Eating Disorders

Best Practice Guidelines for Dietitians

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<td>GP</td>
<td>General Practitioner</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>SMR</td>
<td>Standardised Mortality Ratio</td>
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<td>AN</td>
<td>Anorexia Nervosa</td>
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<td>EDNOS</td>
<td>Eating Disorders Not Otherwise Specified</td>
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<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<td>CNDS</td>
<td>Community Nutrition and Dietetic Service</td>
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Acknowledgement

The authors would like to thank the Dietitians of the Community Nutrition & Dietetic Service, HSE West for peer review and feedback throughout the development of this document. In particular they acknowledge the contribution of Ms. Ruth Kilcawley, Senior Community Dietitian, Child & Adolescent Mental Health Service, HSE West in the development, review and editing of ‘Eating Disorders – Best Practice Guidelines for Dietitians’.
Executive Summary

The 2007 HSE West Business Plan focuses on the development of additional Child and Adolescent Community Mental Health teams and on the development of a dedicated Eating Disorder Service. This plan aims to focus on the development of primary and community care multi-disciplinary teams and integration of services around the client, in line with best practice of management of eating disorders. The Dietitian is a member of these multidisciplinary teams.

Community Dietitians have a designated role in the treatment of clients with eating disorders. At present there is a lack of best practice guidelines on the nutritional care of these clients within HSE West. There are no standard national policies or protocols developed in Ireland for the management of eating disorders. In order to guide future development, the Community, Nutrition and Dietetic Service (CNDS) team have acknowledged the need for the development of best practice guidelines to address future planning of nutrition services for clients with eating disorders.

This report provides guidelines to assist the CNDS in planning a client-focused nutrition and dietetic service for clients with eating disorders (mainly Anorexia Nervosa and Bulimia Nervosa). Client-centred best practice guidelines for Dietitians working as part of the Primary Care Team are developed to enable the Dietitians to provide an efficient service. These should ensure the consistency of service provision, geographical equity and equity of access to treatment and care within HSE West.

A comprehensive literature review was carried out to produce guidelines and best practice in nutrition treatment for clients with eating disorders. Strategic documents and guidelines in relation to the management of eating disorders from UK, USA, Canada, Australia and New Zealand were reviewed. The CNDS of the HSE West collaborated and guided throughout the development process. Nutrition Care plans for Anorexia Nervosa and Bulimia Nervosa have been developed for use by Dietitians and are included in the appendices. These reflect evidence outlined in the document and ensure the service users receive standardised evidence based care from the CNDS.
Chapter I
Introduction

Eating disorders are relatively common conditions affecting mainly, but not exclusively young women. Children and middle aged or even elderly people can be afflicted. Generally males form a minority of clients. Severe forms of eating disorders can lead to chronic disorder, disability and sometimes death. Less severe forms of eating disorders produce physical, psychological and social distress and lead to secondary psychiatric disorders such as depression (Canadian Paediatric Society, 1998). Lifetime prevalence estimates of eating disorders namely, Anorexia Nervosa, Bulimia Nervosa and Binge Eating disorders are 0.9%, 1.5% and 3.5% among women and 0.3%, 0.5% and 2.0% among men (Hudson et al 2007). The Standardised Mortality Ratio (SMR) for eating disorders has been estimated at 538, compared with 136 to 197 for depression, schizophrenia and alcoholism (Harris & Barraclough, 1998).

Eating disorders have a substantial impact on social functioning, including occupational and educational impairment. These disorders are the most common at the age when people are in secondary school, in higher education or at the beginning of their working careers and often result in lost productivity due to the inability of people to work or premature death.

Eating disorders are easier to treat in the early stages and treatment given at this stage is the most cost effective (Rome et al, 2003). Once anorectic or bulimic thinking and behavior patterns have become entrenched the client will have a poorer prognosis.

Appropriate treatment for eating disorders in the early stages can reduce the need for expensive hospital admission and long-term treatment.

Rome et al, 2003
1.1 Need for Client-Centred Best Practice Guidelines for Dietitians

With the adoption of the Report of the Expert Group on Mental Health Policy – ‘A Vision for Change’ by the Health Services Executive (HSE) in 2006, considerable changes started taking place in the Mental Health Services. The 2007 HSE West Business Plan plans to focus on the development of additional child and adolescent community mental health teams and to develop dedicated Eating Disorder Services in each of the administrative areas. This plan aims to focus on the development of primary and community care multi-disciplinary teams and integration of services around the client in line with best practice. The Dietitian will be a member of these multidisciplinary teams.

Dietitians have an essential role within the multidisciplinary team managing eating disorders and have to be involved in the assessment, treatment and monitoring of those patients.

*NHS Quality Improvement Scotland, 2006*

Community Dietitians have a designated role in the treatment of clients with eating disorders. At present there is a lack of best practice guidelines for Medical and Allied Health Professionals on the nutritional care of these clients within HSE West. The CNDS, on addressing future planning of nutrition services for clients with eating disorders, have acknowledged the need for the development of best practice guidelines in order to guide future developments.

This report provides guidelines to assist the CNDS in developing a client focused nutrition and dietetic service for clients with eating disorders, (mainly Anorexia Nervosa and Bulimia Nervosa). Client-centred best practice guidelines for Dietitians working as part of the Primary Care Team will enable the Dietitians to provide an efficient service for the clients with eating disorders. These should ensure the consistency of service provision, geographical equity and equity of access to treatment and care within HSE West.
1.2 Epidemiology of Eating Disorders

The average annual incidence rate of eating disorders in Ireland was 6.18/100,000 in 0-54 yr old population in 1977-1985 year period (Shenkwin & Standen, 2001). This information was obtained using national registers of psychiatric and general hospital admissions over that period. Over half of the clients with Anorexia Nervosa (66%) were admitted under doctors not specialised in psychiatry. Estimates of the incidence or prevalence of eating disorders vary depending on the sampling and assessment methods and many gaps exist in the current knowledge base of the incidence and prevalence figures. These incidence rates have to be viewed with caution as they only depict the tip of the iceberg, while a much larger proportion of clients may be present in the wider community.

Studies in regions of Europe and US have shown different annual incidence rates for Anorexia Nervosa (Table 1). The variant in incidence rates is the product of natural variation between the countries and the sources of data in different studies.

Pawluck & Gorey (1998) calculated the incidence of Anorexia Nervosa in the general population in 12 cumulative studies. It was 19 per 100,000 per year in females and two per 100,000 per year in males and the highest incidence in this study were in females aged 13–19 years where there were 50.8 cases per 100,000 per year.

Some studies have analysed the prevalence rates of different eating disorders in different population groups. In female adult populations in Norway, the lifetime prevalence of eating disorders was 8.7%, Anorexia Nervosa 0.4%, Bulimia Nervosa 1.6% and Binge Eating disorder was 3.2% (Getestam & Agras, 1995). In an Italian sample of young women of 18–25 years, lifetime prevalence of Anorexia Nervosa, Bulimia Nervosa and Binge Eating disorders were 2%, 4.6% and 4.7% respectively (Favora et al 2003). Wade et al (2006) assessed the lifetime prevalence of Anorexia Nervosa, Bulimia Nervosa and eating disorders not otherwise specified in an adult female twin population in Australia. In accordance with other community studies a lifetime prevalence of Anorexia Nervosa of 1.9% were found. Criteria for Bulimia Nervosa were met by 2.9% of the women and an additional 2.9% of women met criteria for Binge Eating disorder (Wade et al, 2006).
Table 1: Incidence of Anorexia Nervosa in Ireland and other Selected Countries, per Year, per 100,000 Population

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<th>Study</th>
<th>Region</th>
<th>Source</th>
<th>Period</th>
<th>Incidence</th>
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<td>William and King (1987)</td>
<td>England and Wales</td>
<td>Nationwide register study (first admissions)</td>
<td>1972 -1981</td>
<td>1.4 –2.0 (F) 0.18 (M)</td>
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1.3 Current Practices of Treating Eating Disorders

1.3.1 Practice in the primary care setting in Ireland

Multiple approaches were utilised to review the current practice of management of eating disorders in the primary care setting. Key informant interviews were conducted with a sample of GPs in the area, the Medical Officer at the Health Centre of the National University of Ireland, Galway and the Dietitians working in the CNDS at HSE West. Information was also gathered from hospital Dietitians.

As revealed in such interviews there are no standard policies or protocols developed in Ireland for the management of eating disorders. The relatively low incidence of the condition among the general population was cited as the reason for such non-availability, though they were mindful of the number of clients they are missing due to poor sensitivity with regard to identification of the eating disorders.

When clients with eating disorders are identified at the General Practice level, the usual practice is to manage the client as an outpatient unless there are indications for hospital admission, such as very low BMI, psychiatric disturbances etc. In such
circumstances either the client is admitted to the Psychiatric Unit of the University Hospital, Galway or is referred to a Psychiatrist in the area. Referrals to the CNDS for the management of eating disorders from an outpatient setting are relatively rare. The GPs interviewed welcomed the setting up of the designated in-patient eating disorder unit in the area and having the services of a Dietitian designated to manage eating disorders.

1.3.2 Awareness of Eating Disorders in Ireland

A survey conducted by the Marino Therapy Centre (Marino Therapy Centre, 2005) on a mixed sample of males and females aged 18-60 years revealed that many in the sample agree that the Fashion Industry is a significant contributor for eating disorders. Most of them stated that people with eating disorders cannot help themselves and believed that they can be treated with medical treatment. Twenty five percent of the sample stated that they would see the GP if they felt that they suffer from an eating disorder. More than 50% stated that they would try to pull themselves together or talk to a friend or relative.

They also interviewed a sub sample of people that had recovered or were at a high stage of recovery from an eating disorder. About half (56%) agreed that medical treatment can improve the condition. Most of them revealed that GPs do not give enough support (62%) and 16% of the sample stated that they would go to the GP if they felt that they suffer from an eating disorder.

1.3.3 Current practice in the UK

In the UK 20% of those with Anorexia Nervosa and 40% of those with Bulimia Nervosa are treated exclusively in primary care (Turnbull et al, 1996). People with Anorexia Nervosa present for treatment to Child and Adolescent Mental Health Services (CAMHS), paediatric, adult psychiatric or student services (Treasure et al, 2005). However, the approach to and resources for managing eating disorders differ considerably between these services. The CAMHS and student services are well equipped to manage eating disorders in the UK. Twenty percent of the beds in the child and adolescent psychiatric inpatient provision in England and Wales are
occupied by clients with eating disorders. As adult psychiatry community mental health services increasingly function as ‘psychosis only’ services. Most of those with eating disorders are managed within tertiary services (Treasure, et al, 2005).

In the UK, many local health authorities use services outside their areas, and only 33% have specialist services within the area.

1.3.4 Policies and protocols used in the United Kingdom

In the UK evidence based best practice guidelines are available for the management of eating disorders, which are updated in a periodical manner. The following are the main guidelines used in the UK:

- Royal College of Psychiatrists London (2005), Guidelines for nutritional management of Anorexia Nervosa.
1.4 The Method Used for the Development of Best Practice Guidelines for Dietitians in the HSE West

A comprehensive literature review was carried out to search for best practice guidelines and to deliver a client-centred nutrition treatment for clients with eating disorders in the HSE West. In order to provide an up to date review of the available evidence on best practice in the area of management of eating disorders a number of different evidence sources such as MEDLINE, EMBASE, PsycINFO, CINAHL- OVID interface, Cochrane Database and CDC recommendations were reviewed for Anorexia Nervosa, Bulimia Nervosa, Binge Eating disorders and atypical eating disorders.

The following strategic documents and guidelines in relation to the management of eating disorders were especially reviewed:

- Royal College of Psychiatrists London (2005), Guidelines for nutritional management of Anorexia Nervosa
- Royal College of Psychiatrists London (2000) Eating disorders in the UK: policies for service development and training
- American Psychiatric Association (2006), Practice Guidelines for the Treatment of Patients with Eating Disorders, 3rd edition
- Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004)
The HSE West developed a research proposal to develop best practice guidelines for Dietitians and commissioned the Health Promotion Research Centre, NUI, Galway to develop them. Dr Dhammica Rowel, Geraldine Nolan, NUI, Galway and Marguerite O’Donnell, HSE West, held regular steering group meetings. Ruth Kilcawley, Senior Dietitian, Child & Adolescent Mental Health Service, HSE West, peer reviewed and edited each draft. Draft guidelines derived from the review of the evidence were also circulated among the Dietitians in Galway University Hospital and Community Nutrition & Dietetic Service, HSE West for peer review and their feedback was incorporated into the final edition of the guidelines.
2.1 Individualised Care and Treatment

Care for clients with eating disorders should be based on the individual needs of the client. It is important to measure the motivation, co-morbidity, severity and personal support for each of the clients. Different clients presenting with similar symptoms at similar weight levels can have very different treatment goals and care needs and their outcomes may be very different (NHS Quality Improvement Scotland, 2006). The following vignettes illustrate the need for individualised care;

Client 1;
A 24-year-old self aware and motivated woman with a 2-year history of Bulimia Nervosa: She is well supported by her husband and prior to referral to a specialist eating disorders service she had already reduced her Binge Eating frequency with the help of internet contacts and a self-help book. She needed just 6 sessions of cognitive behaviour therapy (CBT) to eliminate her Binge Eating completely.

Client 2;
A 35-year-old single woman with a 20-year history of eating disorder: She suffered abuse in childhood and is in no current close relationships. She has a history of taking drug overdoses, self-cutting and of heavy alcohol consumption. Although she made some gains after 20 sessions of CBT there were no further gains after 10 more sessions. At that stage she was still bulimic but it was not the most serious problem behaviour. A longer-term support and crisis management structure was negotiated with the help of the general adult psychiatry mental health team.

NHS Quality Improvement Scotland, 2006

Care and treatment for patients with eating disorders should be tailored to the needs of the individual patient.
National Institute of Clinical Excellence, 2004
2.2 The Multidisciplinary Team Co-ordinating Treatment
Management of eating disorders requires input from a number of disciplines, working together in a co-ordinated manner. Individual healthcare professionals should not work in isolation without adequate support, as eating disorders comprise of both psychological and physiological components. Treatments should combine expertise in both of these components with health professionals understanding the psychological, physiological and nutritional effects these disorders can have on the client.

**Care for individuals with eating disorders should be based on a multidisciplinary model.**
*American Psychiatric Association, 2006*

**Table 2: Core Professionals Involved in the Multidisciplinary Team Managing Eating Disorders**

- General Practitioner
- Psychiatrist
- Clinical psychologist
- Community Psychiatrist nurse
- Dietitian
- Nurse Therapist (e.g. Cognitive Behaviour Therapist)
- Social Worker
- Family therapist
- Occupational therapist
- Physiotherapist
- Art therapist
- Pharmacist
- General Physician.

*NHS Quality Improvement Scotland, 2006*

In treating eating disorders, the Psychiatrist may assume the leadership role within a program or team that includes other Physicians, Psychologists, Dietitians and Social Workers or may work collaboratively on a team led by others. For the management of
acute and ongoing medical and dental complications it is important that Psychiatrists consult other Physician Specialists and Dentists (APA, 2006).

When a client is managed by an interdisciplinary team in an outpatient setting, communication between the professionals is essential in monitoring the client’s progress, making necessary adjustments to the treatment plan and delineating the specific roles and tasks of each team member (APA, 2006).

*When management is shared between primary and secondary care, there should be clear written agreement amongst individual healthcare professionals regarding the responsibility for monitoring patients with eating disorders.*

*National Institute of Clinical Excellence, 2004*

It is vital that team members know the limits and scopes of practice and expertise so they can intentionally overlap practice without going beyond their own expertise. The degree of overlap depends on the expertise and experience of the team members, the client’s needs, and the structure of the treatment plan. Overlap helps to address issues from more than one angle and to prevent issues falling between areas of expertise among team members. Frequent communication among treatment team members is essential (American Dietetic Association, 2000).

*The team members should know the limits and scopes of one another’s practice and expertise so they can intentionally overlap practice without going beyond their own expertise.*

*American Dietetic Association, 2000*
Chapter III
Role of the Dietitian in the Management of Eating Disorders

Dietitians have an essential role within the multidisciplinary team and are involved in the assessment, treatment, monitoring, supporting and rehabilitation of clients with eating disorders. The Dietitian;

- Is specialized in assessing nutritional requirements and can design and review individualised nutrition plans for patients based on dietary intake, metabolic requirements and body weight.

- Can provide accurate, evidence based and relevant information for patients including those patients with additional dietary requirements such as diabetes or food allergies.

- Addresses the patient’s food and nutrition issues and the behaviours associated with those issues.

- Addresses dietary concerns the patient may have leaving other health professionals to deal with the underlying issues of the eating disorder. Poor eating patterns and unhealthy views surrounding food are primarily symptoms of eating disorders and not the cause. The psychotherapeutic issues are the focus of the psychotherapist or mental health team member (American Dietetic Association, 2007).

- Acts as a co-therapist in individual treatments and in therapy groups where nutrition is a major component. Any nutritional intervention will inevitably carry a psychological meaning for the client; management of the client’s nutritional state must therefore always be considered within a wider psychological context. Nutritional interventions that do not take the psychological context into account are unlikely to be successful (Royal College of Psychiatrists, 2005).

- Using Behavior Change techniques such as Cognitive Behavior Therapy the Dietitian can review the patients Food Diary and facilitate positive changes in behavior.

- Runs nutrition education sessions for clients covering general nutrition and basic physiology topics.
The Dietitian also has a central role within the multidisciplinary team by;

- Acting as a nutrition specialist
- Acting as a consultant advising on nutritional aspects of care and appropriate literature to use
- Assisting the medical team member with monitoring lab results, vital signs and physical symptoms associated with refeeding and malnutrition
- Training other health professionals on the nutritional management of eating disorders.

(NHS Quality Improvement Scotland, 2006)

The goals of nutrition therapy in the management of eating disorders are;

- To provide nutrition guidance that fosters a nourishing eating style and promotes normal physiological function and physical activity.
- To support eating behaviours that bring about a peaceful, satisfying relationship with food and eating.

In order to achieve these goals the specific services provided by the Dietitian are outlined below.

3.1 Services provided by the Dietitian in the Management of Eating Disorders

Dietitians provide services in four main areas in the management of clients with eating disorders (NHS Quality Improvement Scotland, 2004);

1. Nutrition assessment
2. Nutrition education
3. Recommendations
4. Support.
3.1.1 Nutrition assessment
In the dietetic assessment the Dietitian assesses the following in a client with an Eating Disorder;

- Current and previous dietary intake, eating habits and weight history
- Other eating disorder behaviour e.g. purging, use of laxatives and diuretics
- History of weight reducing diets, including family history of dieting
- Current nutritional knowledge and dietary rules e.g. counting calories, times of eating, ritualistic behaviours, food combining, avoidance of fats and fatty foods
- Physical activity level and exercise
- Motivation to change and client’s aims from treatment
- Calculation of nutritional requirements for weight maintenance and weight gain
- Treatment plan.

3.1.2 Nutrition education
Nutrition education is sometimes overlooked for clients with eating disorders, as their knowledge and interest on nutrition seem so vast. Clients are often overly concerned with small aspects of nutrition such as avoiding fats and carbohydrates. This results in distorted views on food and nutrition and a diet deficient in many nutrients.

A Dietitian can help a client review their current dietary intake, question their dietary ‘rules’ and provide more accurate information about nutrition and physiology to help them move towards a nutritionally adequate diet.

3.1.3 Recommendations
The Dietitian and the client should work together to set realistic and achievable dietary and weight goals. Results of nutritional analysis and calculation of nutritional requirements for weight gain and maintenance are important and need to be taken into consideration when making a recommendation to the client.
3.1.4 Support

The most important role of the Dietitian is to help the clients to learn to trust food again. Changing poor eating patterns is very difficult even with well-motivated clients.

_A Dietitian can be the best person to instil confidence in clients with eating disorders to make changes regarding food habits._

American Dietetic Association

3.2 Resources Required for a Dietetic Service for Eating Disorders

3.2.1 Knowledge, skills and training requirements of the dietitian

To work with clients with eating disorders a Dietitian requires a sound knowledge of the development and maintenance of eating disorders and an understanding of the physiological, psychological and medical aspects of eating disorders.

This needs to be underpinned by a broad understanding of mental health and psychological interventions, used by other members of the multi-disciplinary team e.g. Motivational Enhancement Therapy, Cognitive Behaviour Therapy, Cognitive Analytical Therapy, Dialectical Behaviour Therapy, Interpersonal Therapy and Psychodynamic Psychotherapy. Enhanced communication, counselling and motivational interviewing skills are also required (British Dietetic Association, 2006).

The core competencies of a Senior Dietitian are essential for such a specialised post and at least 3 years of post qualification dietetic experience is required.

In the long term the patient’s ability to continue treatment with familiar and trusted staff in a partial hospitalisation or outpatient setting contributes to the success of aftercare planning (American Psychiatric Association, 2006).

_Dietetic inputs should be offered to both inpatients and outpatients as an adjunct to other treatments_

NHS Quality Improvement Scotland, 2006
It is appropriate that, where possible the same person continues the care of the client in a primary care setting. For this reason funding has to be available for at least a whole time equivalent post with a remit for both inpatient and outpatient services.

The Dietitian can address their ongoing training needs via a personal development plan and an annual appraisal to ensure that they are adequately skilled to work in this area.

3.2.2 Physical resources

- Consultation room with adequate space for equipment and seating for the patient and family members where privacy of the consultation process can be ensured is essential in the provision of a high quality dietetic service
- Anthrometric Equipment – Weighing Scales, Stadiometer, Waist Circumference Tape, Skinfold Calipers and Handgrip Dynamometer
- IT Requirements – Computer, Computer Software for Dietary Analysis and Anthropometry, Internet access, Email facilities, Printer
- Educational Resources – Food Pyramid and Food Models and other appropriate tools
- Administrative Resources – Filing, Stationary, Communications and Clerical Support.

3.2.3 Multidisciplinary working requirements

It is essential that the Dietitian has access to and can contribute to the management of the client through medical notes, biochemical data and multidisciplinary meetings and reports.

3.2.4 Time requirements

The Dietitian should be able to spend adequate quality time with clients with eating disorders. Generally 1 – 1 ½ hours have to be allowed with each client. Pre and post contact preparation and debriefing with other members of the team would require another 1-2 hours. Therefore it would be necessary to spend 2–3 hours per client.
However more intensive support may be required earlier in the treatment plan with shorter frequent follow up required in outpatient setting (American Psychiatric Association, 1994).
Chapter IV

Eating Disorders

Eating disorders are classified as a range of syndromes encompassing physical, psychological and social features. Anorexia Nervosa, Bulimia Nervosa and atypical eating disorders or eating disorder not otherwise specified and Binge Eating Disorders (DSM IV TR; APA, 2000) are the main forms classified as eating disorders. Loss of appetite and psychogenic disturbance of appetite or other conditions that involve significant weight loss due to known physical illnesses are not considered in this report.

Acute physical complications of these disorders provoke great concern in family members and health service staff. Anorexia Nervosa and Bulimia Nervosa can be chronic conditions with substantial long-term physical and social consequences from which recovery can be very difficult. Long-term disabilities due to eating disorders include negative effects on employment, fertility, relationships and parenting. The impact of a person’s eating disorder on home and family life is often considerable. Most of the time family members are at a loss as to how they can help and how to support the person affected. The physical consequences of these conditions are notable and sometimes prove fatal.

Eating disorders commonly develop during adolescence and affect the physical and social development of the affected person and many of the affected never reach their full academic potential. Depression is the most common psychiatric manifestation of eating disorders, partly because of the adverse consequences and also because of the distressing nature of the symptoms of these disorders. Anorexia Nervosa has the highest mortality rate of any psychiatric disorder of adolescence (Hoek, 2006).

4.1 Aetiology of Eating Disorders

As in many of the psychiatric disorders, the aetiology of eating disorders is considered multifactorial. No single aetiological factor in isolation can account for the development of the eating disorders in an individual nor can it be seen to account for the variation between individuals. Whether or not a person develops an eating
disorder will depend on their individual vulnerability, consequent on the presence of biological or other predisposing factors, their exposure to particular provoking risk factors and on the operation of protective factors.

4.1.1 Genetic factors
Substantial effort has been put into the exploration of the biological background of eating disorders through family, twin and molecular genetic studies. Family studies have shown that Anorexia and Bulimia Nervosa are strongly familial and that familial etiologic factors appear to be shared by both disorders (Slof-Op’t Landt et al, 2005).

4.1.2 Physical risk factors
In both Anorexia Nervosa and Bulimia Nervosa, a history of pre-morbid obesity has been documented; 7-20% in Anorexia Nervosa and 18-40% in Bulimia Nervosa (Cooper, 1995). There is evidence that this experience leads to a propensity to increase in dissatisfaction in their body size leading to a dieting behaviour (Stice, 2002). The dietary restraint model suggests that calorie restriction increases the risk of Binge Eating and Bulimia Nervosa. Though dieting appears to increase negative effects and contribute to eating difficulties, dieting really has a small effect in the contribution to the development of eating pathology (Stice, 2002).

4.1.3 Adverse life events and difficulties
Life stresses have been implicated in the aetiology of both Anorexia Nervosa and Bulimia Nervosa. Approximately 70% of cases are triggered by severe life events or difficulties. These stresses most commonly occur in the area of close relationships with the family or friends.

4.1.4 Family factors
The occurrence of Anorexia Nervosa and Bulimia Nervosa are higher amongst first and second-degree relatives. Evidence reveals that incidences are higher among the relatives of people with affective disorders (Cooper, 1995). Several family studies
have revealed higher rates of alcohol and substance abuse amongst first degree relatives of those with Bulimia Nervosa (Cooper, 1995).

4.1.5 Socio-cultural factors
The aetiology of eating disorders has been explained by different social-cultural theories. Such theories include the meaning of weight and shape for women in different cultures and the impact of advertising and other media. It is a common belief that societal pressure to be thin fosters an internalisation of a thin ideal and body dissatisfaction, which in turn leads to dieting behaviour and places the person at risk for eating pathology (O’Connor et al 1997).

4.1.6 Perfectionism
The personality trait of perfectionism has long been considered a risk factor for eating disorders. Meta-analysis of prospective studies provides support for the notion of perfectionism as a risk factor for bulimic pathology and maintenance factor for a more general eating pathology (Stice, 2002).

4.2 Identification in the Primary Care Setting
The first point of contact with Health Services for most of the clients with an eating disorder is the Primary Care Team, either directly when clients seek help for their eating disorder or indirectly when they seek help for other conditions. In addition many others may seek advice from the Primary Care Team about a family member or a friend with a suspected eating disorder.

Any contact with the primary team should be seen as an opportunity to engage the person with an eating disorder and attempts should be made to ensure that the client returns in the future. This is not simple as many individuals with eating disorders do not wish to engage with health services and the assessment process itself may lead to non co-operation in the future (NHS Quality Improvement, Scotland, 2006).

Common indirect presentations are anxiety, depression, gastrointestinal symptoms, menstrual symptoms or diabetic clients with poor diabetic control. The SCOFF
questionnaire (Table 3) has been validated for use in clients with an eating disorder in
the primary care setting over the age of 18 years (Morgan et al 1999).

**Table 3: The SCOFF Questionnaire**

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you make yourself sick because you feel uncomfortably full?</td>
</tr>
<tr>
<td>Do you worry you have lost control over how much you eat?</td>
</tr>
<tr>
<td>Have you recently lost more than one stone in a 3 month period?</td>
</tr>
<tr>
<td>Do you believe yourself to be fat when others say you are too thin?</td>
</tr>
<tr>
<td>Would you say that food dominates your life?</td>
</tr>
</tbody>
</table>

*Morgan et al, 1999*

*Opportunistic questioning of clients suspected to have eating disorders in primary care should start with non threatening questions and develop further using a recognised eating disorders questionnaire.*

*NHS Quality Improvement Scotland, 2004*

**4.3 History and Examination**

Once it is established that it is likely that a client has an eating disorder then further history taking is required. There should be a detailed review of the family or personal factors. Significant physical symptoms such as vomiting blood, bowel disturbances, weakness, dizziness, fainting, cold intolerance and dental problems should be looked at. Throughout this process priority should be given to maintain a rapport and positively engage the client in the process of evaluating their symptoms.

If the client is comfortable about it, weight and height should be measured and body mass index calculated. If the client is resistant this should not be confronted at the first assessment appointment. More severely ill clients require a more comprehensive physical examination.
Figure 1: Flow Chart to Diagnose Eating Disorders

4.4 Risk Assessment

Risk assessment should be broadly based covering physical, psychological and social issues. This should assist primary care team members in identifying those for whom early intervention and referral would be most beneficial.
4.5 Nutrition Assessment

The goals of nutrition assessment in eating disorders are:

- To determine the level of malnutrition and muscle wasting present
- To ascertain the level of eating disturbance, based on food beliefs, present eating patterns and purging behaviours
- To understand the weight, exercise and diet histories of clients.

Components of a comprehensive nutrition assessment are summarised in Table 4.

**Table 4: Components of Nutrition Assessment for Eating Disorders**

- Anthropometric measurements - height, weight, triceps, skin fold, midarm muscle circumference, and midarm muscle mass (less meaningful for individuals with Binge Eating disorder)
- Weight history - usual and current weight, desired weight, attitude towards weight fluctuations, and significant events associated with changes
- Biochemical data - complete blood count, serum chemistry, urinalysis with specific focus on albumin, cholesterol, hemoglobin, hematocrit, serum glucose, T3 and T4, plus estradiol; initially, biochemical measurements should be repeated as clients are frequently dehydrated upon presentation, which may alter the interpretation of laboratory values
- Medical history - blood pressure, pulse, temperature, physical symptoms, bowel habits, malabsorption and/or transient lactose intolerance, prior hospitalizations, diabetes mellitus, history of infertility, and problems with appropriate weight gain in pregnancy
- Weight management history - previous diets and weight management methods, presence or history of Binge Eating purging and/or fasting, exercise level and patterns, nutrition counselling, current eating behaviours and family eating patterns
• Food history - detailed diet history including food beliefs and rituals, food preferences and aversions, meal and snack patterns, portion size, nutrient content of meals and meal or food supplements such as meal replacement products and functional foods

• Medication and substance use history - medications including thyroid replacement and oral contraceptive agents, unauthorised or unsupervised prescription medication use, vitamin/mineral herbal supplement use, alcohol and other substance abuse, diet pills, diuretics, emetics, laxatives and other over the counter supplements and medications.

*American Dietetic Association, 2000*

### 4.6 Physical Monitoring

Weight is a critical monitoring tool to determine a client’s progress. A protocol for physical monitoring should be established for each client on an inpatient program. This protocol should include who will do the weighing, what clothing should be worn, when the weighing will occur and whether or not the client is allowed to know their weight. A height measurement should be included if the client is still growing. This would be beneficial for standardising practice in primary care. For example, in a clinic model the nurse may weigh the client as part of her responsibilities in taking vital signs. The client then has the opportunity to discuss their reaction to the weight when seen by the Dietitian.

In a community outpatient model the nutrition session is the appropriate place for weighing the client discussing reactions to weight and providing explanations for weight changes. In some cases such as a client expressing suicidality alternatives to the weight procedure may be used. For example, the client may be weighed with their back to the scale and not told their weight, the mental health professional may do the weighing or if the client is medically stable the weight for that visit may be skipped. In such cases, there are many other tools to monitor the client’s medical conditions such as vital signs, emotional health and laboratory measurements (American Dietetic Association, 2007).
4.7 Referral Pathway for Clients with Eating Disorders

The following is an example of a referral pathway for a client presenting with suspected symptoms of eating disorders to a GP;

**Figure 2: The Proposed Care Pathway for Children and Adults with Eating Disorders**

Chapter V
Anorexia Nervosa

Anorexia Nervosa is a syndrome in which the individual maintains a low weight as a result of a pre-occupation with body weight constructed either as a fear of fatness or pursuit of thinness.

In Anorexia Nervosa, weight is maintained at least 15 percent below that expected or the client’s body mass index (BMI) is below 17.5 kg/m².

Weight loss in anorexia is induced by avoiding ‘fattening foods’ sometimes supported by excessive exercising or self-induced purging by vomiting and using laxatives. Due to poor nutrition a widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis develops which manifests in women by amenorrhoea and in men by lack of sexual interest or potency. In pre-pubertal children the puberty is delayed and growth and physical development are usually stunted.

5.1 Signs and Symptoms
The condition generally starts with dieting behavior that may evoke no concern. Some will experience reinforcing compliments about their weight loss. After some time the commitment to dieting increases often with a number of secondary features such as social withdrawal, rigidity and obsessionality, particularly where these traits have previously been features of the person’s personality. A number of secondary difficulties may develop including adverse physical effects, social isolation and/or compromise of educational and employment plans. A smaller number will enter Anorexia Nervosa through a pattern of purging behaviour without dieting, following a viral illness, resulting in weight loss that then became positively valued, or in the context of a chronic illness such as diabetes or Crohn’s disease.

In the acute stage of Anorexia Nervosa, subjective distress may be limited and emotional disturbance is common. With time emotional difficulties usually increase alongside a range of physical and social difficulties, including becoming unable to
care for one self adequately. These affect the person’s quality of life and increase the reliance on and the importance of the eating disorder.

Depression is a common co morbid diagnosis with rates of up to 63% in some studies while obsessive-compulsive disorder has been found to be present in 35% of clients with Anorexia Nervosa (Herzog et al 1992).

Physical problems can be classified as those due to the effects of starvation and the consequences of purging behaviour. Starvation affects every system in the body; the musculo-skeletal system causing weakness, loss of bone density and impairment of linear growth, bone fractures; endocrine system causing infertility, risk of polycystic disease and loss of bone mineralisation.

Social difficulties may result in continued dependence on family and often include difficulties engaging in intimate relationships. Employment prospects may be adversely affected either because of the limitations of the disorder or the disruption caused by lengthy hospitalizations.

5.2 Diagnosis

The diagnosis of Anorexia Nervosa in its typical form is a relatively straightforward one in older adolescents and adults.

Engagement in a supportive, empathic assessment interview is crucial in enabling the client to reveal fears around weight, dieting behaviour and any purging or other maladaptive behaviour such as excessive exercising.

The diagnosis is made on the basis of the history, supported where possible by a corroborative account from a relative or friend. Physical examination, with measurement of weight and height and calculation of body mass index (BMI) can reveal the extent of emaciation. In some instances clinical observation during a hospital assessment can enable characteristic behaviours to be observed. Physical investigations are less useful in making the diagnosis but are crucial in assessing the physical impact of the disorder and its complications (Royal College of Psychiatrists, 2005).
Criterion | Description
---|---
A | Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected: or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)
B | Intense fear of gaining weight or becoming fat, even though underweight
C | Disturbance in the way in which one’s body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight
D | In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g. estrogen, administration).

Specify type:
 Restricting type: During the current episode of Anorexia Nervosa, the client has not regularly engaged in Binge Eating or purging behavior (i.e. self-induce vomiting or the misuse of laxatives, diuretics or enemas)
 Binge Eating/purging type: During the current episode of Anorexia Nervosa, the client has regularly engaged in Binge Eating or purging behavior (i.e. self-induce vomiting or the misuse of laxatives, diuretics or enemas).

Diagnostic and Statistical Manual of Mental Disorders, (2000)

5.3 Indications for Referral to Specialist Services

There are a number of key clinical features which suggest that referral to specialist services is indicated. Because children and young people have marked growth spurts, BMI alone is less meaningful as a measure of emaciation. Reference to height and weight charts is the best way to assess the need for referral in this client group.
In determining a client’s initial level of care or suitability for change to a different level of care, expert consensus indicates that it is important to consider a client’s overall clinical and social picture rather than simply rely on weight criteria.

Furthermore weight level per se should never be used as the sole criterion for discharge from inpatient care. Clients need to gain healthy body weight and learn to maintain that weight prior to discharge; clients who reach healthy body weight but are discharged before this learning occurs are likely to relapse immediately (American Psychiatric Association, 2006). Indications for referral to specialist services and very strong indication for referral to specialist services are given in Table 6.

5.3.1 Children and adolescents
Pre-pubertal children occasionally develop the classic eating disorders Anorexia Nervosa and Bulimia Nervosa. They may also show symptoms of eating difficulty secondary to other psychopathology such as emotional and behavioural disorders of childhood, obsessive compulsive disorders, autism spectrum disorders, phobias and refusal disorders. All of these disorders have to be considered in the differential diagnosis. Physical assessment is also important.

It is important that healthcare professionals ascertain weight loss in children and adolescents by plotting both weight and height on growth charts wherever possible. Specific BMI is of limited value as height may be stunted. Reference to height and weight charts is the best way to assess the need for referral in this client group. Suitable charts for height and weight are centile tables from Child Growth Foundation (1997).
Table 6: Indications for Referral of Clients with Anorexia Nervosa to Specialist Services

<table>
<thead>
<tr>
<th>Strong indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continuing weight loss</td>
</tr>
<tr>
<td>• Severe emaciations e.g. BMI &lt;16</td>
</tr>
<tr>
<td>• Marked vomiting or laxative abuse</td>
</tr>
<tr>
<td>• Physical complications e.g. hypotension</td>
</tr>
<tr>
<td>• When primary care interventions have failed</td>
</tr>
<tr>
<td>• When depression is marked and/or a risk of self harm</td>
</tr>
<tr>
<td>• Co-morbid conditions such as pregnancy or diabetes.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Very strong indicators</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>• BMI &lt; 13.0</td>
</tr>
<tr>
<td>• Rate of weight loss continuing at &gt; 1kg per week</td>
</tr>
<tr>
<td>• Vomiting more frequently than once per day</td>
</tr>
<tr>
<td>• Heavy laxative use</td>
</tr>
<tr>
<td>• Prolongation of QTc interval or other significant ECG abnormality</td>
</tr>
<tr>
<td>• Core temperature &lt; 34°C</td>
</tr>
<tr>
<td>• Muscle weakness – unable to rise from a squat without use of arms for leverage</td>
</tr>
<tr>
<td>• Pulse rate less than 40 per minute or systolic blood pressure less than 80mm/Hg</td>
</tr>
<tr>
<td>• Major abnormality of biochemistry or haematology</td>
</tr>
<tr>
<td>• Signs of significant cognitive impairment.</td>
</tr>
</tbody>
</table>

*NHS Quality Improvement Scotland, 2004*

### 5.4 Nutrition Care of Clients with Anorexia Nervosa

The first goal of dietary treatment in nutrition therapy is to stop weight loss and establish the highest possible level of medical stability. The second step is to initiate weight gain with a long-term goal of restoring body weight to a level where normal metabolism and body function returns (American Dietetic Association 2000).
In all treatment settings, weight restoration through the development of regular, healthy eating patterns using conventional foods (orally) is the preferred method.

Elements of psychological and physical distress can impede food consumption, as many individuals resist or refuse to eat solid foods or may be unable to eat solid food due to early satiety or gastric distress. Though less desirable, nutritional supplements may be used alone or in conjunction with regular foods when the nutrition needs of the clients cannot be met using conventional foods, but they should be used only as temporary interventions. Stabilisation may require medical hospitalisation where oral feeding is accompanied by intravenous restoration of fluids and electrolytes or tube feeding (American Dietetic Association, 2000).

Treatment of Anorexia Nervosa may be primary or secondary, depending upon the severity of the given condition from both medical and behavioural standpoints.

5.5 Nutrition Care in the Primary Care Setting

In Anorexia Nervosa, the goal of primary care treatment is to focus on nutritional rehabilitation, weight restoration, cessation of weight reduction behaviours, improvement in eating behaviours and improvement in psychological and emotional state.

Weight restoration alone does not indicate recovery and forcing weight gain without psychological support and counselling is contraindicated.

Individualised guidance and a meal plan that provides a framework for meals and snacks and food choices (but not a rigid diet) is helpful for most clients. The Dietitian determines the individual caloric needs of the client and develops a nutrition plan that allows the client to meet these nutrition needs. In the early treatment of anorexia those may be done on a gradual basis increasing the caloric prescription in increments to reach the necessary caloric intake. Medical nutrition therapy should be targeted at helping the client understand nutritional needs as well as
helping them begin to make wise food choices by increasing variety in diet and by practicing appropriate food behaviours (Rock, 1999).

**The Dietitian determines the individual caloric needs of the patient and develops a nutrition plan that allows the patient to meet these nutrition needs.**

Rock, 1999

Cognitive Behavioural Therapy can be used as a counselling technique in the management of Anorexia Nervosa. This involves challenging erroneous beliefs and thought patterns with more accurate perceptions and interpretations regarding dieting, nutrition and the relationship between starvation and physical symptoms.

5.5.1 Monitoring weight gain

Monitoring skinfold thickness can be used to determine composition of weight gain as well as an educational tool to show the client the composition of any weight gain (lean body mass vs fat mass). Percent body fat can be estimated from the sum of four skinfold measurements (triceps, biceps, subscapular and suprailiac crest) using the calculations of Durnin and Womersley (1974). This method is validated and Aboul-Seoud & Aboul-Seoud (2001) developed a computer programme based on the table developed by Durnin and Womersley (1974) to estimate the body fat from skinfold thickness, which made the use of skinfold thickness as an estimate of body fat composition convenient.

5.5.2 Dietary supplements/physical activity

The Dietitian will need to recommend dietary supplements as needed to meet nutritional needs. In most of the cases the Dietitian will have to recommend physical activity levels based on medical status, psychological status and nutritional intake. Physical activity may need to be limited or initially eliminated with the compulsive exerciser who has Anorexia Nervosa so that weight restoration can be achieved. The counselling effort needs to focus on the message that exercise is an activity undertaken for enjoyment and fitness rather than a way to expend energy and promote
weight loss. Supervised low weight strength training is less likely to impede weight gain than other forms of activity and may be psychologically helpful for clients (American Dietetic Association, 2007).

5.5.3 Food diaries
Food diaries can be a helpful tool for both the client and Dietitian. It should be integrated into the counselling session. Keeping a food diary can help to track food intake, provide a structure to explore experiences related to hunger and fullness and log feelings and experiences associated with eating. Food diaries can be a powerful tool to help clients identify behaviours, thoughts and behavioural patterns that trigger restricting, Binge Eating or purging. Client’s perspective of portion sizes, calorie content of foods and meal spacing can be examined by using the food diaries. It also provides an opportunity to provide education to minimize ritualised behaviours.

5.5.4 Follow up of clients by the Dietitian
As there is a high rate of relapse nutrition counselling should continue even after weight restoration in a client with Anorexia Nervosa. Once a client is discharged the nutrition principles discussed during the weight gain phase of treatment should be reinforced and adapted to the client’s changing lifestyle. Reassurances should be provided as the client experiences normal weight fluctuations with a continued dialogue between the Dietitian and the client.

Table 7: Evidence Based Key Recommendations for Outpatient Nutrition Care for Clients with Anorexia Nervosa in the Outpatient/Secondary Care Setting

- Most people with Anorexia Nervosa should be treated on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders.
- Family interventions that directly address the eating disorder should be offered to children and adolescents with Anorexia Nervosa.
- In Anorexia Nervosa although weight and body mass index (BMI) are important indicators of physical risk they should not be considered the sole
children).

- In assessing whether a client 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.

- Clients with enduring Anorexia Nervosa not under the care of a secondary care service should be offered an annual physical and mental health review by their GP.

- In most clients with Anorexia Nervosa average weekly weight gain of 0.5kg in outpatient setting should be an aim of treatment. This requires about 3500 – 7000 extra calories a week.

- Regular physical monitoring and in some cases treatment with a multi-vitamin/multi-mineral supplement in oral form is recommended for people with Anorexia Nervosa during primary care weight restoration.

- Health care professionals should monitor physical risk in clients with Anorexia Nervosa. If this leads to the identification of increased physical risk the frequency and the monitoring and nature of the investigations should be adjusted accordingly.

- People with Anorexia Nervosa and their carers should be informed if the risk to their physical health is high.

- Pregnant women with either current or remitted Anorexia Nervosa may need more intensive prenatal care to ensure adequate prenatal nutrition and fetal development.

- Oestrogen administration should not be used to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses.

**Additional consideration for children and adolescents**

- The health care professional should ensure that children and adolescents with Anorexia Nervosa who have reached a healthy weight have the increased energy and necessary nutrients available in the diet to support further growth
and development.

- In the nutritional management of children and adolescents with Anorexia Nervosa carers should be included in any dietary education or meal planning.

*National Institute of Clinical Excellence, 2004*

5.6 Nutrition Care in the Secondary Care Setting

Many clients may respond to outpatient therapy, though there may be still a proportion of clients who do not.

**Table 8: Criteria for Inpatient/Tertiary Care Admission for Clients with Anorexia Nervosa**

- Severe malnutrition (weight < 75% expected weight/height)
- Dehydration
- Electrolyte disturbances
- Cardiac dysrhythmia (including prolonged QT)
- Physiological instability
- Severe bradycardia (< 45/min)
- Hypotension hypothermia ( <36°C)
- Orthostatic changes (pulse and blood pressure)
- Arrested growth development
- Failure of outpatient treatment
- Acute food refusal
- Uncontrollable binging and purging
- Acute medical complication of malnutrition (e.g. syncope, seizures, cardiac failure, pancreatitis, etc)
- Acute psychiatric emergencies (e.g. suicidal ideation, acute psychoses)
- Co morbid diagnosis that interferes with the treatment of the eating disorder (e.g. severe depression, obsessive compulsive disorder, severe family dysfunction).

*Kreipe and Birndorf, 2000*
5.6.1 Goals of therapy in the inpatient/tertiary care setting
The goals of inpatient therapy are the same as outpatient management, except that it is a more intense process. Medical and nutrition stabilisation is the first and most important goal of inpatient treatment. The first phase of inpatient treatment is often in a medical unit to medically stabilise the client. After medical stabilisation the client can be moved to a psychiatric ward or discharged home to try outpatient treatment. If the client is admitted for psychiatric instability, he/she should be admitted directly to a psychiatric ward.

5.7 Role of Nutrition in Inpatient/Tertiary Care
5.7.1 Nutrition plan
It is the duty of the Dietitian to guide the nutrition plan. The nutrition plan should aim to help the client understand their nutritional needs as well as helping the client begin to make wise food choices by increasing variety in their diet and by practicing appropriate food behaviours. Reliance on foods (rather than enteral or parenteral nutrition support) as the primary method of weight restoration contributes significantly to successful long-term recovery. The overall goal is to help the client normalise eating patterns and learn that behaviour change must involve planning and practicing with real food.

5.7.2 Energy requirements
The amount of food given should be limited at first and increased slowly. Initial intake should be sufficient at least to prevent further weight loss. For most clients weighing less than 45kg, 1400kcal (599kJ) daily will achieve this (Royal College of Psychiatrists, 2004). This level of intake should be continued until it can be confirmed that gut function is normal (i.e. bowel sounds are present) and the water overload if present, is beginning to resolve. Thereafter food intake can be increased as quickly as the level of supervision and support will allow.
Carbohydrates should provide approximately 50% of the calories of the initial meal plan. Initial protein intake should provide 0.8-0.9 g/kg body weight and is the macronutrient of choice for initial calorie increase.
In most patients with Anorexia Nervosa an average weekly weight gain of 0.5 to 1kg in inpatient settings should be an aim of treatment.

National Institute of Clinical Excellence, 2004

The rate of gain will slow down as weight increases owing to an increase in metabolic rate and physical activity. It may be appropriate to increase energy intake to compensate for this or to allow a slower rate of weight gain in order to facilitate stopping at the agreed maintenance figure.

5.7.3 Refeeding syndrome

In the early refeeding process the client needs to be monitored closely for signs of refeeding syndrome. A sudden increase in the metabolic load may precipitate biochemical decompensation and excessive protein intake can be hazardous in clients with underlying renal or hepatic impairment (Royal College of Psychiatrist, 2005). Features of refeeding syndrome are;

- Hypophosphatemia
- Hypokalemia and hypomagnesimia
- Hypocalcaemia
- Glucose intolerance
- Gastrointestinal dysfunction
- Cardiac arrhythmias
- Water retention.

5.7.4 Enteral feeding

Enteral feeding has a limited role in the treatment of Anorexia Nervosa, however there are some situations in which it may be required. If enteral feeding is considered necessary the nasogastric route is normally preferred. It reinforces the view that enteral feeding is a short-term measure and there is less medical risk involved than with other procedures. In exceptional circumstances a gastrostomy or jejunostomy may be considered (Neiderman et al, 2000).
The decision to institute enteral feeding is a difficult and complex one and should always be considered carefully. It may be required as a life saving measure but should be used for the minimum length of time. Although enteral feeding may be helpful in restoring weight in the short term it does not require the client to play an active part in the recovery process and so has a limited role in the long term. It is therefore advisable to use only until the client is reasonably medically safe (e.g. has a BMI of 14kg/m²) rather than continuing until a normal weight is achieved (Royal College of Psychiatrists, 2004).

It is important that the client receives encouragement to eat despite nasogastric feeding if physically able to tolerate it. The dietitian should follow locally accepted enteral feeding. It is helpful to provide the client with explanations and reassurances concerning the discomfort that may be experienced. Planning for the restoration of eating should begin as soon as enteral feeding is established. It is important to explain the plan to the client and if appropriate the family (Royal College of Psychiatrists, 2004).

5.8 Review by the Dietitian

At the beginning of therapy, the Dietitian will need to see the client on a frequent basis. Once the client starts responding to the medical, nutritional and psychiatric therapy, nutrition visits may be less frequent.

5.9 Nutrition Education and Counselling

The Dietitian can help modulate the client’s fear of weight gain by consistently reinforcing that refeeding restores identifiable vital bodily functions in a logical orderly fashion and that most of the side effects experienced are due to recovery from starvation (American Dietetic Association, 2000).

Emphasising that adequate calorie and nutrient intake allows for rehydration and restoration of muscle mass, which improves strength and physical endurance, can help to dispel the belief that all new tissue is composed of fat. Helping the client track improvement in energy levels, strength, concentration, mood stability and physical
improvements such as new hair growth, faster wound healing and increased energy levels provides support for improved eating habits. Weight, calorie and nutrient intake goals need to be openly and clearly discussed and agreed with the client. The level of participation by the client in meal planning and weight maintenance will vary with the treatment setting and severity of the eating disorder. The Dietitian needs to facilitate an environment of mutual problem solving which will help to develop a positive therapeutic alliance.

5.10 Partial Hospitalisations
Partial hospitalisations (day treatment) are increasingly utilised in an attempt to decrease the length of some inpatient hospitalizations. For milder Anorexia Nervosa cases, day treatment may be used in place of a hospitalisation. Clients usually attend for 7 – 10 hours per day and are served two meals and 1-2 snacks. During the day they participate in the medical and nutritional monitoring, nutrition counselling and psychotherapy both at group and individual levels. The client is responsible for one meal and any recommended snacks at home. The client who participates in partial hospitalisation must be motivated to participate and able to consume an adequate nutritional intake at home as well as follow recommendations regarding physical activity (Halmi, 1983).

5.11 Recovery
Recovery from Anorexia Nervosa takes time. In long term follow up, the Dietitian’s role is to assist the client in reaching an acceptable healthy weight and to help the client maintain this weight over time. Ideally clients treated as inpatients should have a minimum of two weeks of weight maintenance prior to discharge. The Dietitian’s counselling should focus on helping the client to consume an appropriate varied diet, to maintain weight and appropriate body composition (Royal College of Psychiatrists, 2004).
Table 9: Measures of Successful Outcome of Clients with Anorexia Nervosa

- Maintenance of a stable weight within 15% of ideal or historical weight
- Metabolic rate normalised
- Variety of foods consumed
- Physical effects of starvation returned to normal (menstruation, skin, teeth, energy, gastrointestinal function)
- Normal daily weight fluctuations accepted
- Food consumption patterns normalised
- Hunger cues recognised and responded to appropriately.

*American Dietetic Association (2000)*

Table 10: Evidence Based Key Recommendations for Inpatient Nutrition Care for Clients with Anorexia Nervosa in Inpatient/Tertiary Setting

- People with Anorexia Nervosa requiring inpatient treatment should normally be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) and in combination with psychosocial interventions.
- In most clients with Anorexia Nervosa an average weekly weight gain of 0.5 to 1 kg in inpatient settings. This requires about 3500 to 7000 extra calories per week.
- Regular physical monitoring and in some cases treatment with a multi-vitamin/multi-mineral supplement in oral form is recommended for people with Anorexia Nervosa during inpatient intervention.
- Total parental nutrition should not be used for people with Anorexia Nervosa unless there is significant gastrointestinal dysfunction.
- The involvement of a Physician or Paediatrician with expertise in the treatment of physically at-risk clients with Anorexia Nervosa should be considered for all individuals who are physically at risk.
- Feeding against the will of the client should be a last resort intervention in the care and management of Anorexia Nervosa as this requires expertise in the care and management of those with severe eating disorders and the physical
complications associated with it.

- When making the decision to feed against the will of the client the legal basis for any such action must be determined and understood.

- When inpatient management is required for a client with Anorexia Nervosa this should be provided within a reasonable distance from the clients home to enable the involvement of relatives and carers in treatment to maintain social and occupational links and to avoid difficulty in transition between primary and secondary care services. This is particularly important in the treatment of children and adolescents.

- Inpatient treatment should be considered for people with Anorexia Nervosa whose disorder is associated with high or moderate physical risk.

- People with Anorexia Nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) and in combination with psychosocial interventions.

- Inpatient treatment or day client treatment should be considered for people with Anorexia Nervosa whose disorder has not improved with appropriate outpatient treatment or for whom there is a significant risk of suicide or severe self-harm.

- Health care professionals without specialist experience of eating disorders or in situations of uncertainty should consider seeking advice from an appropriate specialist when contemplating a compulsory admission for a client with Anorexia Nervosa regardless of the age of the client.

- Health care professionals managing clients with Anorexia Nervosa especially that of the binge purging sub-type should be aware of the increased risk of self harm and suicide particularly at times of transition between services or service settings.
Additional considerations for children and adolescents

- Admission of children and adolescents with Anorexia Nervosa should be to age appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities.

- When a young client with Anorexia Nervosa refuses treatment that is deemed essential, consideration should be given to the use of the Mental Health Act or the right of those with parental responsibility to override the young person’s refusal.

- Relying indefinitely on parental consent to treatment should be avoided. It is recommended that the legal basis under which treatment is being carried out should be recorded in the patent’s care notes, and this is particularly important in the case of children and adolescents.

- For children and adolescents with Anorexia Nervosa where issues of consent to treatment are highlighted, health care professional should consider seeking a second opinion from an eating disorder specialist.

- If the client with Anorexia Nervosa and those with parental responsibility refuse treatment and treatment is deemed to be essential, legal advice should be sought in order to consider proceedings.

_National Collaboration Centre for Mental Health, 2004_

_(Please see Appendix I for the Anorexia Nervosa Nutrition Care Plan.)_
Chapter VI
Bulimia Nervosa

6.1 Signs and Symptoms
Bulimia Nervosa is characterised by recurrent episodes of Binge Eating and secondly by compensatory behaviour (vomiting, purging, fasting or exercising or a combination of these) in order to prevent weight gain. As in Anorexia Nervosa self-evaluation is unduly influenced by body shape and weight and there may indeed have been an earlier episode of Anorexia Nervosa.

**In bulimia, weight is maintained above 17.5kg/m² in adults and the equivalent in children and adolescents.**

People with Bulimia Nervosa tend neither to disclose their behaviour, nor to seek out treatment readily, although may be more likely to do so than those with Anorexia Nervosa. The condition develops at a slightly older age than Anorexia Nervosa (the mean age of onset is 18 – 19 years compared to 16 – 17 for Anorexia Nervosa). Bulimia nervosa either arises from a preexisting anorexic illness or from a background of attempts to restrain eating or is broken by episodes of Binge Eating. The client therefore maintains a normal weight despite overeating but commonly progresses into a vicious cycle of attempted dieting, Binge Eating and compensatory purging frequently on a daily basis.

Mood disturbances are very common in Bulimia Nervosa and symptoms of anxiety and tension are frequently experienced. Self-harm commonly by scratching or cutting is common. A proportion of those with Bulimia Nervosa have a history of disturbed interpersonal relationships with poor impulse control. Some of them abuse alcohol and drugs too. In addition to the mood and anxiety symptoms, low self-esteem and body image disturbances can all have a negative effect on social relationships which in turn may be damaged by a lifestyle that may be chaotic and characterised by impulsivity.
The prevalence of the diagnosis of personality disorder in people with Bulimia Nervosa have ranged from 21% - 77%. Obsessive-compulsive and avoidant personality disorders have been described frequently (Braun et al 1994).

6.2 Diagnosis
As in Anorexia Nervosa, the diagnosis depends on obtaining a history supported as appropriate by the corroborative account of a parent or relative. This will require an empathic, supportive, non-judgmental interview style in which the client is enabled to reveal the extent of his or her symptoms and behaviours.

Physical examination is often normal though the salivary glands (particularly the parotid glands) may be enlarged. Calluses on the back of the hand may be found; these result from the use of the hand to stimulate the gag reflex and induce vomiting. About 10% of those with Bulimia Nervosa have electrolyte abnormalities detected on routine screening. Oesophagitis and constipation are common.

Table 11: DSM –IV – TR Diagnostic Criteria for Bulimia Nervosa

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
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</table>
| A         | Recurrent episodes of Binge Eating. An episode of Binge Eating is characterised by both of the following:   
(1) 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 during a similar period of time and under similar circumstances.   
(2) A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating) |
| B         | Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise. |
| C         | The Binge Eating and inappropriate compensatory behavior both occur on average at least twice a week for 3 months. |
Self-evaluation is unduly influenced by body shape and weight.

The disturbance does not occur exclusively during episode of Anorexia Nervosa.

Specify type:

Purging type: During the current episode of Bulimia Nervosa the client has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Non-purging type: During the current episode of Bulimia Nervosa, the client has used other inappropriate compensatory behaviors such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Diagnostic and Statistical Manual of Mental Disorders (2000)

Table 12: Indication for Referral of Clients with Bulimia Nervosa to Specialist Services

**Strong indications**

- Severe and persistent symptoms
- Duration longer than 6 months
- Other dyscontrol behaviours e.g. shoplifting, wrist cutting, overdoses
- Marked depression
- When simple advice/diaries have failed
- Rapid weight loss even if not yet satisfying criteria for Anorexia Nervosa.

**Very strong indicators**

- Persistent suicidal thinking
- Persistent deliberate self-harming
- Rapid weight loss which doesn’t satisfy criteria for Anorexia Nervosa
- Major abnormality of biochemistry or haematology results.

6.3 Care of Clients with Bulimia Nervosa

Bulimia nervosa is different to Anorexia Nervosa, as the need for aggressive nutrition support such as nasogastric feeding and total parental nutrition is rare in Bulimia Nervosa. The majority of clients with Bulimia Nervosa are treated in an outpatient or partial hospitalisation setting. However, as with Anorexia Nervosa, interdisciplinary team management is essential in the management of Bulimia Nervosa. Because of the complexity of bulimia, it is important for the client to be psychologically assessed as the Dietitian is not traditionally trained to deal with all the psychological issues related to bulimia. All clients should be evaluated for possible medical complications and appropriate course and site of management should be decided.

Table 13: Indications for Inpatient Admission for a Client with Bulimia Nervosa

- Severe disabling symptoms that are unresponsive to outpatient treatment
- Uncontrolled vomiting
- Severe laxative abuse
- Metabolic abnormalities
- Vital sign changes
- Suicidal tendencies
- Severe concurrent substance abuse.

*American Psychiatric Association, 2006*

6.3.1 Dietary treatment

The dietary objectives for treatment of Bulimia Nervosa are to normalise eating and stabilise weight along with cessation of bulimic behaviours. The main role of the Dietitian is to help develop an eating plan to normalise eating for the client with Bulimia Nervosa. The Dietitian can also assist with the medical management of clients through the monitoring of electrolytes and weight and monitor intake and behaviors which sometimes allow for preventive interventions before biochemical index change.

Most clients with Bulimia Nervosa desire some amount of weight loss at the beginning of treatment. It is the responsibility of the Dietitian to communicate to the
client that weight loss is incompatible to recovery from the eating disorder. Primarily, the eating pattern of the client has to be normalised (American Dietetic Association, 2007). Any weight loss that is achieved would occur as a result of a normalised eating plan and elimination of Binge Eating. The Dietitian is in a uniquely strong position to dispel the food myths of the client with scientific knowledge on nutrition.

Individuals with bulimia have a difficulty in interpreting normal body signals indicating hunger and fullness. This difficulty leads to fears concerning perceived overeating that in turn may trigger a desire to starve or purge due to a feeling of deprivation (American Dietetic Association, 2000). The following actions have been shown to increase satiety and would be helpful when designing meal plans for bulimics;

- Using warm foods
- Eating items with utensils rather than with fingers
- Use of foods naturally proportioned or purchased in such form
- Incorporating high bulk items such as fruits and vegetables
- Allow adequate fat in the meal
- Allow for proteins at each meal to cover protein needs for the entire day.

**6.3.2 Cognitive Behavioural Therapy**

Cognitive Behavioural Therapy is a well established treatment option for Bulimia Nervosa (Agras et al 2000). The key components of the cognitive behavioural therapy are meal planning and nutrition education.

Nutrition education consists of;

- Teaching about body weight control
- Energy balance
- Effects of starvation
- Misconceptions about dieting and weight control
- Physical consequences of purging behaviour.
Meal planning consists of;
- Planning for three meals per day
- One to three snacks per day prescribed in a structured fashion to help break the chaotic eating pattern that continues the cycle of binging and purging
- Caloric intake should initially be based on the maintenance of weight to help prevent hunger since hunger has been shown to substantially increase the susceptibility to Binge Eating.

Cognitive behavioural therapy provides a structure to plan for and expose clients to these foods from least feared to most feared, while in a safe structured supportive environment.

**6.3.3 Weight expectations**
The usual weight prior to onset of the eating disorder is important as it may shed light on the extent to which the client perceived the need to change their weight and identify a genetically determined weight range. A high level of individualization increases the treatment efficacy (Ghaderi, 2006). It is important to ask the client to identify their goals, realistic or not, to provide empowerment and choice in the recovery process. Frequent weighing of clients is often not helpful as it may perpetuate the preoccupation with weight.

**6.3.4 Counselling and education**
The process of nutrition education and counselling is most effective when the client plays an active role in learning about nutrition and weight, food planning and treatment decisions. This process involves dispelling myths and misconceptions about food and weight, exploring the irrational nature of the binge purge cycle and identifying complications associated with Binge Eating and all forms of purging. Keeping food diaries and preplanning meals and snacks can help to provide structure to eating (American Dietetic Association, 2000). The long-term goal is to assist clients to develop a healthy relationship with food thus allowing food to establish its rightful place in their lives.
6.3.5 Food diary
The Dietitian is the expert in explaining to a client how to keep a food diary, reviewing food diary and understanding and explaining weight changes. A food diary can be a useful tool in helping to normalise the client’s intake. Based on the client’s medical psychological and cognitive status food diaries can be individualised with columns looking at the client’s thoughts and reactions to eating/not eating, to gather more information and to educate the client on the antecedents of her/his behaviour (American Dietetic Association, 2007). The Dietitian can determine whether the change is due to a fluid shift or a change in body mass.

6.3.6 Follow-up
Follow up is a critical component of the treatment plan for bulimia. A healthy weight range should be determined for each client which can be maintained without chronic dieting. The treatment should include teaching clients to listen and respond to their body’s physical, emotional and physiological needs (American Dietetic Association, 2000). Trust and self esteem are built when the client is able to experience weight control without purging. Moderate, regular and properly motivated physical activity can be encouraged to promote physical health and overall well-being. The Dietitian needs to anticipate relapses and use them as opportunities for continued education and counselling. Bridging the road to recovery can occur as clients learn to deal with painful issues through psychotherapy, self-nourish with food and self-nurture in other ways than through food.

6.4 Measures of Successful Outcome of Clients with Bulimia Nervosa
- Metabolic rate normalised
- Variety of foods consumed
- Refeeding oedema resolved
- Physical effects of Binge Eating / purging returned to normal (menstruation, skin, teeth, energy, gastrointestinal function)
- Normal daily weight fluctuations accepted
- Food consumption patterns normalised
- Hunger and fullness cues recognised and responded to appropriately
- Cessation of Binge Eating and purging behaviour.

### Table 14: Evidence Based Key Recommendations for Management of Clients with Bulimia Nervosa

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>As a possible first step, clients with Bulimia Nervosa should be encouraged to</td>
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<tr>
<td>follow an evidence-based self-help programme.</td>
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<tr>
<td>Health care professionals should consider providing direct encouragement and</td>
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<tr>
<td>support to clients undertaking an evidence-based self-help programme as this</td>
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<tr>
<td>may improve outcomes. This may be sufficient treatment for a limited subset</td>
</tr>
<tr>
<td>of clients.</td>
</tr>
<tr>
<td>Cognitive behaviour therapy for Bulimia Nervosa a specifically adapted form</td>
</tr>
<tr>
<td>of cognitive behaviour therapy should be offered to adults with Bulimia</td>
</tr>
<tr>
<td>Nervosa. The course of behaviour therapy for Bulimia Nervosa should normally</td>
</tr>
<tr>
<td>be of 16 to 20 sessions over four to five months.</td>
</tr>
<tr>
<td>Adolescents with Bulimia Nervosa may be treated with cognitive behaviour</td>
</tr>
<tr>
<td>therapy for Bulimia Nervosa adapted as needed to suit their age, circumstances</td>
</tr>
<tr>
<td>and level of development and including the family as appropriate.</td>
</tr>
<tr>
<td>Clients with Bulimia Nervosa who are vomiting frequently or taking large</td>
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<tr>
<td>quantities of laxatives (and especially if they are also underweight) should</td>
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<tr>
<td>have their fluid and electrolyte balance assessed.</td>
</tr>
<tr>
<td>When electrolyte disturbance is detected it is usually sufficient to focus on</td>
</tr>
<tr>
<td>eliminating the behaviour responsible. In the small proportion of cases where</td>
</tr>
<tr>
<td>supplementation is required to restore the client’s electrolyte balance oral</td>
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<tr>
<td>rather than intravenous administration is recommended, unless there are</td>
</tr>
<tr>
<td>problems with gastrointestinal absorption.</td>
</tr>
<tr>
<td>The great majority of clients with Bulimia Nervosa should be treated in an</td>
</tr>
<tr>
<td>outpatient setting.</td>
</tr>
<tr>
<td>For clients with Bulimia Nervosa who are at risk of suicide or severe self-harm,</td>
</tr>
<tr>
<td>admission as an inpatient or a day client or the provision of more intensive</td>
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<tr>
<td>care may be necessary.</td>
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</table>
outpatient care should be considered.

- Psychiatric admission for people with Bulimia Nervosa should normally be undertaken in a setting with experience of managing this disorder.

- Health care professionals should be aware that clients with Bulimia Nervosa who have poor impulse control notably substance misuses may be less likely to respond to a standard programme of treatment. As a consequence treatment should be adapted to the problems presented.

- Adolescents with Bulimia Nervosa may be treated with cognitive behaviour therapy for Bulimia Nervosa adapted as needed to suit their age, circumstances and level of development and including the family as appropriate.

National Institute of Clinical Excellence, 2004

(Please see Appendix II for the Bulimia Nervosa Care Plan.)
Chapter VII
Atypical Eating Disorders (Eating Disorders Not Otherwise Specified; EDNOS)
Including Binge Eating Disorders

7.1 Diagnosis
People who suffer from eating disorders similar to Anorexia Nervosa or Bulimia Nervosa but do not meet the precise criteria for the diagnosis are classified under atypical eating disorders (Fairburn & Harrison, 2003). These are often termed atypical eating disorders in Europe (Fairburn & Harrison, 2003). The American Psychiatric Association (1994) classifies them as eating disorders not otherwise specified. Binge eating disorder is a recently described condition first defined as a research category by the American Psychiatric Association in the DSM-IV in 1994. In this condition individuals engage in uncontrollable episodes of Binge Eating but do not use compensatory purging behaviours.

Table 15: DSM –IV TR Diagnostic Criteria for Atypical Eating Disorders (Eating Disorders Not Otherwise Specified; EDNOS)

<table>
<thead>
<tr>
<th>Disorders that do not meet the criteria for a specific eating disorder. Examples include:</th>
</tr>
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<tbody>
<tr>
<td>• All the criteria for Anorexia Nervosa are met, except the individual has regular menses or despite significant weight loss, the individual’s current weight is within the normal range.</td>
</tr>
<tr>
<td>• All the criteria for Bulimia Nervosa are met except binges occur at a frequency of less than twice a week or duration of less than three months.</td>
</tr>
<tr>
<td>• An individual of normal body weight who regularly engages in inappropriate compensatory behavior after eating small amounts of food (e.g. self induced vomiting after the consumption of two biscuits).</td>
</tr>
<tr>
<td>• An individual who repeatedly chews and spits out but does not swallow large amounts of food.</td>
</tr>
</tbody>
</table>

American Psychiatric Association (2006)
Table 16: DSM –IV TR Diagnostic Criteria for Binge Eating Disorders (BED)

<table>
<thead>
<tr>
<th>A. Recurrent episodes of Binge Eating; an episode of Binge Eating is characterised by both of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eating in a discrete period of time (eg, 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</td>
</tr>
<tr>
<td>2. A sense of lack of control over eating during the episode (eg, a feeling that one cannot stop eating or control what or how much one is eating)</td>
</tr>
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<table>
<thead>
<tr>
<th>B. The Binge Eating episodes are associated with 3 (or more) of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eating much more rapidly than normally</td>
</tr>
<tr>
<td>2. Eating until feeling uncomfortably full</td>
</tr>
<tr>
<td>3. Eating large amounts of food when not feeling physically hungry</td>
</tr>
<tr>
<td>4. Eating alone because of being embarrassed by how much one is eating</td>
</tr>
<tr>
<td>5. Feeling disgusted with oneself, depressed, or very guilty after overeating</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Marked distress regarding Binge Eating is present</th>
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</table>

| D. Binge Eating is not associated with the regular use of inappropriate compensatory behaviours (e.g. purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa. |

*American Psychiatric Association (2006)*

Atypical eating disorders are conditions of clinical severity that do not conform to the diagnostic criteria for Anorexia Nervosa or Bulimia Nervosa. Many people with atypical eating disorders have suffered with Anorexia Nervosa or Bulimia Nervosa in the past.

In Binge Eating disorder defining Binge Eating can be problematic and there may be a discrepancy between the subjective experience and clinical assessment of a binge.
People with Binge Eating disorder usually tend to present later in their 30s or 40s when they have become overweight or obese.

7.2 Nutrition Care of Clients with Binge Eating Disorder (BED)
Clients with Binge Eating disorder are classified under the diagnostic criteria Eating Disorder Not Otherwise Specified (EDNOS). The binge eater if overweight can suffer from chronic degenerative complications and medical diseases associated with obesity such as diabetes, hypertension respiratory problem, decreased mobility, reactive hypoglycemia, higher surgical risk, difficult pregnancies, menstrual irregularities and gallbladder disease. As with all eating disorders, physical symptoms need to be identified treated and clearly explained both for health reasons and to educate the client on the consequences of certain eating behaviors.

7.2.1 Nutritional rehabilitation
The dualistic nature of this condition has to be taken into consideration when considering nutritional rehabilitation for such clients. To address obesity and Binge Eating disorder expertise in psychotherapy and nutrition therapy has to be employed. Various combinations of diets, behaviour therapies, interpersonal therapies, psychodynamic psychotherapies, non-weight directed psychosocial treatment and even some ‘non-diet/health at every size’ psychotherapy approaches may be of benefit for Binge Eating and weight loss and stabilisation. Clients with a history of repeated weight loss followed by weight gain (“yo-yo” dieting) or clients with an early onset of Binge Eating may benefit from programmes that focus on decreasing Binge Eating rather than on weight loss (American Psychiatric Association, 2007).

Negative eating behaviours in Binge Eating disorder can be achieved through education about body awareness (hunger/fullness), meal planning, meal mix and how to moderate food intake without triggering feelings of food deprivation. Placing the emphasis on body awareness instead of only caloric restriction helps build a sense of self-trust (American Dietetic Association, 2000). Once a stable pattern of food consumption is established weight normalization goals and expectations can be discussed with the client.
7.2.2 Meal plan design
When designing a meal plan for those with Binge Eating disorder, the nature and severity of disordered eating, the presence or absence of obesity and the individual’s treatment model has to be considered. Meal plans that focus on internal cues rather than caloric restrictions only produce positive long-term results when combined with cognitive behavioural therapy and behavioural weight loss treatment.
Food plans for weight loss should generally stay at or above 1500kcal to help re-stimulate the metabolism and for physical, physiological and psychological satisfaction. Incorporating physical activity can increase metabolic rate and self-esteem. A weight loss of no more than 0.5 – 1 kg per week is recommended.
The goal in dietary treatment with everyone is to encourage healthy eating without food deprivation and its resulting rebound effect. Food diaries can be useful to increase the client’s awareness of actual intake, feelings of hunger and satiety and emotions associated with eating. Weight goals and ranges should always be individualised by focusing on reasonable weight loss taking into account family weight histories and other factors.

7.2.3 Education and counselling
During the education and counselling process it is beneficial to help the client identify trigger situations such as food thoughts, beliefs, emotions or activities that promote loss of control over eating. Education also should include description of a healthy eating style which demonstrates an understanding of variety, balance, and appropriate meal mix, attentiveness to cues of hunger and fullness and accounting for any special dietary needs due to medical diagnosis.

7.2.4 Other psychological treatment
Substantial evidence supports the efficacy of individual or group cognitive behavioural therapy for the behavioural and psychological symptoms of Binge Eating disorder. Substantial evidence supports the efficacy of self-help and guided self-help
cognitive behavioural therapy programmes and their use as an initial step in a sequenced treatment programme.

**Table 17: Evidence Based Key Recommendations for Management of Clients With Atypical Eating Disorders Including Binge Eating Disorder**

- In the absence of evidence to guide the management of atypical eating disorders other than Binge Eating disorder, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual client’s eating disorder.
- Health care professionals should consider providing direct encouragement and support to clients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of clients.
- Cognitive behaviour therapy for Binge Eating disorder a specifically adapted form of cognitive behaviour therapy should be offered to adults with Binge Eating disorder.
- Other psychological treatment (interpersonal psychotherapy for Binge Eating disorder and modified dialectical behaviour therapy) may be offered to adults with persistent Binge Eating disorder.
- Clients should be informed that all psychological treatments for Binge Eating disorder have a limited effect on body weight.
- When providing psychological treatments for clients with Binge Eating disorder consideration should be given to the provision of concurrent or consecutive interventions focusing on the management of comorbid obesity.
- Suitable adapted psychological treatments should be offered to adolescents with persistent Binge Eating disorder.

*National Institute of Clinical Excellence, 2004*
Recommendations

1. A Dietitian has a central role within the multidisciplinary team involved in the assessment, treatment and monitoring of patients with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder.
2. Eating disorders should be treated in the early stages after diagnosis so that the need for expensive hospital admission and long term treatment can be reduced.
3. Interdisciplinary team communication is essential in monitoring the client’s progress, and there should be clear agreement among individual healthcare professionals on the specific roles and tasks of each team member.
4. Dietitians are specialized in assessing nutritional requirements, so can provide accurate and relevant information for clients including those with additional dietary requirements e.g. diabetes or food allergy.
5. A Dietitian should act as a consultant to other health professionals advising on nutritional aspects of care, appropriate literature to use and providing training as required.
6. Dietetic input should be offered to clients in primary, secondary, and tertiary care as an adjunct to other treatments.
7. Care and treatment for clients with eating disorders should be tailored to the needs of the individual client.
8. Dietitians need more than one session to complete a comprehensive nutrition assessment.
9. Engagement in a supportive, empathic assessment interview is crucial in enabling the person to reveal fears around weight, dieting behaviour and any purging or other maladaptive behaviour such as excessive exercising.
10. Dietetic service should be provided by a Senior Grade Dietitian.
11. Adequate resources are essential to deliver a best practice dietetic service for clients with Eating Disorders.
12. Treatment of eating disorders should be evidence based, and outcomes should be evaluated on a regular basis.
13. Dietitians providing a dietetic service for clients with Eating Disorders should adhere to recommended care plans (see appendices).
References


American Dietetic Association (2007) Nutrition Intervention in the treatment of anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (EDNOS). Position paper. ([papers@eatright.org](mailto:papers@eatright.org))


British Dietetic Association (2006) *A briefing paper for Dietitians working with patients with eating disorders.* Produced by the Northern Eating Disorders dietitians’ interest Group, affiliated to the Mental Health Group in consultation with the British Dietetic Association.


Food Safety Authority of Ireland (1999) *Recommended Dietary Allowances for Ireland.*


Appendix I
Anorexia Nervosa Nutrition Care Plan

Referral criteria for Anorexia Nervosa
Advice and Management should be offered to those who:
- Are newly diagnosed with Anorexia Nervosa
- Have continuing weight loss
- Are severely emaciated
- Have a BMI below 17.5Kg/m²
- Have marked vomiting or laxative abuse.

Nutritional management aim
- To provide help with nutritional rehabilitation, weight restoration, cessation of weight reduction behaviours, improvement in eating behaviours and improvement in psychological and emotional state

Nutritional management goals
- To determine the level of malnutrition and muscle wasting present
- To ascertain the level of eating disturbance based on food beliefs, and present eating patterns
- To understand the weight, exercise and diet histories of clients.

Nutritional assessment

Anthropometry
- Height and Weight – BMI
- Skinfold thickness.

Biochemistry
Dietitian should have access to the following:
- Blood Tests- complete blood count, serum chemistry
- Blood Pressure, Urinalysis
- Bone Density Measurements.

History
- The length of time the client has had the eating disorder
• Medical History – menstrual cycle, skin, teeth, energy, gastrointestinal function
• Weight History- usual and current weight, desired weight, attitude towards weight, weight fluctuations, and significant events associated with changes.
• Weight Management history-previous diets and weight management methods, presence or history of binge –eating, purging and/or fasting, nutrition counselling
• Physical Activity History
• Family History- Family eating patterns, Food avoidance or allergy
• Social and Work History- work and home environment
• Emotional State
• Mental Health-Depression, borderline personality, and obsessive compulsive disorder
• Medication and substance–use history –medications including thyroid replacement, vitamin/ herbal supplement use, alcohol consumption, diet pills, diuretics, laxatives.

Initial Consultation
• Assess clients understanding of condition and need for treatment. Educate as appropriate
• Nutritional History
  Meal pattern- The usual distribution of meals and snacks throughout the day and the extent to which this varies from day to day, between weekdays and weekends, or is influenced by factors such as shift work, business, school meals, travel.
  Food Choices- Food beliefs, and rituals, food preferences and aversions, ‘safe vs ‘scary’ or forbidden foods, ‘triggerfoods’, portion sizes, nutrient content of meals, and meal or food supplements.
  Overall dietary balance-How the dietary pattern compares with recommendations for all food groups in the food pyramid
  Nutritional adequacy- The likelihood of dietary surplus or deficiency
  Alcohol consumption- Typical intake and whether this exceeds safe limits
  Eating pattern- Where client eats meals, alone, with family or friends. Length of time client takes to prepare and eat foods.
• Assess readiness to change eating pattern and lifestyle. Using motivational interviewing techniques and ‘stages of change’ model discuss behaviour change
• Address any specific actions requiring change as identified by client
• Agree dietary and physical activity plan until next appointment
• Agree level of weight gain in short and long term
• Offer support and reassurance with respect to gastric discomfort
• Provide support literature and written action plan
• Liaise with patient’s spouse/guardian/parents where appropriate
• Liaise with other members of multidisciplinary team as appropriate.

**On Review**

• Follow procedure for anthropometry, biochemistry, and nutritional assessment.
• Discuss positive and negative changes in the diet and behaviour since initial appointment
• Using behavioural therapy, assess and motivate client
• Assess dietary intake and physical activity levels
• Agree dietary and physical activity action plan until next appointment
• Provide ongoing nutrition education to the client, dispelling any myths that may arise
• Provide ongoing support to client.

**Topics to be addressed include:**

• Appropriate food portion sizes
• Use of cold or room temperature foods, finger foods, and calorie containing foods to minimize early satiety
• Meal planning to introduce nutrient dense food to substitute for low calorie foods
• Limiting caffeine due to its appetite suppressing properties
• Inclusion of high fibre foods.
Appendix II
Bulimia Nervosa Care Plan

Referral criteria for Bulimia Nervosa
Advice and management should be offered to those who
- Have recurrent episodes of Binge eating
- Have recurrent, inappropriate compensatory behaviour in order to prevent weight gain such as: self-induced vomiting, misuse of laxatives, diuretics, enemas, other medications, fasting or excessive exercise.

Nutritional management aim
- To provide nutrition guidance that fosters a nourishing eating style and promotes normal physiologic function and physical activity.
- To support eating behaviors that bring about a normal relationship with food and eating.
- To separate weight and eating control problems from wider personal issues.

Nutritional management goals
- To normalize eating and stabilizing weight along with cessation of bulimic behaviours.
- To determine the level of malnutrition and muscle wasting present.
- To understand the weight, exercise and diet histories of clients.
- To assist in the medical management of patients through monitoring of electrolytes, vital signs, weight, food intake and exercise behaviours.

Nutritional Assessment

Anthropometry
- Height and Weight. –BMI
- Skinfold Thickness.

Biochemistry
Dietitian should have access to the following:
- Blood Tests-complete blood count, serum chemistry (low potassium levels may be associated with vomiting or abuse of laxatives, and there may be nutritional anaemia)
• Blood Pressure, Urinalysis
• Bone Density Measurements.

History
• The length of time the client has had the eating disorder
• Medical History – menstrual cycle, skin, teeth, energy, gastrointestinal function
• Weight History- usual and current weight, desired weight, attitude towards weight, weight fluctuations, and significant events associated with changes
• Weight Management history-previous diets and weight management methods, presence or history of binge –eating, purging and/or fasting, nutrition counselling
• Physical Activity History
• Family History- Family eating patterns, Food avoidance or allergy
• Social and Work History- work and home environment
• Emotional State
• Mental Health-Depression, borderline personality, and obsessive compulsive disorder
• Medication and substance–use history –medications including thyroid replacement, vitamin/ herbal supplement use, alcohol consumption, diet pills, diuretics, laxatives.

Initial consultation
• Assess clients understanding of condition and need for treatment. Educate as appropriate
• Nutritional History
  Meal pattern-The usual distribution of meals and snacks throughout the day and the extent to which this varies from day to day, between weekdays and weekends, or is influenced by factors such as shift work, business, school meals, travel.
Food Choices - Food beliefs, and rituals, food preferences and aversions, ‘safe vs ‘scary’ or forbidden foods, ‘triggerfoods’, portion sizes, nutrient content of meals, and meal or food supplements.

Overall dietary balance - How the dietary pattern compares with recommendations for all food groups in the food pyramid

Nutritional adequacy - The likelihood of dietary surplus or deficiency

Alcohol consumption - Typical intake and whether this exceeds safe limits

Eating pattern - Where client eats meals, alone, with family or friends. Length of time client takes to prepare and eat foods.

- Ascertaining the importance attached to shape and weight
- The reaction to changes to weight
- Previous attempts at dieting
- Frequency of episodes of ‘overeating’
- Frequency of purging behaviour
- Use of over-exercising
- Assessing readiness to change eating pattern and lifestyle. Using motivational interviewing techniques and ‘stages of change’ model discuss behaviour change
- Encouraging client to monitor behaviour to become aware of patterns of dieting behaviour, and precipitants to binge eating
- Addressing any specific actions requiring change as identified by client
- Agreeing dietary and physical activity plan until next appointment
- Educating client on dietary needs and support in establishing a regular meal plan that excludes dietary rules
- Agreeing level of weight gain in short and long term
- Offering support and reassurance with respect to gastric discomfort
- Providing support literature and written action plan
- Liaising with patient’s spouse/guardian/parents where appropriate
- Liaising with other members of multidisciplinary team as appropriate.

On Review

- Following procedure for anthropometry, biochemistry, and nutritional assessment.
- Discussing positive and negative changes in the diet and behaviour since initial appointment
- Using behavioural therapy, assess and motivate client
- Assessing dietary intake and physical activity levels
• Agree dietary and physical activity action plan until next appointment
• Provide ongoing nutrition education to the client, dispelling any myths that may arise
• Provide ongoing support to client.

Topics to be addressed include:
• Appropriate food portion sizes
• Eat food items with utensils rather than fingers
• Use foods naturally proportioned or purchased in such form
• Incorporate high-bulk items such as fruits and vegetables.

Allow client to exclude certain high-risk binge food from their diet early in the course of treatment or choose foods that feel ‘safe’. (These foods may be added back into the diet slowly after some stability in eating has been achieved.)