cause that has been identified for eating disorders. Often parents feel that the eating disorder is their fault, that they have caused it, and it is important to help them to understand that we do not know why a person develops an eating disorder, and for the most part it is due to multiple factors.
- However, parents have a responsibility to ensure that their child gets the care and treatment they need, and they can help by trying to understand what is happening to their child.

'Eating Disorders - A Resource for Parents' may be obtained free of charge from Bodywhys, P.O. Box 105, Blackrock, Co. Dublin or info@bodywhys.ie

Treating and supporting within your practice.

As a GP, you are well placed for the early detection and treatment of eating disorders.

Keeping in mind the goals of treatment, seeing the patient on a regular basis and engaging with them in an empathic manner while keeping focused on moving forward in recovery, are the essentials of being able to treat a person within the GP practice.

It is also important for the GP to recognise when this process is becoming problematic, or unproductive and be vigilant in presenting the person with alternative, more supportive, intense and specialised options, when and if they see fit.

Stepped Care Approach: Management Role

- **Primary Care** → early detection/screening
- **Secondary Care** → medical complications, accessing counselling/ psychotherapy
- **Tertiary Care** → complex cases

Treatment options:

The following is a list of treatment options available to a person who has been diagnosed with an eating disorder [*note: you may still refer a person if you have not made a diagnosis yourself. If you have a concern, but are unsure, you can still refer on, as what you are hearing and seeing is a person who is suffering in some way*].

Options:

- Remain within the care of the GP and work together towards recovery
- Refer to the mental health services for assessment, diagnosis and treatment
- Refer to a counsellor / psychotherapist with experience in eating disorders
- Refer to a dietician with experience in eating disorders
- Refer to specialist eating disorder service
- Refer to Bodywhys - The Eating Disorders Association of Ireland - for support and information. See centrefold for Contact Information Cards.

Types of talking therapies:

There are various approaches to the counselling process, which can be summarised as follows:

- Psychodynamic Therapy
- Cognitive Behavioural Therapy (CBT) / CBT-e (enhanced CBT specialised treatment for eating disorders)
- Humanistic & Integrative Psychotherapy
- Systemic & Family Therapy

When making a referral to a counsellor or psychotherapist, GPs should refer to the ICGP/HSE's *Guidance Document on the Provision of Counselling in a Primary Care Setting* (2006) which recognizes the following professional accreditation bodies:

- The Irish Association for Counselling & Psychotherapy (IACP)
- The Irish Council for Psychotherapy (ICP)
- Irish Association of Humanistic & Integrative Psychotherapy (IAHIP)
- Association for Psychoanalysis and Psychotherapy in Ireland (APPI)
- Irish Association for Alcohol and Addiction Counsellors (IAAAC)
- National Association for Pastoral Counselling and Psychotherapy (NAPCP)
- European Association for Psychotherapists (EAP)
- European Association for Counselling (EAC)
- Psychological Society of Ireland (Clinical & Counselling Psychology) (PSI)
- Irish College of Psychiatrists

Remember - If you begin with a trusting relationship, it is important to foster this and focus on keeping up this connection, as ***frequently it is the relationship with the health professional rather than the specific form of treatment that people identify as crucial to their recovery***. If your patient decides they need another form of support, it is crucial that the GP both respects this and ensures that their relationship with the patient remains intact throughout.

KEY POINTS

- Allow the next step of the process to be 'patient-led'
- Understand the goals of treatment – physical, psychological, behavioural, emotional
- Present options – talk them through – help your patient decide
- Remember there is NO 'one size fits all' when it comes to treatment

NOTES

4. Bodywhys Services

Bodywhys – the Eating Disorders Association of Ireland - is the national voluntary organisation supporting people affected by eating disorders.

Our Services

Bodywhys provides a network of **SUPPORT GROUPS** across the country for those affected by eating disorders - these groups are limited to those aged 18 and older. Groups for family and friends, who may be in need of support, are also available. The groups are facilitated by trained volunteers and are free to attend. For up-to-date times and locations, see the website (**www.bodywhys.ie**).

The Bodywhys **LOCALL HELPLINE 1890 200 444** is available six days per week, and is staffed by trained volunteers who provide support and information to people affected by eating disorders including family and friends. For up-to-date times of operation, see the website (**www.bodywhys.ie**).

BodywhysConnect is an **ONLINE SUPPORT GROUP**, which is particularly popular with those who wish to maintain anonymity or are living in an isolated area. The service is available 4-5 nights per month and is based on the website at **www.bodywhys.ie**. This group is open to those aged 19 and over. A separate group, **Teens Online Group**, is available to those aged 13-18. Registration for these groups is through the website (**www.bodywhys.ie**).

The Bodywhys **EMAIL SUPPORT SERVICE**, **alex@bodywhys.ie** allows for increased anonymity and flexibility while providing the optimal level of support.

'SeeMySelf' is on online psycho-education programme for young adults. For further information and registration contact **info@bodywhys.ie**

www.bodywhys.ie

The Bodywhys website provides a wide variety of information on eating disorders, treatment options and support services.

Also accessible from the site:

- Directory of service providers, searchable by location
- Links to other relevant eating disorder and mental health websites
- Reading list

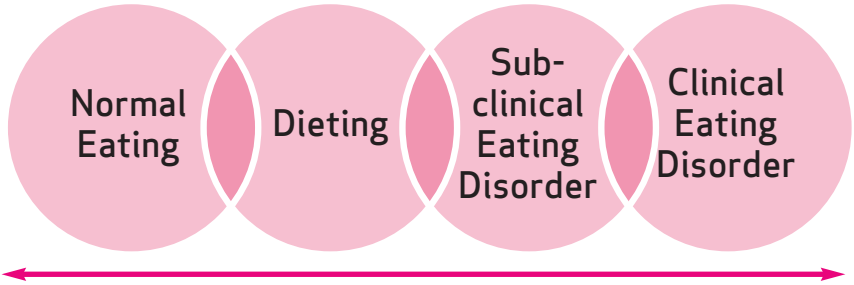
Bodywhys services are available to carers as well as to those affected by eating disorders.

NOTES

5. Appendix 1
Understanding the spectrum of disordered eating[11]

1. ***Natural, Normal Eating*** – eats in response to hunger, comprehends when sated, comfortable and accepts body shape and size.
2. ***Dieting*** – Dieting behaviours such as restricting certain foods/food groups, counting calories and fat content, following a faddy diet plan.
3. ***Sub-Clinical Eating Disorder*** – engages in disordered eating behaviours, such as occasional binge / purge, restricting food, self starvation, loss of control over food, preoccupied about body shape and size.
4. ***Clinical Eating Disorder*** – Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder.

TOOL - Think of assessment in terms of a SPECTRUM of disordered eating[11]:



[11] *Eating Disorders Resource for Health Professionals*, The Victorian Centre of Excellence in Eating Disorders

NOTES

6. Appendix 2

DSM-5™ Diagnostic Criteria for Eating Disorders

ANOREXIA NERVOSA

Core Features

Deliberate weight loss.

Fear of weight gain and fat.

Body image disturbance.

Diagnostic Criteria (DSM-5™)

- Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory and physical health.
- Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

SUBTYPES

Restricting - during the last 3 months the person has not engaged in recurrent episodes of binge-eating or purging behaviour (self-induced vomiting or the misuse of laxatives, diuretics or enemas).

Binge-eating / purging - during the last 3 months the person has engaged in recurrent episodes of binge-eating or purging behaviour.

Severity Scale

For adults this is based on BMI, for children and adolescents this is based on BMI percentile.

Mild	BMI > 17 kg/m^2	**Severe**	BMI 15-15.99 kg/m^2
Moderate	BMI 16-16.99 kg/m^2	**Extreme**	BMI < 15 kg/m^2

BULIMIA NERVOSA

Core Features

Pattern of Dietary restriction broken by binges and then purges.

Diagnostic Criteria (DSM-5™)

- Recurrent episodes of binge-eating characterised by:
  - *Eating, within any 2 hour period, an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.*
  - *A sense of lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating).*
- Recurrent inappropriate compensatory behaviours in order to prevent weight gain (self induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise).
- Binge-eating and compensatory behaviour both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of AN.

Severity Scale

Mild	Average 1-3 episodes of inappropriate compensatory behaviours per week.
Moderate	Average 4-7 episodes of inappropriate compensatory behaviours per week.
Severe	Average 8-13 episodes of inappropriate compensatory behaviours per week.
Extreme	Average 14 or more episodes of inappropriate compensatory behaviours per week.

BINGE EATING DISORDER

Core Features

Recurrent episodes of binge eating which are not followed by compensatory behaviours, hence the person gains considerable amounts of weight.

Diagnostic Criteria (DSM-5™)

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both the following:
  - *Eating, in a discrete period of time (e.g. within any 2 hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances.*
  - *A sense of lack of control over eating during the episode (e.g. feeling that one cannot stop eating or control what or how much one is eating).*
- The binge episodes are associated with three (or more) of the following:
  - *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.*
- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for 6 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behaviours as in bulimia nervosa, and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

OTHER SPECIFIED EATING DISORDER

Core Features (DSM-5™)

This category applies to presentations in which symptoms characteristic of an eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the eating disorders diagnostic class.

Examples are:

1. **Atypical Anorexia Nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
2. **Bulimia Nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviours occur, on average, less than once a week and/or for less than 3 months.
3. **Binge-Eating Disorder (of low frequency and/or limited duration):** All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging Disorder:** Recurrent purging behaviour to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

7. References

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NOTES

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