BELMATT
HEALTHCARE TRAINING

Eating Disorders

Aims and Objectives

This course aims to raise awareness of the different types of eating disorders

Session Objectives

This session will explore the following:

- Different types of eating disorders
- Classification of Anorexia Nervosa, Bulimia nervosa, binge eating disorders and atypical eating disorders
- Investigations and assessments
- Management strategies
- Consider how we can best support young people who are suffering
- How to signpost practitioners to further sources of support

Eating Disorders and the NHS

- The NHS is investing an additional £79 million into children's mental health services due to increased demand during the pandemic. The funding is being used to ensure at least 2,000 more children and young people start treatment for eating disorders.
- Mental health services, including eating disorder services, are being backed by an additional £2.3 billion every year in additional funding until 2023/24 as part of the NHS Long Term Plan's commitment to improving mental health services.

What are Eating disorders

Eating disorders are characterised by persistent disturbance of eating or eating-related behaviour which leads to altered intake or absorption of food and causes significant impairment to health and psychosocial functioning.

The main types of eating disorders are:

1. Anorexia Nervosa
2. Bulimia Nervosa
3. Binge Eating Disorder
4. Atypical Eating Disorders

Aetiology of Eating Disorders

Not well understood

Factors associated with eating disorders include

- General Factors
- Neurobiological Factors
- Psychosocial Factors
- Family History of Eating disorders

Prevalence

- Estimates suggest that over 700,000 people in the UK have an eating disorder. 90% of whom are female.
  - This is likely an underestimate as many cases do not present to health services.
  - Eating disorders can develop at any age but risk of onset is highest for adolescents and young adults.
- Atypical eating disorders are the most common, followed by binge eating disorders, and bulimia nervosa
- Anorexia nervosa is the least common.

Dieting

- High percentage of population is on a “diet” at any one time.
- 95 % of those who lose weight will regain within 5 years.
- Billion pound industry.
- Dieting has become a “normal” way of eating.
- 35% of “normal dieters” will develop some form of an eating disorder.

Prognosis

- Eating disorders can persist for decades if untreated or treated inadequately — illness varies in severity and course over time from person to person.

Anorexia nervosa The course of anorexia nervosa is very variable — complete recovery is less likely the longer the person has the illness.

  - Estimates suggest that 46% of people will fully recover, 34% improve partially and 20% develop chronic anorexia nervosa.
  - Prognosis is best in young people with a short illness duration — up to 60% of adolescents with anorexia nervosa make a full recovery with early specialist treatment.
- Relapse is common - 31% of people relapsed after treatment and that the highest risk of relapse was during the first year after discharge.
- Mortality rates are over 5 times higher for people with anorexia nervosa than the general population.
  - Anorexia nervosa has the highest rate of mortality of all mental health disorders.
  - The most common causes of death are cardiac complications, severe infection and suicide (20%).

Prognosis

Bulimia nervosa is associated with better recovery rates and lower mortality than anorexia nervosa.

- The course of illness typically consists of cycles of remission and relapse.
  - Between 30–60% of people with bulimia nervosa make a full recovery with treatment.

Binge eating disorder

- Less is known about binge eating disorder — typically there are cycles of remission and recurrence with periods (often many months) where the person is free of the eating disorder.
  - It is thought that approximately 70–80% of people with binge eating disorders will recover over time (12-year follow-up).

Atypical eating disorders

- Prognosis varies widely and depends on the severity of associated physical and psychological features.
  - There may be movement between one diagnosis and another — some people with atypical eating disorders may go on to develop bulimia nervosa or, more rarely, anorexia nervosa.

Groups at Risk

- Eating disorders can occur in anyone at any age and may present in people of normal or above normal weight.
- Risk in young men and women is highest between 13 and 17 years of age.
- Behaviours associated with eating disorders are often covert.
- Some people may talk openly about an eating disorder, others might be unaware that they have one or find it too difficult to disclose.
- Some occupational or recreational activities are associated with a greater risk of eating disorder such as professional sport, fashion, dance, and modelling.
- Eating disorders may present atypically or with faltering growth or delayed puberty in children and adolescents.
- Other causes must be excluded but clinicians should have a high index of suspicion in people presenting with weight loss, faltering growth, delayed puberty or menstrual irregularities.

Red Flags for Eating Disorders

- Menstrual irregularities
- Fertility problems
- Unexplained seizures
- “Funny turns”
- Chronic fatigue
- Callouses on hands
- Loss of dental enamel

BMI

- Commonly used index of adiposity
- Controls for effects of height when assessing weight
- BMI= weight in kg divided by height (in meters) squared
- Used in actuarial tables
- BMI 20-25 associated with lower morbidity and mortality
- May be blind to fall-off in expected height or weight

When to Suspect an Eating Disorder

- Unusually low or high BMI for their age (including children with faltering growth).
- Rapid weight loss.
- Change in eating behaviour including dieting or restrictive eating practices that are causing concern to the person, their family/carers, or other professionals.
- Mental health problems (such as stress, anxiety and depression) or social withdrawal.
- Disproportionate concern about body weight or shape.
- Poor control of chronic diseases affected by diet (such as diabetes or coeliac disease).
- Menstrual or other endocrine disturbances.
- Unexplained gastrointestinal symptoms, electrolyte imbalance or hypoglycaemia.
- Physical signs of malnutrition (such as poor circulation, dizziness, palpitations, fainting or pallor) or compensatory behaviours such as laxative misuse, vomiting or excessive exercise.

Anorexia

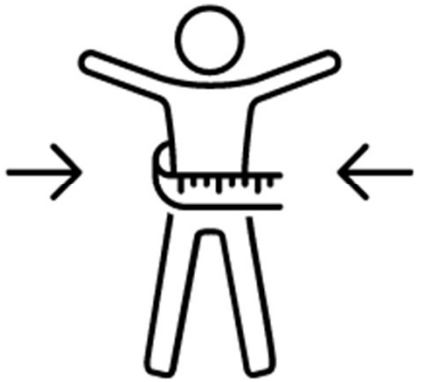
A serious mental illness where people are of low weight due to limiting their energy intake. As well as restricting the amount of food eaten, they may do lots of exercise to get rid of food eaten. Some people may experience cycles of bingeing (eating large amounts of food at once) and then purging.

Recognizing the Signs and Symptoms in Eating Disorders

- General: Frequently skips meals and has a preoccupation with food, unable to express feelings, worries about other’s opinions, perfectionist, overly critical of self and others
- Anorexia: Weight loss, strict dieting, perceives being overweight, denies hunger, rituals, excessive exercise
- Bulimia: Visits restroom after meals, eats large amounts without gaining weight,, eats rapidly, mood swings, unexplained disappearance of food, empty wrappers
- Binge Eating Disorder: Weight gain, eats large amounts rapidly, eats in isolation, eats to point of being overly full

Prognosis

- Anorexia
  - 5-20% mortality (cardiac arrhythmia's)
  - More than 75% will regain weight to near-normal levels, with return of menses, but abnormal eating habits and psychosocial problems often persist.
  - 50% become bulimic.

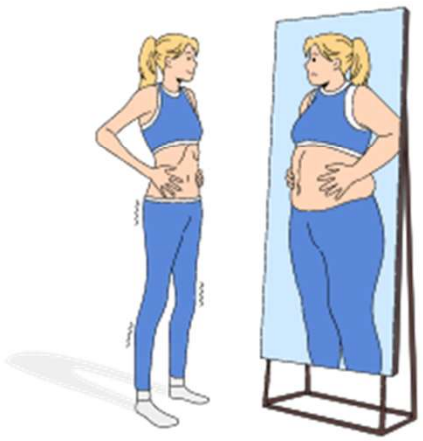


Clinical Features of Anorexia Nervosa

- Restriction of energy intake resulting in low body weight.
- Intense fear of gaining weight.
- Behaviour that interferes with weight gain.
- Psychological disturbance which may include:
  - -Denial of seriousness of malnutrition and its impact on physical health.
  - -Hormonal disturbance.
- Many physical signs are associated with anorexia nervosa

Anorexia

- Average age of onset= 15-19
- Most common cause of:
  - Weight loss in teen girls
  - Inpatient admission
- Life history--1% in 20 year old women
- Increased risk of comorbidities
- 90% female prevalence



Anorexia

- Loss of 15% of minimal normal weight
- BMI <17.5 in adults
- Exceptions
  - Other specified feeding or eating disorder:
  - Atypical anorexia
  - Children and adolescents—watch fall-offs from trends in growth charts
- Menstruation typically absent in females
- Low testosterone leading to atrophied genitalia and absence of morning erections in males

DSM-IV Criteria : Anorexia

1. Refusal to maintain adequate weight: (less than 85% of IBW or BMI<17.5)
2. Intense fear of gaining weight
3. Body image distortion
4. Amenorrhea (3 months)
    - 2 sub-types: restricting and purging

Physical Exam - Anorexia

- Specifically note state of nutrition and hydration, height, weight without clothing) used to calculate BMI, BP and pulse with orthostatic, hypothermia
- Skin (pallor), nails (brittle) and hair (lanugo)
- Chest (rhales), CV (arrhythmia), extremities (edema, cyanosis), DTR's (delayed relaxation)
- Abdominal and rectal (bowel sounds, epigastria pain, heme positive stool)

Notes on NICE for A.N.

- Psychological therapies including CBT and family interventions – with the aim of encouraging weight gain and healthy eating
- Most people with anorexia should be treated as outpatient
- Family members should be considered in all cases because of the effects of AN on the family
- Medication is not the primary treatment of anorexia nervosa
- Caution should be used when treating comorbid mental health problems – depression may resolve with weight gain alone – QT prolongation
- In most patients with AN, an average weekly weight gain of 0.5 – 1kg in inpatients, and 0.5 kg in outpatient settings should be the aim
- Feeding against patient will is treatment of last resort under Mental Health Act.

Recurrent (at least once per week for 3 months) episodes of uncontrolled eating of an abnormally large amount of food over a short time period (binge eating) followed by compensatory behaviour such as self-induced vomiting, laxative abuse or excessive exercise.

Bulimia Nervosa

Bulimia

- People with this eating disorder are caught in a cycle of eating large quantities of food (called bingeing), and then trying to compensate for that overeating by vomiting, taking laxatives or diuretics, fasting, or exercising excessively (called purging).

Clinical Features of Bulimia Nervosa

- Recurrent episodes of binge eating occurring on average at least once a week for 3 months.
- Recurrent inappropriate compensatory behaviour to prevent weight gain (occurring on average at least once a week for 3 months).
- Weight is often within normal limits or above weight range for age.
- Psychological features
- Physical symptoms, such as bloating, fullness, lethargy, gastro-oesophageal reflux, abdominal pain, and sore throat (from vomiting).

A serious mental illness where people experience a loss of control and eat large quantities of food on a regular basis.

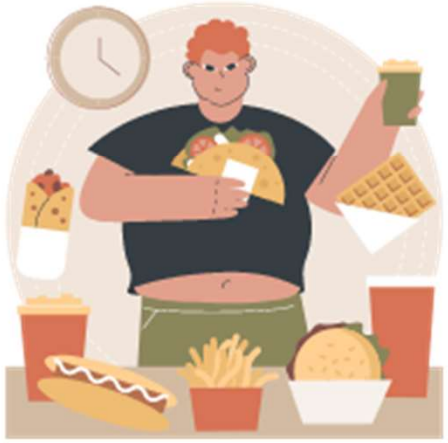
Recurrent episodes of binge eating in the absence of compensatory behaviours.

Episodes are marked by feelings of lack of control.

Binge Eating Disorder

Binge Eating Disorder

- Emergence corresponds with:
  - Media glorification of thinness
  - High calorie snack food
  - Loss of mealtimes
- Peak age of onset=15-20 yrs
- Average clinical presentation after 10 yrs
- 12% adolescent girls have some form
- Gay boys may be more vulnerable
- Increasing prevalence in men>15 yrs



Clinical Features of Binge Eating Disorders

- **Clinical features of binge eating disorder**
- **Recurrent episodes of binge eating (at least once per week for 3 months) in the absence of compensatory behaviours.**
  - A binge is defined as consuming an excessive amount of food in a discreet time period accompanied by a feeling of loss of control where the person cannot stop eating or control the amount of food they eat at that time.
  - During a binge the person may eat more rapidly than normal, eat until uncomfortably full or when not hungry and experience significant distress and feelings of guilt and shame.
- **Body weight may be maintained at normal, overweight or obese.**
  - Many people with binge eating disorder are overweight or obese.

DSM-IV Research Criteria: Binge Eating Disorder

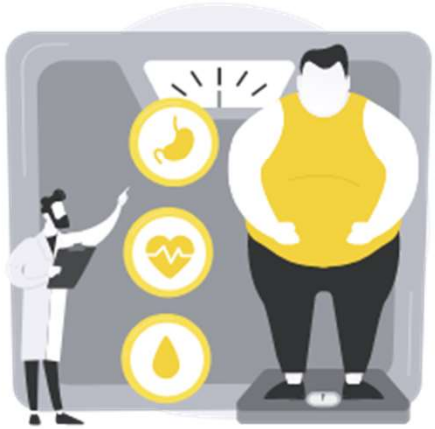
- Recurrent binge eating (at least twice a week for **6 months**) *loss of control + *eating very large amounts
- Marked distress with at least **three** of the following:
  - Eating very rapidly
  - Eating until uncomfortably full
  - Eating when not hungry
  - Eating alone due to shame or guilt
  - Feelings of disgust, guilt, depression after overeating
- No recurrent purging, excessive exercise, or fasting
- Absence of anorexia nervosa

Potential Medical Consequences of BED

- Obesity
  - Cardiovascular disease
  - Hyperlipidemia, Diabetes
  - Renal, Gallbladder disease
  - Osteoarthritis
  - Sleep apnea and Respiratory problems
  - Infertility, complications of pregnancy
  - Colon, breast, endometrial, prostate CA
  - Depression, suicide, substance abuse

Binge Eating Disorder

- Tends to be a chronic condition for those not in therapy or support group.
- 50% remission for those treated with CBT.
- Morbidity and mortality are directly related to the many diseases associated with obesity.



Atypical Eating Disorders

- **Atypical eating disorders** (also known as ‘eating disorder not otherwise specified’ (EDNOS) or ‘other specified feeding or eating disorder’ [OSFED]) — symptoms of an eating disorder such as anorexia nervosa, or bulimia nervosa, which do not meet the precise diagnostic criteria.
- For example, all of the criteria for anorexia nervosa are met, there is significant weight loss, but the person's weight is within or above normal range.

Clinical Features of Atypical Eating Disorders

- Atypical eating disorders have features that closely resemble but do not meet the strict criteria for other diagnostic categories for example the person's weight may be just above the diagnostic threshold for anorexia nervosa or binge eating/purging may occur infrequently.
- The majority of eating disorders are atypical.
- Over-concern with body weight and shape is generally present.
- Many people with atypical eating disorders have had anorexia or bulimia nervosa previously or may in the future develop the full diagnostic criteria for anorexia or bulimia nervosa

Investigation of Physical Conditions and Psychological Symptoms

- Physical investigations
- Food diaries
- Growth charts
- Psychiatric assessment
- Family history and involvement
- Observation of family meal
- Height and weight
- Routine blood tests: glucose, thyroid, electrolytes, liver function tests, pregnancy, complete blood count
- Electrocardiogram
- Bone density

Screening Tools and Risk Assessment

Eating disorders can be difficult to detect in primary care as those affected may be slow to present, reluctant to disclose symptoms, or be unaware they have an eating disorder.

A variety of tools can be used for screening and risk assessment such as:

- A baseline eating disorder assessment tool available on the National Institute of Health and Care Excellence (NICE) website.
- The SCOFF questionnaire — two or more positive answers to the following questions are suggestive of anorexia nervosa or bulimia nervosa.
  - 'Do you ever make yourself sick because you feel uncomfortably full?'
  - 'Do you worry that 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?'

History taking

- **Take a history asking about:**
  - Look for symptoms such as change in weight (increase, decrease, or failure to thrive).
  - Dietary restriction or binge eating.
  - Fear of gaining weight and body image disturbance — ask about perceived ideal weight.
  - Compensatory behaviours (such as excessive exercise, purging, vomiting or use of weight loss medications) — consider insulin misuse in diabetic patients.
- Look for complications such as fatigue, constipation, reflux, hair loss, and amenorrhoea.
  - Be alert for symptoms suggestive of a serious complication requiring urgent admission such as syncope, pre-syncope or severe abdominal pain.
- **Consider co-morbidities and symptoms suggestive of** any other cause such as inflammatory bowel disease or coeliac disease.
- **Mental health**
- **Family history** of eating disorders, depression, or substance abuse.
- **Medication** (including over-the-counter).

Examination

- **Calculate the person's body mass index (BMI) and compare with previous recordings.**
  - Use centile charts if the person is younger than 18 years of age — it is important to make an early diagnosis in children because they are at risk of irreversible growth impairment.
  - Be aware that some people may refuse to be weighed or falsify their weight by drinking large amounts of water beforehand or by hiding heavy objects in their clothes.
- **Check vital signs including:**
  - Temperature (hypothermia is a red flag).
  - Pulse (bradycardia for example <50 beats per minute or postural tachycardia are red flags).
  - Blood pressure checking for postural differences (hypotension or orthostatic hypotension are red flags).
  - Hydrations state.
  - Peripheral circulation.

Examination

- **Look for muscle wasting and assess muscle strength:**
  - Scores of 2 or less (especially if scores are falling) on the Sit up–Squat–Stand (SUSS) test are a red flag.
    - The sit up test — the person lies flat on a firm surface such as the floor and has to sit up without, if possible, using their hands.
    - The squat test — the person is asked to rise from a squatting position without, if possible, using their hands.

Investigations

- **Consider the need for investigations:**
- **Extensive investigation is not usually required in primary care.**
  - Most people with an eating disorder will have normal blood results which are a poor indicator of risk, however, some tests may be useful to rule out complications.

- **Depending on clinical situation, consider the following investigations in primary care**
  - Full blood count — may show anaemia from malnutrition or gastrointestinal losses, or mild leucopoenia or thrombocytopenia from malnutrition.
  - Erythrocyte sedimentation rate (ESR) — usually normal in people with anorexia, a raised ESR may indicate an organic cause of weight loss.
  - Urea and electrolytes — hypokalaemia is suggestive of vomiting or laxative abuse; hypernatremia may be a result of excess water intake. Electrolytes may be elevated due to dehydration.
  - Liver function tests — may be slightly elevated from malnutrition.
  - Blood glucose

Investigations

- **Depending on clinical situation, consider the following investigations in primary care (continued)**

  - Creatinine, and urinalysis — chronic hypokalaemia and chronic volume depletion can lead to the development of kidney disease.
  - Electrocardiography (ECG) — this should be considered for all people with rapid weight loss, excessive exercise, severe purging behaviours (such as laxative or diuretic use or vomiting), bradycardia, hypotension, excessive caffeine (including from energy drinks), prescribed or non-prescribed medications, muscle weakness, electrolyte imbalance, or previous abnormal heart rhythm.
- Further tests may be required in more severe cases or to assess complications (seek specialist advice):
  - Calcium, magnesium, phosphate.
  - B12, folate and ferritin.
  - Thyroid function tests.
  - Follicle stimulating hormone, luteinising hormone, oestradiol, prolactin and urinalysis (including pregnancy test) may be considered if presenting with amenorrhoea.
- Other investigations may be indicated for example coeliac screening.

Management

Management of suspected eating disorder in primary care

- **If there is a risk of self harm, suicide, or serious physical harm, then consider consider emergency medical or psychiatric admission.**
- **For all other people with a suspected eating disorder:**
  - **Refer *immediately* to an age appropriate eating disorder service** for specialist assessment and management – do *not* use a watchful waiting strategy for managing eating disorders.
    - Depending on locally agreed care pathways and service provision referral may be to a community mental health team (CMHT), child and adolescent services (CAMHS), or a specialist eating disorder unit.
    - Consider simultaneous paediatric referral for children and young people with eating disorders.
    - Urgency of referral depends on the specific clinical situation and on clinical judgement — if unsure seek advice from the nearest specialist eating disorders service.

Management while waiting for specialist referral

- **While awaiting specialist assessment:**
  - Arrange regular reviews. l
  - Monitor for complications – mental and physical
  - Increased monitoring if co-morbidities or special groups
  - Prescribe with care and check local guidelines

Risk Factors

- Risk is increased by rapid weight loss, fasting for over five days, BMI less than 16kg/m2, compensatory behaviours (such as laxative misuse or vomiting), dehydration, use of diet pills or diuretics, water loading or excessive exercise.
- Consider psychiatric crisis care or psychiatric inpatient care – discuss with a specialist if unsure whether admission to medical/paediatric ward is more appropriate.
- Consider admission if the person may not be kept from significant harm at home or where the home environment impedes recovery.

Communication

- Take time to talk to with the child or young person you care for: young people may find it difficult to accept that they have a problem or that they may need help. Some young people may find it easier to talk while doing something together such as playing a board game or engaging in a craft or other activity. Find a time when you will not be disturbed and both of you feel calm. If they find it difficult to talk to you, encourage them to talk to another trusted adult such as a family member, teacher or GP.
- Make time to listen to them: create a calm safe space where they can communicate how they are feeling without judgement. Try to avoid saying things that could feel accusatory, critical or dismissive.
- Try to understand the problems and provide reassurance that you have heard them and are there to help: ask how they are feeling rather than focussing all the conversation on their eating or weight as this can often be more productive. Complimenting them on things other than their appearance can help the young person feel valued and is less likely to be interpreted negatively.

Support and Care

- Encourage regular mealtimes as a family: sitting down together for regular mealtimes as a family can help encourage social and healthy eating behaviours and help monitor any concerns about eating problems. Keep the conversation neutral.
- Keep an eye on the young person you care for. Consider if eating problems persist, deteriorate and/or are impacting on the young person's day to day living: seek specialist health advice and support and increase vigilance, including checking if the young person is losing weight, developing secondary physical health symptoms (see list above) or accessing websites/social media content that is pro-eating disorders.
- Help the child or young person you care for do positive activities which means they aren't isolating themselves: positive activities including safe contact with family and friends can provide a distraction from negative and intrusive thoughts and may help the young person open up about their feelings.

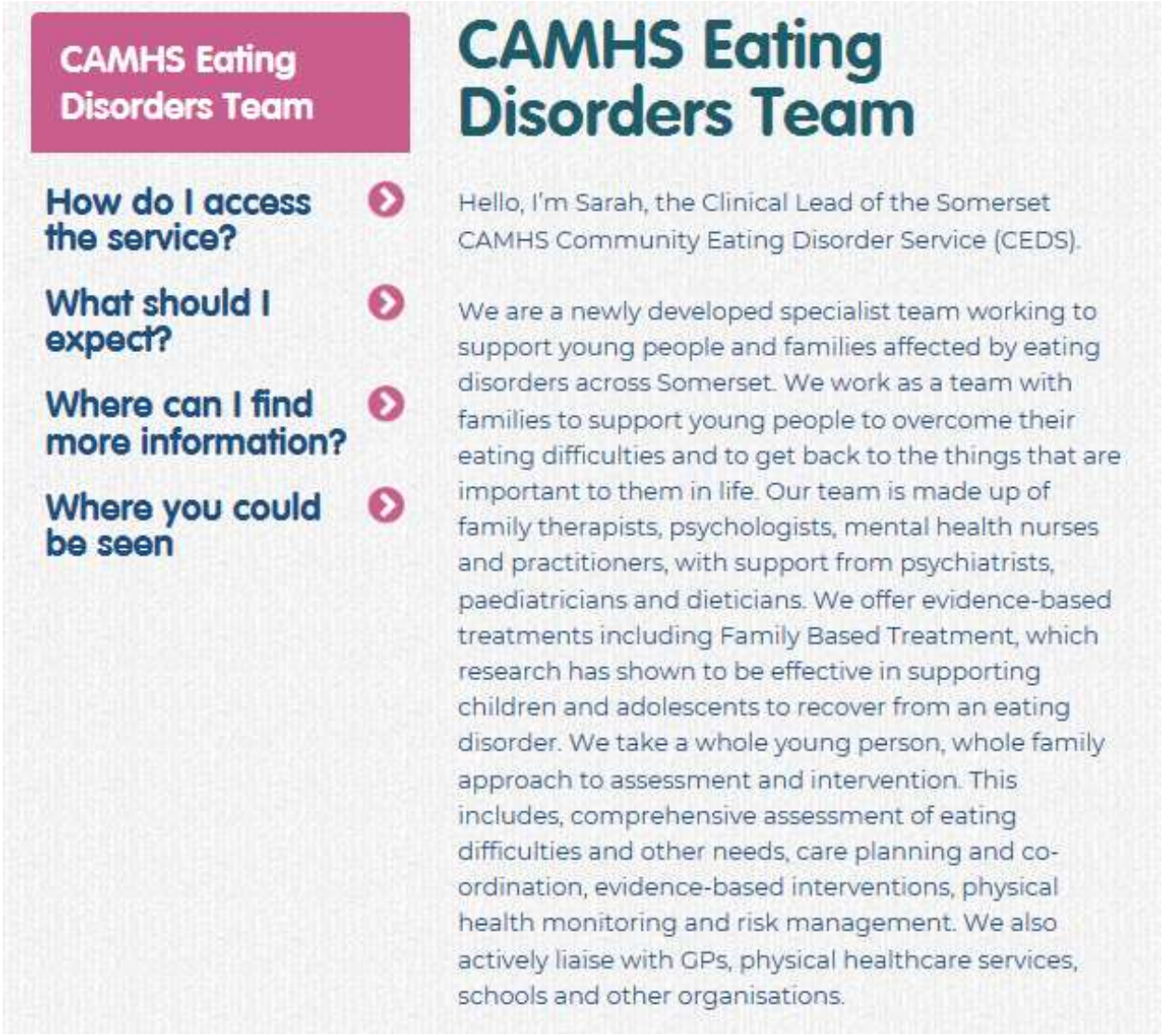
Support and Care

- Encourage parents and carers to provide structure and routine (including for sleep): frequent changes to routine and restrictions can cause some children and young people to feel more anxious and upset.
- Many children and young people may also experience difficulties with their sleep. Providing structure through the development of daily and weekly timetables, including bedtime routines can be helpful in providing some predictability for young people in this unsettled time and distraction from negative thoughts.
- Support children and young people with disabilities: children and young people with disabilities including those with autism spectrum disorder or learning disabilities may find the impact of COVID-19 particularly difficult to manage. It is important to explain change and manage any anxiety and distress they may be experiencing as this may impact on their eating behaviours including restrictive patterns of eating or overeating.
- The National Autistic Society have helpful advice on their website on how to deal with this uncertain time.
- Seek specialist advice and support quickly if you think the young person you care for has physical symptoms secondary to weight loss, suicidal thoughts or are self-harming: It is important that you do not ignore these and that you speak to the GP or crisis mental health team urgently to get the right help and support – or contact some of the services available.

Criteria for Hospitalization

- Loss of more than 40% of ideal weight (or 30% if in 3 months)
- Rapid progression of weight loss
- Cardiac arrhythmia
- Persistent hypokalemia unresponsive to outpatient treatment
- Symptoms of poor cerebral perfusion or mentation (syncope, severe dizziness, or listlessness)
- Psychiatric disturbances beyond patient's control, severe depression
- Suicidal ideation

CAMHS Eating Disorder Service



Admission under the Mental Health Act 1983(amended 2007)

- **The Mental Health Act allows compulsory admission and treatment of people who:**
  - Have a mental disorder of a nature and degree that warrants treatment in hospital, *and*
  - Need to be admitted in the interests of their own health or safety, or for the protection of other people.
- **Compulsory admission is arranged using the appropriate section of the Mental Health Act:**
  - **Section 2 allows compulsory admission for up to 28 days for assessment.**
  - **Section 3 allows compulsory admission for up to 6 months for treatment** (in people with an established diagnosis).
    - Sections 2 and 3 require an application from an Approved Mental Health Professional (AMHP, formerly an Approved Social Worker), or, rarely, the person's nearest relative, and recommendations from two doctors; one of whom is section 12-approved (usually a psychiatrist) and one who has previous acquaintance with the person (usually the person's GP if at all practicable).
    - Ideally, the person should be examined jointly by the two doctors with the AMHP also present. Where this is not possible, each doctor may carry out a separate examination. If the AMHP is not present, it is essential that at least one of the doctors discusses the person with the AMHP.

Admission under the Mental Health Act 1983(amended 2007)

- **Section 4 is used in exceptional cases to permit compulsory admission for up to 72 hours** if there is urgent necessity, and undesirable delay would occur while trying to arrange admission under section 2.
    - It requires an application from an AMHP (or, rarely, the person's nearest relative) and just one medical recommendation, preferably from a doctor with previous acquaintance (usually the person's GP).
- **Section 136 is used by police to take people from a public place to a place of safety** to enable examination by a registered medical practitioner and interview by an AMHP. The person's GP, where known, may be informed

Management in primary care of confirmed eating disorders

- **Ensure there is a clear agreement between primary and secondary or tertiary care about the responsibility for monitoring a person with an eating disorder.** Monitoring of general medical problems usually occurs in primary care.
- Good co-ordination of care is particularly important when young people move from child to adult services, if more than one service is involved in care, or care is needed in different places at different times (for example university students)

Treatment for Anorexia Nervosa

- **For adults with anorexia nervosa, one of the following may be considered:**
  - Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) — typically up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks.
  - Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) — typically 20 sessions, with weekly sessions for the first 10 weeks, and a flexible schedule after this. Up to 10 extra sessions may be added for people with complex problems.
  - Specialist supportive clinical management (SSCM) — typically 20 or more weekly sessions (depending on severity).
  - If individual CBT-ED, MANTRA, or SSCM is unacceptable, contraindicated or ineffective eating-disorder-focused focal psychodynamic therapy (FPT) may be considered — typically 40 sessions over 40 weeks.

Treating Anorexia

- When treating anorexia nervosa, be aware that:
  - helping people to reach a healthy body weight or BMI for their age is a key goal **and**
  - weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery
- When weighing people with anorexia nervosa, consider sharing the results with them and (if appropriate) their family members or carers
- Be multidisciplinary and coordinated between services
- involve the person's family members or carers (as appropriate)

Bulimia Nervosa

- **Psychological treatments in adults:**
  - Bulimia-nervosa-focused guided self-help programmes may be considered for example 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly initially.
  - If bulimia-nervosa-focused guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks of treatment, individual eating-disorder focused cognitive behavioural therapy (CBT-ED) may be considered. This typically consists of up to 20 sessions over 20 weeks.
- **Psychological treatments in children and young people:**
  - Bulimia-nervosa-focused family therapy (FT-BN) may be considered in children and young people with bulimia nervosa — typically 18–20 sessions over 6 months.
  - If FT-BN is unacceptable, contraindicated or ineffective, individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) for children and young people with bulimia nervosa may be considered — typically 18 sessions over 6 months, with more frequent sessions early in treatment and up to 4 additional sessions with parents or carers.

Binge eating disorder

- **Psychological interventions that may be offered to adults and children and young people with binge eating disorder include:**
  - Evidence-based self-help programmes with brief supportive sessions (for example 9 sessions over 16 weeks).
  - If guided self-help is unacceptable, contraindicated or ineffective after 4 weeks, group eating-disorder-focused cognitive behavioural therapy (CBT-ED) may be offered — typically 16 weekly 90 minute group sessions over 4 months.
  - If group CBT-ED is refused or unavailable, individual CBT-ED may be considered — typically 16–20 sessions.
- Psychological treatments aimed at binge eating have a limited effect on body weight and weight loss is not in itself a goal of therapy.

Consent and Confidentiality

- When working with people with an eating disorder and their family members or carers (as appropriate):
  - hold discussions in places where confidentiality, privacy and dignity can be respected
  - explain the limits of confidentiality (that is, which professionals and services have access to information about their care and when this may be shared with others)
- When seeking consent for assessments or treatments for children or young people under 16, respect Gillick competence if they consent and do not want their family members or carers involved

Communication and Information

When assessing a person with a suspected eating disorder, find out what they and their family members or carers (as appropriate) know about eating disorders and address any misconceptions

Offer people with an eating disorder and their family members or carers (as appropriate) education and information on:

- the nature and risks of the eating disorder and how it is likely to affect them
- the treatments available and their likely benefits and limitations

When communicating with people with an eating disorder and their family members or carers (as appropriate):

- be sensitive when discussing a person's weight and appearance
- be aware that family members or carers may feel guilty and responsible for the eating disorder
- show empathy, compassion and respect
- provide information in a format suitable for them, and check they understand it

Ensure that people with an eating disorder and their parents or carers (as appropriate) understand the purpose of any meetings and the reasons for sharing information about their care with other

Working with family members and carers

- Be aware that the family members or carers of a person with an eating disorder may experience severe distress. Offer family members or carers assessments of their own needs as treatment progresses, including:
  - what impact the eating disorder has on them and their mental health
  - what support they need, including practical support and emergency plans if the person with the eating disorder is at high medical or psychiatric risk
- If appropriate, provide written information for family members or carers who do not attend assessment or treatment meetings with the person with an eating disorder

Updated NICE Guidelines 16 December 2020

Urgent Referral necessary if:

- BMI below 14
- Weight loss 7kg in 4 weeks
- BP < 90/70
- Unable to get up from chair without arms
- T<35C
- Oedema
- Abnormal U&E, Mg+, FBC (lowered), LFTs (raised), albumin

Role of Primary Care Provider

- Team coordinator
- Rule out other causes of weight loss and/or complications
- Obtain early psychiatric and nutritional consultations and coordinate a multidisciplinary team approach to management
- Educate the patient about the medical complications of the illness

Summary, Take home messages:

- Eating Disorders are extremely common.
- Often underdiagnosed.
- They are the prototypical bio-psychosocial diseases.
- It has little to do with food and a lot to do with underlying thoughts and feelings.
- Dieting is THE BIGGEST risk factor.
- Focus on prevention and early intervention.
- Most effective treatment involves a multifactorial approach.
- The earlier treatment begins, the better the chance of recovery.

Finally

- Finally, as a healthcare professional, look after your own mental health too: this will help you to best support yourself and those you care about. Remember to talk to your family and friends about how you are feeling and seek help for yourself from the NHS and other support services if it's all getting too much.

Useful contacts

Anorexia and Bulimia Care (ABC 03000 11 12 13. anorexiabulimiacare.org.uk

Advice and support for anyone affected by eating problems.

Association for Family Therapy and Systemic Practice (AFT)aft.org.uk Information about family therapy, including a directory of therapists.

Beat 0808 801 0677 (England)
0808 801 0433 (Wales)
beateatingdisorders.org.uk
Offers information and advice on eating disorders, and runs a supportive online community. Also provides a directory of support services at HelpFinder.

British Association for Behavioural and Cognitive Psychotherapies (BABCP) babcp.com
Information about cognitive behavioural therapy and related treatments, including details of accredited therapists.

British Association for Counselling and Psychotherapy (BACP) bacp.co.uk Professional body for talking therapy and counselling. Provides information and a list of accredited therapists.

National Institute for Health and Care Excellence (NICE) nice.org.uk
Produces guidelines on best practice in healthcare.

Overeaters Anonymous Great Britain oagb.org.uk Local support groups for people with eating problems.

Useful contacts

Papyrus HOPELINEUK 0800 068 41 41 07860039967 (text)
pat@papyrus-uk.org papyrus-uk.org
Confidential support for under-35s at risk of suicide and others who are concerned about them. Open daily from 9am–midnight.

Samaritans 116 123 (freephone)
jo@samaritans.org
Freepost SAMARITANS LETTERS
samaritans.org

Samaritans are open 24/7 for anyone who needs to talk. You can visit some Samaritans branches in person. Samaritans also have a Welsh Language Line on 0808 164 0123 (7pm–11pm every day).

Student Minds studentminds.org.uk Mental health charity that supports students.

Tommy's tommys.org Information and support for people affected by stillbirth, miscarriage and premature birth.

YoungMinds 0808 802 5544 (Parents Helpline) 85258 (Crisis Messenger for young people – text the letters YM)
youngminds.org.uk
Committed to improving the mental health of babies, children and young people, including support for parents and carers.

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