A SCHOOL NURSE GUIDE TO EATING DISORDERS

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1. What are Eating Disorders?

Eating disorders (EDs) are a range of illnesses characterized by psychological and behavioural disturbances associated with food and weight. Traditionally there are three main types:

- Anorexia nervosa
- Bulimia nervosa
- Binge eating disorder.

Classification systems differ and therefore it can be more helpful to think in terms of symptom traits (see table) rather than a rigid diagnosis. Additionally, an individual may

fit different diagnostic categories over time as his or her symptoms evolve.

Differential Diagnosis ED categories

	AN	BN	BED
Over concern weight shape	++	+++	+/-
Extreme wt control measures	+/-	++	-
Low wt & endocrine problems	++	+	-
Binge	+/-	++	++

1.1 What is Anorexia Nervosa?

Triad of:
Weight, measured as Body Mass Index (BMI) < 17.5kg/m2 due to controlled eating.
Distorted body image and abnormal attitudes to food and weight.
Amenorrhoea (loss of periods) and often other signs of starvation.

1.2 What is Bulimia Nervosa?

Triad of:
Binge eating real or perceived excessive amounts of food with loss of self-control.
Desire for thinness and preoccupation with food and weight.
Strategies aimed at weight reduction - vomiting, laxative and/or diuretic abuse, excessive exercising.

1.3 What is Binge Eating Disorder?
Binge eating real or perceived excessive amounts of food with loss of self-control.
No use of extreme weight control strategies therefore often associated with obesity.

2.0 How common are eating disorders and who suffers?

About 5-10% of the adolescent girls will have some form of eating disorder
1% will have anorexia nervosa

2% will have bulimia nervosa.
3% will have binge eating disorder
Women with eating disorders outnumber men by 10 to 1.
However, it is important to remember that ANYONE can develop an eating disorder, regardless of age, sex, cultural or racial background.

3. What are the signs and symptoms that alert you to an eating disorder?

EDs can present in a wide variety of ways. , The last person to acknowledge they have a problem and seek help will often be the sufferer themselves. A sufferer usually resists help and denies all problems, reacting angrily when confronted. Individuals with bulimia nervosa and binge eating disorder are ashamed of their behaviours and often present with different symptoms. Often, it is a concerned friend, relative or tutor who brings the sufferer to attention.

The first signs of an ED are subtle and are often meticulously concealed by
A sufferer. Behaviours are often misconstrued as just "normal" growing-up or perceived as a change in hobbies, interests or concerns. The "classic" emaciated appearance of AN trigger immediate alarm bells and a spot diagnosis but, when bodyweight is "normal", to detect an ED requires looking deeper, beyond physicalities.

It is best to think of ED presentation in terms of 3 categories:

3.1 Physical

- Loss of weight
- Absence of periods
- Other physical signs- swollen glands, hoarse voice, puffy face, hamster cheeks, tooth decay, (all consequences of vomiting regularly) dry and pale skin, blue hands and feet, visible veins and feathery downy hair on the face, arms and back. Lethargy, tiredness and loss of sex drive.

3.2 Psychological

- Low mood
- Low self-esteem
- Self criticism – dissatisfaction with physical appearance and general achievements, personality and social capabilities; self deprecating comments such as "I'm rubbish", "I'm lazy", "I'm such a freak" and "I'm so useless at that".
- Anxiety, irritability and unpredictable fluctuations in temperament.
- Or, alternatively, emotionless and "numb" – rarely showing anxiety, sadness, anger, joy or pleasure.
- Behavioural changes (restless, continually "on the go", unable to sit still and insisting on rising early) and obsessional symptoms (tidying, cleaning, hand washing, meticulous personal hygiene)

3.3 Social

- Isolation – an ED takes precedence over everything and everyone. Hobbies may be forgotten or replaced with food or exercise related activities. Friends are often ignored and social contacts lost.
- Academic problems – studying may be neglected; a sufferer has new priorities. Although, equally, many sufferers are meticulous, diligent and perfectionistic when in comes to academic work. They are "model students" and high achievers.
- Friends notice unusual eating or exercise habits:
- cooking elaborate meals for others but not eating themselves
- encouraging and watching others eat
- talking incessantly about food and its preparation
- an unusual interest in recipe books, cookery programmes and product ingredient lists
- Spending hours shopping for food.
- endless excuses for not attending birthday meals or lunch invitations
- reluctance to eat in public, always having "eaten earlier" or "don't worry I'll have something later"
- distractions to hunger – constantly chewing gum or consuming vast quantities of diet fizzy drinks or black coffee
- Food fads – a liking of foods with strong flavours – mustard, chilli, tomato ketchup, Tabasco, marmite, vinegar. Copious amounts may be added to a meal to "mask" its taste.
- Consuming large quantities of "empty calorie" foods such as vegetables. Skipping meals and small portions.
- Walking everywhere regardless of the distance, weather or hour of day.
- Relentless and gruelling exercise routine. Energy expenditure outweighing energy input.
- Secret eating and food disappearing. Food may be hoarded or unwanted food may be hidden in unusual places.
- Compensatory actions – vomiting after meals (visiting the bathroom mid meal or straight after a meal, vomit blocking sinks and use of air fresheners to conceal smells), laxative abuse and exercising immediately following eating to counteract calorie intake.

4. What are the first Approaches?

- Take any approach from a peer worried about a friend seriously.

- Believe any initial suspicions you have and consult colleagues. Avoid denial.

- Show concern, but focus chats away from food issues. Try and create openings for the individual to talk freely. For example, "I can't help noticing that things are quite difficult for you at the moment, would you like to talk about it or is there anything I

can do?" or "Is everything ok at school/work/university at the moment, you seem slightly anxious, low, distracted etc".

- After raising general concerns, GENTLEY ask about ED related behaviours. Be warned, any challenge related to food, weight loss, eating habits or exercise will be met with fervent denial and anger.

- Dr John Morgan has developed some simple questions that may help probe for eating symptoms see Table 2

Table 2. The SCOFF questions:

- Do you ever make yourself Sick because you feel uncomfortably full?
- Do you worry you have lost Control over how much you eat?
- Have you recently lost more than one stone in a 3 month period?
- Do you believe yourself to be Fat when others say you are too thin?
- Would you say that Food dominates your life?

- Remember, concerns will be met with the same response – "nothing's wrong. I'm fine", "no, everything's ok thanks", "I'm fine but are you ok?", "I just haven't really felt like eating much recently but it will pass, don't worry". DO NOT be falsely reassured.

- Watchful waiting. If you meet a blank let it be for the moment but offer a new appointment. "It's great that you do not feel there is a problem. I hope you are right. Let's meet in a week's time to check in again. It may well be a long time before they admit it to themselves and even longer before they talk openly. DON'T give up trying and keep in touch regularly. Watch patiently, don't leave and most importantly, be there for them. They need you.

- Raise awareness in meetings.

- Ask other staff to watch for characteristic behaviours. Gather evidence; isolation, absence from lunch, a faultless academic record. Observe a keenness for physical education, "calorie consuming sports" and enthusiasm for any academic work related to food – home economics, a nutrition degree or aspirations to be a dietitian.

- Seek help and get more people involved – find out about the schools policy.

- If the situation continues to deteriorate, tell the sufferer of your great concern and gain consent to involve their parents. Occasionally confidentially may have to be breeched regardless of the sufferer's wishes because of your duty of care. Never underestimate the power of an eating disorder.

- Get information from B-EAT

5. When should I be worried about someone's medical risk?

Eating disorders have both high acute risk and problems accumulate to build further harm in all domains in life. The symptoms themselves- poor nutrition compromise brain function-thus the organ that is needed to recover from the problem is damaged by the problem. Early intervention is essential to stop this trap developing.

An assessment of the level of medical risk can be measured by a medical practitioner. The level of risk in part, relates to the degree and rate of weight loss but methods used to compensate for eating or weight control measures such as vomiting, laxative abuse and fluid restriction can cause serious, and sometimes life threatening, electrolyte imbalances leading to cardiac arrest or heart arrhythmias. A risk assessment based on BMI alone is Insufficient. Too much of a focus on weight alone has the potential for deceit with water loading and concealed weights falsifying figures.

It is possible to down load a BMI chart from www.eatingresearch.com in the section for health professionals. In order to use this you need an individual's weight in kg and height in metres. A medical risk chart can also be down loaded from the same site.

Although you may not want to get involved in the details of health monitoring yourself, it may be a helpful exercise for the individual to take some responsibility for thinking in terms of health risk and the dangerous, sometimes long-term, consequences of their actions.

6. How can I manage people with eating disorders?

People with EDs are usually ambivalent about change and. Engaging such individuals to think about change can be difficult.

General pointers:

- Help move the patient into the position where they are interested in considering change – for example, discussing the pros and the cons of their behaviour.
- A motivational interviewing approach can help with patient's ambivalence about change (link to MI)

- Guide the patient to an expert resource outlining the long-term effects of starvation, nutrition advice and general information about eating disorders. (See list of resources)

6.1 The Educational needs.
People with eating disorders may have specific learning needs For example; they are often highly perfectionistic and terrified of making mistakes. This can make time management and prioritizing difficult.
Also they often have a cognitive style in which they focus too much on detail and find the ability to synthesize information concisely and coherently very difficult. They may get overwhelmed in their overly analytical approach. Skills to help them extract and produce the gist of argument are often needed.

6.2 Early Interventions
EDs are a complex mixture of physical and psychological morbidity. The NICE guidelines suggest stepped care initially with guided self help. This involves using general counselling skills, warmth and empathy in order to support the eating disorder patient following the specialist advice. A variety of self help books have been developed usually based on Cognitive Behavioural Therapy (CBT) principles. Additionally, some resources have been written for carers (professional and non professional) (Treasure J, Smith G, & Crane A, 2007).

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7. Developing a collaborative team.

A team approach is the best way to be effective and joining forces with parents is an important step.
Confidentiality
Often people with eating disorders do not want their parents to be involved. In part this is because they want their eating disorder to be secret and have mixed feelings about change. Also there is a sensitivity to being judged and criticised.

As a responsible adult you cannot promise confidentiality if a child discloses concerns to you as you are duty bound to progress the matter if the child is at risk.

Sometimes parents themselves have difficulty accepting that something is wrong. Further details of how parents can help can be obtained from web sites or from books from our web site. (Treasure J, Smith G, & Crane A, 2007).

8. Where can I get further help?

B- Eating Disorders Association
This is a nationwide organization that offers a number of services including telephone advice, self-help groups, family groups and individual counseling, training courses and information on service provision.

The Royal College of Psychiatrists
www.rcpsych.ac.uk General diagnosis and treatment information including national guidelines.

Kings College London www.eatingresearch.com This web site includes information for professionals and carers.