A student counsellor guide to eating disorders
by Professor Janet Treasure and Dr Anna Crane (January 2008)

What are eating disorders?

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

1. Anorexia nervosa
2. Bulimia nervosa
3. Obesity

In this guide, we focus on anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED). However, classification systems differ and it can be more helpful to think in terms of symptom traits (see table below) rather than a rigid diagnosis. Additionally, an individual may fit different diagnostic categories over time as his or her symptoms evolve.

Differential diagnosis eating disorders categories

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<th>Anorexia</th>
<th>Bulimia</th>
<th>Binge eating</th>
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<tr>
<td>Over concern about weight/shape</td>
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<td>Extreme weight control measures</td>
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<td>Low weight and endocrine problems</td>
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<td>Binge</td>
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What is anorexia nervosa?

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

What is bulimia nervosa?

Triad of:
1. Binge eating real or perceive excessive amounts of food with loss of self-control;
2. Desire for thinness and preoccupation with food and weight;
3. Strategies aimed a weight reduction – vomiting, laxative and/or diuretic abuse, excessive exercising.

What is binge eating disorder?

1. Binge eating real or perceived excessive amounts of food with loss of self-control;
2. No use of extreme weight control strategies, therefore often associated with obesity.
How common are eating disorders and who suffers?
• About 5-10 per cent of adolescent girls will have some form of eating disorder.
• One per cent will have anorexia nervosa.
• Two per cent will have bulimia nervosa.
• Women with eating disorders outnumber men by 10 to one.
• It is important to remember that anyone can develop an eating disorder, regardless of age, sex, cultural or racial background.

What outcome should I expect?
• All forms of eating disorder have a somewhat protracted course.
• AN has a high medical risk. In fact, of all other psychiatric diagnoses, AN has the highest death rate.
• Cases of AN can evolve into BN.
• Cases of BN can evolve into substance abuse.
• Early intervention improves long-term outcome.

How may a patient with an eating disorder present?
Eating disorders can present in a wide variety of ways. The above statement, that early intervention improves outcome, is a true paradox. Indeed, the last person to acknowledge they have a problem and to seek help will often be the sufferer themselves. Their illness swears them to secrecy and silence. Routinely, a sufferer will resist help and intervention and deny all problems, reacting angrily when confronted. 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. Behaviour may begin over many years and are often misconstrued as just ‘normal’ growing up, or perceived as a change in hobbies, interests or concerns. The ‘classic’ emaciated appearance of AN triggers immediate alarm bells and a spot diagnosis, but when body weight is ‘normal’, to detect an ED requires looking deeper, beyond the physical signs.

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

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.

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 such a bitch’, ‘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).

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 perfectionist when it 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 them 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 have ‘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 eating small portions;
  – walking everywhere, regardless of the distance, weather, or time 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, use of air conditioner to conceal smells), laxative abuse and exercising immediately following eating to counteract calorie intake.

What should tutors or other responsible adults do?
Take any approach from a peer worried about a friend seriously.
Believe any initial suspicions you have and consult colleagues. Avoid denial.

Ask other staff to watch for characteristic behaviours. Gather evidence: new 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 dietician.
Raise awareness in meetings.

Seek help and get more people involved – contact the institution’s counsellor or head of pastoral care. Talk to beat (formerly the Eating Disorders Association) for advice and information.

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 okay at school/university at the moment, you seem slightly anxious, low etc’.

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

Remember challenges and concerns will be met by ‘nothing’s wrong. I’m fine’, ‘no, everything’s okay, thanks’, ‘I’m fine but are you okay’, ‘I just haven’t really felt like eating much recently, but it will pass, don’t worry.’ Do not be falsely reassured.

Continue challenging, voicing your concerns and watching. Let the sufferer know that you know they have a problem. It may 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.

If the situation continues to deteriorate, tell the individual of your great concern and gain consent to involve their parents. At home, they too may have been aware of difficulties. Occasionally, confidentially may have to be breached, regardless of the individual’s wishes. Never underestimate the power of an eating disorder.

When should I be worried about someone’s medical risk?

It is important to link up with a medical practitioner so the level of medical risk can be measured. In part this relates to 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 patient risk assessment based on BMI alone is therefore wholly inadequate. Additionally, monitoring weight has the potential for deceit with water loading and concealed weights falsifying figures.

You can download 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 downloaded 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.

What questions should I ask?

As emphasised previously, early recognition of an ED improves long-term prognosis. The SCOFF questionnaire uses five simple screening questions. Its use is recommended by the National Institute for Health and Clinical Excellence (NICE) and it additionally has been validated for the initial detection of EDs in both specialist and primary care settings. It has a sensitivity of 100 per cent and specificity of 90 per cent for AN. Although not diagnostic, a score of 2 or more positive answers should raise your index of suspicion and highlight the need for a more detailed history as delineated below.

The SCOFF questions:
Do you ever make yourself sick because you feel uncomfortably full?
Do you worry you may have lost control over how much you eat?
Have you recently lost more than one stone in a three month period?
Do you believe yourself to be fat when others say you are too thin?
Would you say that food dominates your life?

The eating history

Eating and anorexic behaviour
• Do you avoid eating with others?
• 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?
• Do you ever lose control or binge? How often and what do you eat?

Eliciting psychopathology
• What do you think of your current weight?
• What do you see as your ideal weight?
• How would you feel if you were the normal weight for your height?
• How much of the day do you spend thinking of food and your weight?
• Do you ever get depressed or guilty? Do you ever feel suicidal?
• Has your life become more ritualised?
• Do you have compulsions to do things eg binge, over exercise?

Screen of Important physical symptoms
• When was your last period?
• Have you noticed any weakness in your muscles? What about climbing stairs or brushing your hair?
• Are you more sensitive to the cold than others?
• What is your sleep like?
• Have you fainted or had dizzy spells?
• Have you problems with your teeth?
• Have you had any problems with your digestive system?

Is there anything tutors and teachers should not say or do?
• Do not get into confrontation. State what you have noticed and what your concerns are calmly.
• Do not expect the individual to accept the problem at the first attempt. You do not have to win every battle to win the war.
• Agree to disagree. Suggest a later meeting to review things.
• Do not get into the details about food, or shape, or weight. Consider the bigger picture of broad quality of life.
• Join with the patient in working within the constraints of ‘higher powers’, ie nutritional safety, duty of care, Mental Health Act, etc.

How can I manage people with eating disorders?

People with EDs are usually ambivalent about change and gain professional help only to please others. Engaging such individuals in treatment can be difficult.

EDs are a complex mixture of physical and psychological morbidity. 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). In most studies, the best outcome is attained by a form of guided self-help. This involves using general counselling skills, warmth and empathy in order to support the eating disorder patient to follow specialist advice. Books and web-based treatments are available for AN and BN. Some are listed below, or visit our website, www.eatingresearch.com

General pointers
1. Help move the patient into the position where they are interested in considering change – by discussing the pros and cons of their behaviour, for example.
2. A motivational interviewing approach can help with patient's ambivalence about change. There is a downloadable resource about MI on www.eatingresearch.com
4. Counselling of other issues – eg relationship problems, perfectionist, rigid and anxious traits.
5. Information sharing with carers can be invaluable and should be encouraged even if the individual herself will not come

Be aware that:
People with EDs may have specific learning needs and benefit from support and guidance from the educational support unit. For example, they are often highly perfectionist and terrified of making mistakes. This can make time management and prioritising difficult.
Also, they often have a cognitive style in which they focus too much on detail and
find the ability to synthesise 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. The brain itself is a hungry organ and requires more than 500 kcal a day itself. Anything less than this, then attention and working memory are preoccupied with food issues and there is less capacity for efficient intellectual work.

When should I refer to psychiatric services?

Indications for urgent referral to psychiatric services include:
All cases of anorexia nervosa;
Cases of bulimia nervosa that have failed to respond to guided self-help (see below).

How do I manage someone with bulimia nervosa

There are self-treatment books and web-based treatments based on CBT.

Step 1, focus on regular eating
- Aim to eat three regular meals per day to reduce the urge to binge.
- Aim for a diet with low glycaemic index food to keep blood sugar levels constant.
- Gradual goals to minimise weight-reducing behaviors (vomiting, laxatives, etc)
- Education about the medical consequences of weight reducing behaviors and the fact that the brain becomes addicted to food (and other substances) if there is (a) starvation (b) intermittent consumption of high sugar/fat food (c) stress (d) vomiting.
- Advice on a healthy balanced diet.

Step 2, establish a therapeutic relationship
- Aim for a collaborative approach to the disturbed behaviour.
- Acknowledge that there will be many relapses and difficulties on the path to regular eating.
- Counselling of other issues – eg sexual abuse, relationship problems, alcohol and/or drug abuse.

Step 3, specific strategies
- Self-monitoring by the use of food diaries.
- Behavioural strategies – these can be used with the diaries.
- Cognitive approaches – to challenge beliefs and change behaviours.

Keeping food diaries
These are the mainstay of help in BN, and can also be helpful in AN. A diary encourages linking of feelings (sadness, inadequacy, rejection, guilt etc) to food related behaviours – eg restriction, vomiting, exercising. Often, the need for a sufferer with AN to restrict their intake has been explained by the continual feeling of physical fullness. In fact, sufferers are ‘full of feelings’ and not physically full. Their anorexia is a way of stemming and dampening their emotions, bottling everything up inside. Equally, bulimics can be so ‘full of feelings’ that they feel a need to purge those feelings away. ED sufferers would prefer to feel numb. Their feelings and emotions are too uncomfortable to sit with.

A diary may take weeks for a patient to commit truthfully to, as it is often difficult to confront the pain of reality.
**Behavioural strategies**

Using the diary, the patient should be encouraged to see her behavior and how she may change this, eg.

- Visualise and plan in detail a healthy eating plan with the following targets that can be gradually approximated to: sufficient quantity of food for metabolic needs (>2000 kcal); sufficient variety of food nutrient; social eating.
- Decide that she will try not to vomit before 9am, and then 10am, etc.
- Decide on certain foods that feel ‘safe’ and eat those at times that feel more difficult.
- Plan to do something immediately after eating to take her mind off vomiting.
- Decide before she starts eating how much she is going to eat and try to stick to that.
- Only keep so much food in the house.
- Only go shopping with preplanned lists and limited money and avoid the sight and smell of highly palatable foods when hungry.

**Cognitive approaches**

- Identify beliefs (using the diary), eg ‘if I eat a chocolate bar I will put on a stone’, and underlying assumptions, eg ‘all people who are fat are worthless’.
- Challenge beliefs by discussion and support from literature.
- Change beliefs by consistent approach.

*Where and who can I ask for further help?*

**Local Psychiatric Service**

There may be one consultant who has a special interest in eating disorders in your local district.

**Specialist eating disorders unit**

There may be a regional or national centre.

**beat**

This is a nationwide organisation that offers a number of services, including telephone advice, self-help groups, family groups and individual counseling, training courses and information about services. www.b-eat.org.uk.

**Royal College of Psychiatrists**

www.rcpsych.ac.uk

General diagnosis and treatment information, including national guidelines.

**Self-help books**


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<tr>
<th>Time</th>
<th>Food and liquid consumed</th>
<th>Place and circumstances/ how I felt before</th>
<th>Bingeing/vomiting/laxative use</th>
<th>How I felt after after</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.45</td>
<td>3 bowls of cereal and milk</td>
<td>kitchen, felt worried about the day and felt fat</td>
<td>binged/vomited in the toilet and took 10 laxative tablets</td>
<td>depressed. Bound to be a terrible day. I’m not going eat anything else all day</td>
</tr>
<tr>
<td>9.45</td>
<td>apple</td>
<td>office at work, felt hungry but not panicky</td>
<td>none</td>
<td>guilty and depressed because I wasn’t going to eat anything today</td>
</tr>
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**Reference list**


