Understanding eating disorders

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Eating disorders can be severe and enduring mental illnesses that have serious physical, psychological and social consequences. They can also have a significant effect on the person’s friends and family. In this patient group, control of body shape, weight or eating is over-valued and becomes the main or only way of judging self-worth. Eating disorders can be mild and self-limiting, but they commonly run a chronic course unless treatment is successful. Nurses play an important role in early detection, assessment and treatment.

Eating disorders are classified as mental disorders and can be divided into two main diagnostic categories: anorexia nervosa and bulimia nervosa (Garfinkel, 2002). People who do not fit these categories but have a clinically significant problem are diagnosed as having an atypical eating disorder. Although there are important differences between each diagnosis, most people with eating disorders share similar attitudes, behaviours and feelings.

In this patient group, control of body shape, weight or eating is over-valued and becomes the main or only way of judging self-worth. People with an eating disorder typically move from anorexia nervosa or bulimia nervosa to an atypical eating disorder. Signs and symptoms for each are given in Box 1. Eating disorders can be mild and self-limiting, but they commonly run a chronic course unless treatment is successful.

Most people with eating disorders do not seek help, but some suffer severe, enduring illnesses that require treatment in hospital. However, those who are diagnosed are referred to mental health services. About half of patients with eating disorders seen by mental health services are atypical (Fairburn and Harrison, 2003).

**The effects of eating disorders**

Eating disorders cause physical, psychological and social suffering and can have a damaging effect on the lives of friends and relatives. Psychological features include:

- Intrusive thoughts about food;
- Impaired concentration;
- Preoccupation with food;
- Poor alertness, comprehension and judgement;
- Tearfulness and irritability;
- Anxiety and depression;
- Obsessional behaviour;
- Self-harm;
- Drug and alcohol misuse.

The physical consequences of eating disorders can

**Box 1. Signs and Symptoms of Eating Disorders**

**Anorexia Nervosa**

- Deliberate weight loss to a point at least 15 per cent below that expected for age, sex and height
- Changes in hormone levels, which in females result in amenorrhoea. If the weight loss occurs before puberty, sexual development will be delayed and growth may cease
- The person feels driven to lose weight because he/she sees himself/herself as fat, even at a subnormal weight
- The person is intensely afraid of becoming fat and is preoccupied with worries about body size and shape
- The person directs all his/her efforts towards controlling his/her weight by restricting food intake, but may also binge eat, self-induce vomiting, misuse laxatives or diuretics (purging behaviours), exercise excessively or misuse appetite suppressants

**Bulimia Nervosa**

- Frequent episodes of binge eating, in which the person consumes a large amount of food within a short time
- An overwhelming urge to binge. The person can only stop eating once it becomes too uncomfortable to eat the food
- The person feels unable to control his/her appetite and feels a sense of losing control
- The person feels guilty, anxious and depression
- The person tries to regain control by getting rid of the calories consumed. The most common method is vomiting, but may involve misuse of laxatives, diuretics or appetite suppressants, fast or excessive exercise
- The person is usually within a normal weight range, but may be obese

**Atypical Eating Disorder**

- The person does not quite meet the diagnostic criteria for anorexia nervosa or bulimia nervosa (for example, laxative abuse)
- The person may vomit after eating small amounts of food
- The person may admit to chewing food and then spitting it out
- The person may binge eat, but not attempt to get rid of the calories consumed, known as binge eating disorder (Garfinkel, 2002). The phrase compulsive eating is sometimes used, but has never been adequately defined
- The person may eat for emotional reasons (comfort eating), but not eat large amounts of food at one time
affect almost every part of the body and are potentially fatal. They include anaemia, amenorrhea, dental erosion, dehydration and low blood glucose (Box 2). Social consequences include:

- Avoidance of eating in public;
- Decreased sociability, sense of humour and camaraderie;
- Increased social anxiety;
- Social withdrawal, anxiety, depression;
- Mothers with an eating disorder can have problems relating with their children regarding feeding and play;
- Rigid/obsessional or erratic/disorganised behaviour;
- Debt due to binge eating;
- Shoplifting.

The causes of eating disorders
The current expert consensus view is that eating disorders are caused and maintained by combinations of predisposing, precipitating and perpetuating factors (Garner, 1997).

Predisposing factors
These can be:

- Psychological and emotional – including low self-esteem and perfectionism;
- Physical – including a probable genetic component;
- Gender – women are far more at risk;
- Interactional – including relationship difficulties;
- Cultural – including pressures on women to diet.

The causes of low self-esteem are multifactorial. Some people with eating disorders have experienced trauma, but many have not. Whatever the cause, low self-esteem leaves some people vulnerable to believing that weight loss will improve their self-worth and confidence.

Precipitating factors
These vary from person to person, but most eating disorders start with dieting. Any event or threatened event that causes stress can lead to a sense of being overwhelmed and out of control, pushing the person to find a way to manage those feelings. The interpretation of events is probably more important than the events themselves, as precipitating factors are often a normal part of growing up.

If the developing eating disorder relieves stress, the behaviour will continue. Dieting, binge eating, exercise, vomiting and laxative misuse quickly become the only behaviour that causes stress can lead to a sense of being overwhelmed and out of control, pushing the person to find a way to manage those feelings. The interpretation of events is probably more important than the events themselves, as precipitating factors are often a normal part of growing up.

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Perpetuating factors
These include:

- Psychological and emotional – including over-valuation of shape, weight and control of eating, avoidance of life difficulties, cognitive distortions, depression and anxiety;
- Interational – including relationship problems and secondary gain;
- Cultural – including pressures on women with regard to their appearance.

Body image
Alongside over or under-eating, the individual becomes preoccupied with and highly sensitised to his or her appearance, investing heavily in controlling and managing his or her shape and weight. The core psychopathology of eating disorders involves the over-evaluation of weight, shape and control of eating. The individual judges self-

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**REFERENCES**


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**KEYWORDS**

Mental health ▪ Eating disorder ▪ Therapy
Men and eating disorders

Eating disorders are typically associated with young females, and sometimes stereotyped as ‘female disorders’. However, men constitute five to 10 per cent of cases of anorexia nervosa (Hock, 2002). There is an increased prevalence in certain subgroups of males vulnerable to weight and shape concerns, for example wrestlers and gay men.

Despite the uneven distribution, the clinical features, prognosis and treatment of males and females with eating disorders are broadly similar (Anderson, 2002). Box 3 shows features specific to males.

Management and treatment

People with eating disorders typically have mixed feelings about change. The prospect of treatment and recovery can feel incredibly frightening. Their behaviours may give a sense of being in control, albeit in an insecure and distressing way. Letting go of an eating disorder can increase fears of loss of control, evoking a deep fear of change.

Recovery involves a collaborative effort between the individual and the therapist. It requires sufficient motivation to change and adequate support and guidance. Children and young adolescents are often unable to collaborate with efforts to help them in the early stages of treatment, making parents’ and families’ involvement especially important. The therapist needs to understand the patient’s dilemmas and ambivalent feelings, while promoting the possibility of change and recovery.

The broad aim of intervention is to engage people in working towards their own recovery. An approach that encourages active participation by the patient is more likely to achieve this aim. This involves:

- Establishing a healthy eating pattern;
- Gradually restoring weight to a normal range;
- Ceasing purging behaviour;
- Improving self-esteem and diminishing over-evaluation of weight and shape;
- Using healthier coping strategies;
- Developing relationship and communication skills.

Treatment options

Evidenced-based treatment is possible for bulimia nervosa. A specific form of cognitive behavioural therapy (CBT) (Fairburn et al, 1993) has been developed and tested and is considered the treatment of choice (Wilson and Fairburn, 2002). CBT focuses on tackling the behavioural and cognitive processes that maintain the eating disorder. Binge eating declines rapidly, but only about 40–50 per cent of patients recover completely.

An alternative treatment that is as effective at one-year outcome, but takes longer to work, is interpersonal psychotherapy (IPT) (Fairburn, 1997). IPT has no focus on eating, but instead encourages patients to make changes in their relationships, thereby improving self-esteem and problem-solving skills.

Antidepressants, specifically fluoxetine, have been shown to reduce binge eating rapidly in some patients, but they have no effect on over-evaluation of weight and shape, and therefore leave patients vulnerable to relapse. There is no long-term outcome data available for antidepressants (Wilson and Fairburn, 2002).

There are very few treatment studies for anorexia nervosa and the results do not show clear evidence in favour of any particular psychotherapy. However, most patients can be treated as outpatients using an approach that focuses on improving eating and weight as well as providing psychotherapy for the underlying maintaining factors (Wilson and Fairburn, 2002).

Treatment for children and adolescents should usually involve the family, but individual therapy is probably more effective for adults. However, there are often occasions when it makes sense to involve family members, even if it is simply to provide education about eating disorders and their effects. Medication has little role to play in the treatment of anorexia nervosa, other than for co-morbid conditions, although fluoxetine may help to prevent relapse (Wilson and Fairburn, 2002). A small number of patients with anorexia nervosa will require hospital admission due to extreme weight loss and risk
to physical health, or failure of previous outpatient treat-
ment. Day care programmes increasingly provide ther-
apy for patients once physical safety has been restored.
There have been no published treatment trials for
atypical eating disorders, other than binge eating disor-
der. Treatment can follow that advised for whichever
eating disorder most resembles the patient’s difficulties.
Binge eating disorder can be chronic and severe, but is
commonly episodic in response to life stress. Evaluated
treatments include self-help (using a self-help book),
guided self-help, antidepressants (fluoxetine), CBT, IPT
and behavioural weight loss programmes.
CBT and IPT should be reserved for patients with more
severe and enduring binge eating, as less intensive
treatments are often successful. Only behavioural weight
loss programmes have any effect on weight loss, so as
most patients with binge eating disorder are obese
(defined as having a body mass index (BMI) >30), a
behavioural weight loss programme may be the most
sensible first choice treatment (Wilson and Fairburn, 2002).

The role of nurses in prevention
and early intervention

School nurses, practice nurses and health visitors all have
a role to play in the detection and initial management of
people with eating disorders.

School nurses

Many school nurses provide drop-in sessions at second-
ary schools, where they are approached by pupils who
are concerned about their own or a friend’s eating.
Careful and sensitive questioning can elicit problematic
eating behaviours. Weighing and measuring the pupil
allows assessment of BMI. Rapid referral to Child and
Adolescent Mental Health Services (CAMHS) is recom-
manded for any pupil who is purposely losing weight
(when there is no need), self-inducing vomiting after
eating, misuse of laxatives or excessively exercising.
School nurses are also approached by teachers or par-
ents and can arrange to see pupils to undertake an assess-
ment of attitudes and behaviours relating to
eating, weight and shape is recommended for all
mothers with children younger than 12 months
and assessment of attitudes and behaviours relating to
eating, weight and shape is recommended for all
women who have depression. Patients with eating disor-
ders commonly report low mood, which is usually a
consequence of the eating problem and does not respond to
treatment for depression.

Another reason to screen mothers for eating disorders
is that research shows that children of mothers with an
eating disorder have lower birth weights and continue to
be significantly slower in their development than chil-
dren of mothers without eating disorders (Stein, 2002).
The health visitor could provide guided self-help for
mothers with mild-to-moderate binge eating, but should
refer patients who do not respond or who have more
severe eating difficulties to the GP or Community Mental
Health Team (CMHT).

Box 4. The SCOFF QUESTIONS

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

“One point for every ‘yes’, a score of two indicates a
likely case of anorexia nervosa or bulimia

Practice nurses

Practice nurses undertake the initial health screen when
new patients join. Height and weight are measured so
low or high BMI can be detected. Either presentation
should trigger questioning on attitudes/behaviours relat-
ing to weight/body shape. It is probably worth asking all
new female patients if they have concerns about weight,
shape or eating. A simple screening tool such as the
SCOFF assessment (Box 4) (Luck et al, 2002; Morgan et al,
1999) can quickly establish if referral to the GP is required.

Some practice nurses are developing skills in detecting
and treating common mental health problems. CBT self-
help books can be used effectively in primary care for
mild-to-moderate mental health problems. Practice nurses
can guide and encourage people to practise the strategies
advised within the self-help book (Fairburn, 1995). This
could take place in six to eight, 20-30 minute sessions
held on a weekly to fortnightly basis. Practice nurses can
also offer behavioural weight loss programmes to
patients with binge eating disorder and obesity.

Health visitors

Health visitors are involved in the postnatal care of all
new mothers and monitor the development of children
below the age of five. Depression is a common experi-
ence for mothers with children younger than 12 months
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Current research

The National Institute for Clinical Excellence will publish
clinical guidance on eating disorders in January 2004. NICE
has thoroughly reviewed the evidence in:
● Physical effects and treatments;
● Psychological treatments;
● Service organisation.
Draft guidance for clinicians and separate guidance for
service users and carers is already available on the NICE
website (www.nice.org.uk).

Conclusion

Eating disorders can be severe and enduring mental ill-
nesses that have serious physical, psychological and
social consequences. Nurses can play an important role
in their early detection, assessment and treatment.

INFORMATION FOR PATIENTS

Anorexia Nervosa: The Wish to Change
by Arthur Crisp and colleagues.
Psychology Press.

Anorexia Nervosa: A Survival Guide
for Families, Friends and Sufferers
by Janet Treasure. Psychology Press.

Eating Disorders: A Parents’ Guide
by Rachel Bryant-Waugh and Bryan Lask.
Penguin.

Binge Eating Disorder and other
atypical eating disorders: Overcoming
Binge Eating by Christopher Fairburn.
The Guilford Press.

The Eating Disorders Association (EDA)
is a national charity that offers
information and support to sufferers,
carers and professionals. It has a
helpline on 01603 621414.
The association’s website
www.edauk.com provides high quality information.

NHS Direct also provides useful
information at www.nhsdirect.nhs.uk

Gloucestershire Eating Disorders
Project provides guidance on the
management of eating disorders in
primary care and secondary schools on
its website www.edglos.org.uk