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EATING DISORDERS: IDENTIFICATION AND MANAGEMENT IN COMMUNITY SETTINGS

The thought of working with an individual with an eating disorder can be a challenging prospect and many healthcare professionals express a reluctance to work within this specialist area. However, with appropriate additional training and suitable clinical supervision, the possibility of making a significant positive contribution can be extremely rewarding.

Eating Disorders (ED) are a group of Mental Health (MH) conditions that involve difficulties with body weight and shape. This results in abnormal attitudes towards food and causes changes to eating habits and behaviours.[1,2,3]

Worryingly, the incidence of ED appears to be increasing, with recent estimates as high as 725,000 individuals being affected in the UK alone.[1] Although still relatively rare MH conditions, ED are associated with the highest risk of mortality and are considered complex conditions that require coordinated treatment to address the physical, psychological and social aspects.[1,3]

It is suggested that early identification and treatment is associated with improved outcomes, with over one half of sufferers making a full recovery and many more making significant improvements. The picture in the later stages becomes more complex and the risk of comorbidities increases. Furthermore, early treatment can reduce the risk of relapse by approximately 50%.[1]

Recently, ED have featured in the news/media and discussions have arisen regarding the apparent variability on service provisions across the UK, which can range from age appropriate specialist to generic/limited services. Additional funding (£150 million) is being made available for the development of community services for children and young people,[4] which will hopefully ensure improved access to appropriate treatment in the future.

IDENTIFICATION AND ASSESSMENT

Full diagnostic criteria for ED are described within the 5th Edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and *The International Classification of Disease* (ICD 10, 2016). Table 1 opposite provides a brief summary of the characteristics of the main ED, alongside estimated incidence and average age of onset.

The first contact with healthcare professionals (HCP) that many individuals struggling with an ED have is within a primary care setting. They may seek help directly for an ED (i.e. disclose their difficulties with body weight and shape), but many initially request help with other health concerns. Common presentations include gastrointestinal symptoms, poorly controlled diabetes, along with anxiety and depression symptoms. As such, it is possible for a non-ED specialist dietitian (or other HCP) to find themselves completing an initial assessment with an individual who may by struggling with a ED, despite asking for support with other difficulties.

Table 2 overleaf provides some example cases of how individuals may present with one condition and then, after collecting additional information at assessment, the possibility of an underlying ED may be suspected.

If an ED is suspected, it is important to remember that any contact is an opportunity to engage the individual

Table 1: Brief summary of characteristics of main eating disorders

Diagnosis	Main characteristics	Estimated incidence	Average age of onset
Anorexia nervosa (AN)	Fear of fatness and/or drive for thinness. Persistent restriction of energy intake, leading to significantly low body weight (BMI <17.5kg/m2 in adults).	1 in 250 women 1 in 2,000 men	16-17, but can affect any age
Bulimia nervosa (BN)	Over evaluation of importance of body weight, shape or size. Restrict, binge, purge cycle of eating.	2-3 times more common that AN and appears to affect mainly females (90%)	18-19, but can affect any age
Binge Eating Disorder (BED)	Compelled to eat large amount of food in a short period of time .	Unclear, currently estimated at 5% of population	Usually develops in later life ~30-40 years
Eating Disorder Unspecified/Eating Disorder Not Otherwise specified (EDU/EDNOS)	Some but not all the typical characteristics of AN or BN.	Unclear Most common ED	Any age

*Information sourced/adapted from NICE 2004, DMS - 5, ICD 10 and BEAT

with treatment, and also that >60% of sufferers wait >6 months before seeking help.[1] It is advisable to initially use non-threatening questions: "Have there been any changes to your eating, appetite?" Then move onto more direct screening questions: "Do you think you have an eating problem?" and/or, "Do you worry excessively about your weight?"[3]

The SCOFF questionnaire was developed by researchers at St George's Hospital Medical School and provides a simple validated and reliable screening tool to aid in the identification of and ED in >18 years. It is not a diagnostic tool, but, if an individual answer yes to two or more of the questions, it suggests an ED is likely and warrants a further investigation/comprehensive assessment.

Figure 1: SCOFF questions

Do you make yourself **S**ick because you feel uncomfortably full?

Do you worry you have lost **C**ontrol over how much you eat?

Have you recently lost more than **O**ne stone in a three-month period?

Do you believe yourself to be **F**at when others say you are too thin?

Would you say that **F**ood dominates your life?

COMMUNITY MANAGEMENT/TREATMENT

If an ED is suspected, a referral to a local specialist service is recommended. A discussion with the providers of the service will be required to obtain referral criteria/procedure. Unfortunately, as previously discussed, the availability of specialist services vary significantly depending on local service agreements and funding.

Full recommendations for the management and treatment of ED are provided within NICE 2004 guidelines 'Eating Disorders: Core interventions in the treatment and management of Anorexia Nervosa, Bulimia Nervosa and related eating disorders'. These are currently under review and publication is expected in April 2017. In summary, it is suggested that treatment requires a number of HCPs to work together in a co-ordinated manner and that individual professions should not work in isolation without appropriate support/supervision. Core professionals include psychologist, psychiatrist, nurse therapist, other therapists and dietitians.

Pharmacological treatment is not considered as a first choice for ED, but may be used as an adjunct to psychological therapy, or to treat physical or co-morbid psychological conditions. Table 3 overleaf provides a brief explanation of the psychological treatment recommended for ED.

Table 2: Brief case examples of possible ED presentations in a non-specialist setting*

Setting	Presenting condition	Initial information	Additional information after further exploration
General/Gastro dietetic clinic	IBS	Commenced with IBS type symptoms. Tried changing diet to improve symptoms. Currently following FODMAP diet, with limited improvements to symptoms. Weight stable, BMI 23.5kg/m2.	Main symptom of IBS is bloating - difficult to tolerate due to perceived increase in size. Initially avoided food associated with bloating. Restricts for long periods (FODMAP aids in legitimising food restricting). Perceived binges - results in feelings of guilt/ shame and worry that weight gain will result. Exercises daily and feels guilty/unable to cope if unable to exercise. Avoids some social engagements if perceived bloating is present (fear of others judgments and feeling fat/uncomfortable).
General/Diabetes clinic	Poorly controlled Type 2 diabetes	Recent weight gain, BMI 40kg/m2. Aiming to follow healthy eating for diabetes advice but finding it difficult and requesting further support.	Wants to reduce weight and worried weight is increasing. Strictly following healthy eating for diabetes during the day and over eating in the evenings, including 'naughty foods'. Feels unable to stop eating when starts eating in the evening and eats a large amount in a short period of time. Has tried to avoid having 'naughty foods, foods in house, but if not available will go to shop a buy them.
General/Nutrition Support clinic	Malnutrition	Recent significant weight loss (18% ~3months), BMI 16.7kg/m2. Poor appetite. Further medical investigations planned (NAD to date). Family expressed concerned about weight loss.	Minimises weight loss, reports not lost as much weight as people say. Denies wanting to lose weight, but states does not want to gain too much weight as considered self 'chubby' previously (BMI 19.0kg/m2). Not concerned about weight loss, attended due to others concerns. Expresses reluctance to increase high fat/ sugar foods in diet. Considering following a vegetarian/vegan diet.

*Please note these are illustrative examples only

THE ROLE OF THE DIETITIAN

Considering that nutritional difficulties can be a major symptom of ED, and changing eating behaviours a significant part of recovery, it is clear to see how the considerable nutritional knowledge and skills of a dietitian can make an obvious contribution to treatment. However, it is also essential to understand and accept that dietary difficulties are a symptom of an underlying MH condition and, as such, dietary intervention alone is not suitable and could indivertibly cause harm.

A dietitian is best placed to make a positive contribution as a part of a suitably qualified, trained, supervised and experienced MDT, allowing a collaborative environment and ensuring well-planned and considered interventions. To ensure safe practice, it is recommended that dietitians working with individuals with ED have completed additional appropriate training and receive clinical supervision from a suitably experienced Dietitian. The British Dietetic Association (BDA) MH ED sub group provides recommendations on training and supervision and this information can be obtained from www.dietitiansmentalhealthgroup.org.uk/eating-disorders/.

If in a non-ED specialist setting, the dietitian's role may be identification, engagement and

Table 3: Psychological therapies and ED

Psychological therapy	Description	Evidence
Cognitive Behavioural Therapy (CBT)	Psychotherapy that examines how beliefs and thoughts are linked to behaviours	Researched supports efficacy as treatment of ED 1st line treatment for BN, BED and EDOS/EDU Limited research for use with AN
Interpersonal Therapy (IPT)	Psychotherapy that examines how illnesses can be triggered by events involving relationships with others	Some research for efficacy as treatment of ED
Cognitive Analytic Therapy (CAT)	Uses methods from psychodynamic and CBT, examines how behaviours cause problems	Considered in complex cases
Dialectical Behaviour Therapy (DBT)	Based on CBT, but adapted for individuals who experience emotions very intensely	Considered in complex cases and where self-harm is evident

suitable onward referral, ensuring adequate information is provided to allow the specialist services to identify whether the individual is suitable for service. What is vitally important at this stage is that the individual feels heard, understood and encouraged to engage in treatment, thus an empathic, supportive and reassuring approach is needed. Initially, it is common for those experiencing an ED to be ambivalent about their symptoms and/or behaviours; it is essential, therefore, that any HCP working with a patient at this time is accepting of this, so that they are able to explore further.

To gain more knowledge and experience of ED, it may be beneficial to consider membership of the BDA ED specialist group, which offers some online resources and regular meetings. It may also be advantageous to approach a specialist ED services and enquire about shadowing opportunities; of particular value would be attending MDT meetings to observe assessment/diagnosis discussions and care planning.

As previously mentioned, additional funding is being made available for the development of ED services and, thus, an increase in career opportunities within ED is currently occurring. Working within community ED service provides an exceptional opportunity to work as part of an MDT and to make a genuine contribution to the enhancement of individuals' quality of life.

SUMMARY

ED are complex and require a MDT approach. Nutritional difficulties are a symptom of the illness and although symptom management can be extremely beneficial, psychological support is also needed to address the underlying MH condition.

Individuals suffering with an ED may present directly or indirectly when seeking support and often wait >6 months before asking for help. Commonly, GI disturbances and poorly controlled diabetes may be first presentation in a primary care setting.

A dietitian may be best placed to identify a suspected ED and given that early treatment appears to be an important factor of successful treatment, an awareness of how to screen for ED whilst positively engaging the individual may prove vital in enhancing overall treatment outcomes.

In addition to identification, a dietitian's role may involve working directly with the individual struggling with an ED; this is best done as part of an MDT, with relevant training and suitable clinical supervision. Recent increases in funding are resulting in increased career opportunities within ED, providing an excellent opportunity to join this challenging and extremely rewarding specialism. Further knowledge and experience can be gained by accessing the available resources, completing additional training and/or making links with specialist ED services.