GENERAL PRACTICE AND THE DETECTION AND TREATMENT OF EATING DISORDERS

In the first part of a new series, the authors consider the role GPs can play in the diagnosis and treatment of a variety of eating disorders.

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CASE STUDY

Sarah, aged 15, is brought to the practice by her mother who is concerned by Sarah's recent reduction in food intake and weight loss, accompanied by change in mood and behaviour. Previously, Sarah had been 'a perfect child'; popular, fun, kind and a grade 'A' student. She become a vegetarian four months ago and seemed to lose her generally happy demeanour. There is no past or family history of note and there are no obvious triggering factors. On examination there are no striking physical findings, other than Sarah being very thin, with a weight of 39kg (noted to be 44.5kg a year previously) and a height of 161 cm, giving her a weight for height ratio of 77% (normal range 90-110%) and placing her on the 2nd BMI centile for age. Her Tanner staging is 3 and her periods had stopped two months previously. She is sad, withdrawn and avoids eye contact.

**NB: This is a fictitious case based on the authors' experiences.*

Eating disorders and who they affect

Eating disorders are estimated to affect 1.6 million people in the UK, of whom 11% are male.[1] Eating disorders are complex and mystifying illnesses. Anorexia nervosa (AN) and bulimia nervosa (BN) are the more commonly recognised of these but there are a number of others that are less familiar, although in some cases more common (see Box 1). However, as AN is the most complex and problematic, we have chosen to focus this paper on its assessment and management, though many of the principles we outline are applicable to other eating disorders.

The core characteristics of each eating disorder are also outlined in Box 1. These are not necessarily the diagnostic criteria, which serve limited usefulness in the clinical setting, as they are commonly based upon arbitrarily chosen quantitative data, eg, number of binges per week, rather than the clinical features.

Aetiology

There is no single factor that can cause an eating disorder, but rather a complex interaction between biological, social and psychological factors. Genetic vulnerability – ie, the genetic profile renders the patient vulnerable to the development of the illness – as with very many illnesses, plays a major part, acting as a substrate upon which other phenomena build. For example in AN, genetics contribute over 50% of the variance in aetiology, but socio-cultural pressure to be thin is a necessary contributor. However, the latter is unlikely to lead to AN in the absence of genetic vulnerability. Puberty and a range of stresses may act as triggers but in themselves are not causes. Furthermore, once the illness has developed other factors may serve to perpetuate it, eg, inappropriate or coercive treatments. Seeking a single causative agent is a fruitless exercise.

> *Eating disorders are not a phase or a fad and do not just go away or are grown out of*

Prognosis

Prognosis is relatively poor with no more than about 50% making a full and sustained recovery at five year follow-up in those with AN and BN[2] and up to 10% dying from the illness or associated morbidities eg, suicide. In spite of this, the outcome for eating disorders significantly improves with early recognition and treatment. Herein lays the crucial role that GPs play in the effective and timely diagnosis and treatment of eating disorders.

Guidelines

General guidelines for the diagnosis and care pathway for eating disorders are readily accessible online for clinicians in primary care. Of note, the Junior Management of Really Sick Patients under 18 with

Anorexia Nervosa (MARSIPAN) and the Section of Eating Disorders at the Institute of Psychiatry guides offer comprehensive and up to date advice, which will be an important aide to GPs. These include direction on presentation, questions to ask (see Box 2 for the SCOFF questionnaire), what to look out for in physical examinations (mandatory when an eating disorder is suspected) and investigations (see Box 3), how to manage an eating disorder in the practice, when to refer and recommended treatments. Despite these detailed guidelines the engagement and management of this population is far more complex than following a pathway or a box-ticking exercise.

BOX 1: EATING DISORDERS CORE CHARACTERISTICS

Anorexia nervosa

- Determined food avoidance
- Significant weight loss
- Intense body-related anxiety and shame
- Distorted body image (experiencing oneself as fat when actually thin)
- Sometimes accompanied by depression, obsessive-compulsive features, excessive activity, bingeing and purging
- Peak age of onset 13-18
- Prevalence 1% of females between 15 and 40, males <0.1%

Bulimia nervosa (BN)

- Episodes of food restriction followed by binge eating and purging, such as self-induced vomiting or laxative misuse
- Weight is generally maintained within the normal range
- Whilst there is rarely distorted body-image, there is body-related anxiety and shame
- Peak age of onset 15-19
- Prevalence 1-4% of females between ages 15 and 40, males < 0.5%

Binge eating disorder

- Frequent episodes of binge eating without purging
- Often accompanied by such features as disgust, depression, or guilt after the episode
- No abnormal body-related cognitions
- Peak age of onset – early adult life
- Life-time prevalence males 2%, females 3.5%

Selective eating

- Consumption of a very narrow range of foods, often carbohydrate-based
- Determined, anxiety-based, avoidance of trying new foods
- Commonly starts as the normal developmental phase of 'picky eating' but because of intense anxiety, or possibly coercion, fails to resolve and may persist well into adult life
- Prevalence unknown
- Gender ratio equal

Food-avoidance emotional disorder

- Determined food avoidance and significant weight loss in the absence of abnormal body-related cognitions
- Food avoidance is commonly attributed to anxiety, low mood, feeling full or
- bloated, or to abdominal pain
- Prevalence unknown
- Gender ratio females > males

Functional dysphagia

- Avoidance of lumpy or solid foods for fear they may trigger choking or vomiting
- Commonly precipitated by witnessing a loved one choking or vomiting whilst eating
- Prevalence unknown
- Gender ratio equal

First port of call

Unlike most illnesses, a core aspect of eating disorders is that those suffering them may deny their existence and resist help.[3] It is unlikely that a young person with an eating disorder will actively seek help regarding the illness itself. It is more common for the child or adolescent with an eating disorder to "play down"or ignore other people's concerns. It is also possible that a young person may become defensive, upset and even argumentative/angry when questioned about their eating and their weight. Therefore an open, non-judgemental and non-blaming approach is essential and may lead to a more frank response to the difficulties being experienced.

BACK IN THE GP'S OFFICE:

Mother: *"We are very concerned about Sarah. She says she eats everything at school and when out with her friends but at home she isn't eating much and after our holiday recently we noticed how thin she was looking. She hardly spends time with us anymore, preferring to be in her room, which is very unusual for her. Also, her periods have stopped recently and a colleague told me this might be a sign of anorexia." (Sarah remains silent not engaging in eye contact with anyone).*

GP: *"Sarah, it sounds like your mother is very concerned about your eating and weight loss. What do you think about this? Is it something you are worried about?"*

Sarah: *(shrugs shoulders still not engaging in eye contact)*

Mother: *"Sarah, please stop this! I know there is something wrong with you. You have taken this vegetarian thing too far!"*

Sarah: *"Ugh Mum stop it! I'm fine. I'm healthier than ever – you're just making a big deal about this as you do with everything!"*

GP: *"Sarah, I can see that you are uncomfortable talking about this. However, I will need to ask you some questions and do some physical checks, as your mother is very worried."*

(Sarah shrugs her shoulders looking away from GP).

For children and adolescents it is more common that a parent or carer will be the first to consult a GP. Parents who seek advice and support from professionals are already likely to be very worried about their child. It is important to listen to and ask about parents'/carers' concerns and observations regarding the changes they have noticed. Many young people may diet but given

BOX 2. THE SCOFF QUESTIONS*

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14lb/6.35kg) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are t oo thin?
- Would you say that **F**ood dominates your life?

Morgan JF *et al*. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. *BMJ*. 1999 Dec 4;319(7223):1467-8

BOX 3. SUGGESTED INVESTIGATIONS

***These are not inclusive and the more emaciated or dehydrated the child is, the more rigorous the screening should be**

- Full blood count – look out for anaemia
- Full electrolyte screening – look out for low potassium, <3.5 mmol/l, suggestive of purging, high urea >7mmmol/l suggestive of dehydration, and low phosphate, a warning sign for re-feeding syndrome – refeed slowly to avoid
- Glucose – normal range 4.4 -6.66mmol/l – higher than 7.5 consider bingeing, below 4.4 inadequate nutrition and need for refeeding to be implemented quickly

the severity and poor prognosis of eating disorders it is crucial to take any suspicion seriously. Eating disorders are not a phase or a fad and do not just go away or are grown out of. It is likely, more often than not, that parents/carers will be able to distinguish whether their child has stepped into a more dangerous territory.

Bryant-Waugh and Lask[4] outline "crucial principles" for parents for the management of eating disorders. These are useful and applicable for any clinician's management. They include:

- No one chooses to have an eating disorder nor do they particularly like having one
- Someone with an eating disorder is unlikely to know how to overcome it without support
- Resistance to change and help are integral parts of eating disorders. Patients are commonly terrified of giving it up as it may be a coping mechanism for other difficult situations or feelings
- Poor self-esteem is a crucial underlying issue for people with an eating disorders and shame is a significant feeling that may prevent seeking help in many cases
- Eating disorders take a long time to resolve and need the correct treatment to do so; it is important to advise parents/carers that there is no quick fix
- It is essential not to blame; there is no evidence that patients choose to have an eating disorder or that adverse parenting can produce one
- It is equally important to help parents not to blame or be angry with their child for the illness. Eating disorders dictate thoughts, feelings and behaviour, just as infections cause fever, fatigue and malaise.

In essence, children and families facing an eating disorder need to be heard, acknowledged and worked with empathically.

Unlike in the case of most illnesses, the person afflicted by an eating disorder is 'captured' by the illness,[5] driving them to become more and more unwell rather than to seek recovery, therefore the role of parents/carers taking charge is fundamental. Particularly in the case for young people, guidelines and evidence support family based work as the main treatment for eating disorders,[6] especially for AN. The therapeutic alliance with the young person should be integrated in the collaborative work with parents where possible. However, there are cases where mental health legislation and parental consent may be necessary for issues of compulsory treatment and confidentiality; NICE offer guidelines for these situations.[7] Regardless, from the outset, professionals should work on establishing a collaborative and consistent working partnership, both between, and with parents/carers, that enhances their coping and management skills – the main thrust of treatment is through parents, not through the child. GPs as the "first port of call" have the opportunity to help engage and support parents from when they first seek help, setting the path for a more successful partnership in tackling the eating disorder.

BACK IN THE GP'S OFFICE:

The GP has carried out a physical examination, and then asks Sarah about food avoidance. She shrugs her head and 'retreats' further. The GP suspects Sarah is suffering from anorexia nervosa:

GP: *"Sarah, I understand it hasn't been an easy time for you and you don't agree on being here at the moment. From my experience, girls who have had similar difficulties to you also don't want to think that there is a problem or feel very upset thinking about it. This often changes and has different 'phases'. I want to understand more about how you feel things are right now." (Sarah continues to avoid eye contact and appears to be tearful, hiding her face behind her hands).*

(To Mother): "I am concerned about Sarah as she is clearly not eating enough and is in obvious distress. We will carry out some tests but we all need to act on these difficulties now. I appreciate the last few months have been really difficult for Sarah and for the whole family. We need to take action straight away. You and your husband's role in fighting this illness together is crucial as she will be unable to do it without your help, support and guidance."

Additionally, the role of those professionals who are the first point of contact for support and advice is to offer accurate information on the eating disorder. GPs should provide information on the features of

the illness, what to expect, and services, treatment options and what support organisations or networks are available.[3] Extensive information and links are available for young people and families on the beat organisation website (available www.b-eat.co.uk).

Information on the eating disorder and some basic ways of managing the illness are invaluable tools that clinicians can offer frightened parents. One such tool is the use of "externalisation". This is a fundamental tool used in the treatment of eating disorders whereby through the use of language, distance is created between the person and the problem.[8]

BACK IN THE GP'S OFFICE:

GP: *(To Sarah) "Sarah, I know that right now this illness is giving you a very tough time, saying mean things to you and telling you not to listen to what your parents or any doctors say. It will do its best to make you feel horrible but if we don't help you, then you will become more and more ill, and will almost certainly need to go into hospital. I know how difficult it makes life for you; I know that when you are terrified of eating or when you are shouting at your mother as she described, this is the illness, not you. This is why your parents, with support from others are going to help you fight it."*

(To Mother): "I know sometimes it feels like this illness has completely taken Sarah over and she seems to be a different person. When you see Sarah acting out of character, you can safely assume it is the illness tormenting her. At these times you can take a stance and not engage in conversation with the illness [eg, negotiations regarding food, weight, portions etc]. At these times, try to reach out to Sarah and comfort her (not the illness!)."

Helping parents/carers by modelling externalisation of the illness will help mobilise them to fight against the illness and for their child.

The importance of multi-disciplinary treatment

Treatment of eating disorders requires a multi-disciplinary approach, tackling the physical, psychological, and social components, as well as provision of intense support for the parents/family. Referral to one discipline, such as a dietitian or counsellor is insufficient. A multi-disciplinary team is required, however this might be accessed, preferably with expertise in the assessment and management of eating disorders in childhood and adolescence.

In the case of delayed or very limited access to specialist services, a comprehensive care package spearheaded by the GPs may be necessary. What can be offered depends on what resources are available in the practice. Regular reviews, repeat appointments to monitor nutritional and psychological health are important until specialist care or a more robust and specialist care package is in place. As stated above, including psychiatric/medical, dietetic advice and family therapy are essential and should be sought by anyone managing the care of young person with an eating disorder.

BACK IN THE GP'S OFFICE:

GP: *(To both) "I am going to make a referral to your Child and Adolescent Mental Health Service, usually known as CAMHS. They should offer you an appointment so that they may further assess and start the appropriate treatment."*

(To Sarah) "This very likely will include your parents, as we know that parents are crucial in helping you fight the illness. You will also have regular physical check ups. In the meantime, we need to do some blood tests and I will see you again next week." (To Mother) "You will need to take charge of Sarah's eating for the time being until she is able to do so for herself. You and her father will need to take a very firm line about this, ensure she is given normal meals, and do not get into pointless discussions about amount of calories, her weight etc. The two of you as parents need to be united, consistent, firm, as well as sympathetic and loving. If you find yourself negotiating with her you are on the wrong track. If she tells you she is fat and needs to lose weight, it's okay to sympathise with her concerns but ensure you tell her that it's the illness that gets her seeing herself that way and that actually she is much too thin. The illness is very likely to draw you into irrational discussions – avoid them as they will get you nowhere. This is going to take some time and it's not going to be easy for any of you, but if you can follow these guidelines, she will recover."

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References available online