



National
Eating Disorders
Collaboration



Eating Disorders: A Professional Resource for General Practitioners

nedc.com.au

Eating Disorders: A Professional Resource for General Practitioners



**A professional resource developed by the
National Eating Disorders Collaboration**

© 2014 This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or within your organisation. Apart from any use permitted under the Copyright Act 1968, all other rights are reserved.



General information about Eating Disorders

Eating disorders are serious mental illnesses; they are not a lifestyle choice or a diet gone ‘too far.’

Eating disorders are associated with significant physical complications and increased mortality. The mortality rate for people with eating disorders is the highest of all psychiatric illnesses, and over 12 times higher than that for people without eating disorders. Eating disorders occur in people of all genders, ages and backgrounds. About one in 20 Australians has an eating disorder and the rate in the Australian population is increasing.

There are four specified eating disorders defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and Other Specified Feeding and Eating Disorder (OSFED).

Eating disorders defy classification solely as mental illnesses as they not only involve considerable psychological impairment and distress, but they are also associated with major wide-ranging and serious medical complications, which can affect every major organ of the body.

As a GP you are likely to be one of the first health professionals a person with an eating disorder will come in contact with. A GP’s role in the treatment of eating disorders can encompass prevention, identification, medical management in a primary care setting and referral.



Step 1: Screening and assessment

Early intervention depends on early detection of symptoms. There is an average delay of approximately 4 years between the start of disordered eating symptoms and first treatment, and this delay can be 10 or more years. A reduction of this delay can result in improved health and quality of life.

The delay in the commencement of treatment can be for a number of reasons. We do know the majority of people with eating disorders have contact with health professionals. They present with apparently unrelated complaints and do not disclose their eating problems. While people may not volunteer information about their eating problem, asking questions and allowing the person to see that their eating habits are important may offer a non-judgemental environment for them to start seeking help.

For many people with eating disorders, their first attempt at seeking treatment is a test of attitudes and responses. If the first help seeking is a positive experience then the person is more likely to engage successfully with future treatment.

Common health presentations include:

- emotional problems
- weight loss
- gastro-intestinal problems
- infertility issues
- injuries caused by overexercising
- fainting or dizziness
- feeling fatigued or not sleeping well
- feeling cold most of the time regardless of the weather
- swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath (signs of vomiting).

The full list of the physical, psychological and behavioural warning signs of an eating disorder is available under the Mental Health First Aid Guidelines: <http://www.mhfa.com.au/Guidelines.shtml>.

Screening questions

Screening questions help to initiate a disclosure which may then lead to earlier access to treatment for individuals with eating disorders (Gilbert et al., 2012). Screening for eating disorders involves asking a small number of evidence based questions posed on an opportunistic basis when the patient presents for other reasons (e.g. weight related concerns, depression or anxiety). The questionnaires do not diagnose eating disorders but detect the possible presence of an eating disorder and identify when a more detailed assessment is warranted.

SCOFF

- S** – Do you make yourself Sick because you feel uncomfortably full?
- C** – Do you worry you have lost Control over how much you eat?
- O** – Have you recently lost more than 6.35 kg in a three-month period?
- F** – Do you believe yourself to be Fat when others say you are too thin?
- F** – Would you say Food dominates your life?

An answer of ‘yes’ to two or more questions indicates the need for a more comprehensive assessment.

A further two questions have been shown to indicate a high sensitivity and specificity for bulimia nervosa.

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?

Eating Disorder Screen for Primary Care (ESP)

- Are you satisfied with your eating patterns? (A “no” to this question is classified as an abnormal response).
- Do you ever eat in secret? (A “yes” to this and all other questions is classified as an abnormal response).
- Does your weight affect the way you feel about yourself?
- Have any members of your family suffered with an eating disorder?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?

Cotton, Ball & Robinson, 2003 found that the best individual screening questions are:

- Does your weight affect the way you feel about yourself?
- Are you satisfied with your eating patterns?

Screening for high risk groups

Eating disorders occur in both males and females; in children, adolescents, adults and older adults; across all socio-economic groups and cultural backgrounds. Within this broad demographic however there are some groups with a particularly high level of risk. Based on the known risk factors for eating disorders, high risk groups who may benefit from screening for eating disorders include:

Adolescents: The peak period for the onset of eating disorders is between the ages of 12 and 25 years, with a median age of around 18 years.

Women, particularly during key transition periods: from school to adult life, pregnancy and menopause. Targeting preventive interventions at women with high weight and shape concerns, a history of critical comments about eating weight and shape, and a history of depression may reduce the risk for eating disorders.

Women with Polycystic Ovary Syndrome or Diabetes: Adolescents with diabetes may have a 2.4-fold higher risk of developing an eating disorder, particularly Bulimia Nervosa and binge eating, than their peers without diabetes. Polycystic Ovary Syndrome is associated with body dissatisfaction and eating disorders. Screening for abnormal eating patterns is recommended.

Athletes: People engaged in competitive fitness, dance and other physical activities where body shape may be perceived as affecting performance have a high level of risk of eating disorders.

People with a family history of eating disorders: There is evidence that eating disorders have a genetic basis and people who have family members with an eating disorder may be at higher risk of developing an eating disorder themselves.

People seeking help for weight loss: Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating.

Eating disorders in males

Population studies have suggested that males make up approximately 25% of people with Anorexia or Bulimia and 40% of people with Binge Eating Disorder. In a recent study lifetime prevalence for anorexia nervosa in adolescents aged 13 – 18 years found no difference between males and females.

One unique difference between males and females with eating disorders is that men more typically engage in compulsive exercise as a compensatory behaviour, often with the aim of achieving a more muscular, and not just slender, body type. Compulsive exercise describes a rigid, driven urge to exercise, which is a serious health concern.

The Compulsive Exercise Test (CET) is a screening questionnaire of 24 questions (1 page) which asks people to rate their own behaviour and emotions in relation to exercise.

The CET can be used with adolescents. You can download the CET at www.lboro.ac.uk/media/wwwlboroacuk/content/ssehs/downloads/compulsive-exercise-test.pdf Physical assessment can also be useful in the identification of compulsive exercise.

Risk Assessment

Patients must be screened for physical health risks and risk of suicide. Medical stabilization, where required, must be provided before or simultaneously with other interventions. Eating disorders can impair a person's insight and ability to make informed decisions. Decisions regarding treatment must always take into consideration the person's capacity to make decisions for their own safety.

When taking the patients general history and conducting physical examinations assess their general state (eg. well/unwell), alertness/somnolence, height and weight history, disproportion in weight for height (>1 standard deviation apart), menstruation pattern/menstrual history, hydration (tongue, lips, skin, sunken eyes), ketones on breath, deep, irregular, sighing, breathing seen in ketoacidosis, temperature <36°C, pulse rate <60 beats per min, regular or irregular, BP – lying and standing (postural drop in BP > 20mmHg), limbs – peripheral circulation, cold peripheries, ankle oedema, abdomen scaphoid, symptoms of electrolyte disturbance (thirst, dizziness, fluid retention, swelling of arms and legs, weakness and lethargy, muscle twitches and spasms) and alkaline urinary pH. More information about medical assessments can be found in the resource 'Eating Disorders: An Information Pack for General Practitioners' produced by The Eating Disorders Association Inc (Qld) at <http://eda.org.au/wp-content/uploads/Complete-GP-Information-Kit-2013.pdf>



Step 2: Referral to appropriate services

The eating disorders treatment team requires a multi-disciplinary approach to address the physical components of the illness, the eating behaviours, the psychological thought processes, and the social and work needs of the person. Members of the multidisciplinary team will vary depending on the needs of the patient but a minimum team for safe interventions will include both physical and psychological disciplines. GPs should be aware of the risks of rapid deterioration of health in people with Eating Disorders and should consider the impact of very low BMI on cognition and the role of mental health legislation and compulsory treatment for some patients. More information about treatment and recovery including treatment approaches for specific disorders and complementary treatment approaches can be found on the NEDC's treatment and recovery page.

A 'complete' team could include a range of the following professionals depending on individual needs and treatment plans:

- GP or paediatrician
- Psychiatrist
- Dietitian
- Psychologist
- Psychiatric Nurse
- Nurse Practitioner
- Family therapist
- Specialists working with co-morbid conditions
- Social worker
- Occupational therapist
- Physiotherapist
- Educator
- Community support organisation
- School counsellor

Specialist interventions may also be required by some patients to prevent or treat a wide range of physical health conditions including gastrointestinal disorders, malnutrition, osteoporosis, damage to teeth, infection, cardiac complications, kidney failure, menstrual problems and treatment of comorbid conditions such as diabetes. Some patients may require referral to a Hospital Emergency Department or an Eating Disorders specialist. More information about treatment options including inpatient treatments, outpatient treatments, day programs, community based support and rural options can be found on the NEDC's treatment options page. Criteria for admitting a patient with an eating disorder to hospital can be found in the resource 'Eating Disorders: An Information Pack for General Practitioners' produced by The Eating Disorders Association Inc (Qld) at <http://eda.org.au/wp-content/uploads/Complete-GP-Information-Kit-2013.pdf>



Step 3: Ongoing treatment and management

A flowchart depicting a management plan for eating disorders can be found in the resource 'Eating Disorders: An Information Pack for General Practitioners' produced by The Eating Disorders Association Inc (Qld) at <http://eda.org.au/wp-content/uploads/Complete-GP-Information-Kit-2013.pdf>

Important points to consider in the treatment and management of an eating disorder include:

Develop and implement a treatment plan by

- Working with the patient to identify their strengths and resources for goal setting
- Remembering general medical care is critical with regular assessment of physical health risks
- Actively promoting normal physical growth in children and adolescents as a priority of care
- Applying strategies to reduce the risk of re-feeding syndrome (more information available at <http://eda.org.au/wp-content/uploads/Complete-GP-Information-Kit-2013.pdf>)
- Appointing a case coordinator to coordinate the individual care plan by acting as a principle point of contact, coordinating shared information, and facilitating collaboration to support the implementation of complex care plans (this may be the GP)
- Monitoring the patients progress and measuring treatment outcomes
- Supporting transfer between services and providing appropriate follow-up of the patient

Work collaboratively with patients and their families by

- Providing information, education and support for the patient and their family

- Including the patients family in assessment, engagement, treatment and recovery support
- Engaging the patient, and where possible their family, in collaborative decision making to enhance motivation for change
- Identifying and responding to engagement difficulties and ambivalence about treatment
- Modelling an understanding and supportive attitude
- Being aware of your personal attitudes, values and beliefs (e.g. re: body shape) so that you can manage countertransference or collusion with the patient

Support recovery by:

- Valuing the role of recovery support in reducing the risk of relapse and recurrence
- Utilising community based support services and resources

Clinical Guidelines

There are a number of established treatment guidelines, which may be helpful including: NICE, AMA and RANZCP. When determining which guidelines to utilise, the date of publication should be taken into consideration and the guidelines should be interpreted in the context of emerging evidence on effective and safe treatment approaches, the clinical environment, the individual patient and the National Standards Schema for the treatment of eating disorders.

Criteria for Recovery (Bardone-Cone, et al., 2010)

1. Diagnosis – no longer meeting diagnostic criteria
2. Behaviour – no longer engaging in eating disorder behaviours
3. Physical health – weight within healthy BMI range
4. Psychological – positive attitudes to one’s self, food, the body, expression of emotions and social interaction
5. Practical – quality of life including capacity for engagement in work or education, and leisure

Relapse prevention refers to strategies to reduce the risk of relapse after treatment and interventions, and responses to early signs of recurring illness for people who have already experienced an eating disorder. Some experience of relapse (or ‘lapse’) is common during and immediately post treatment and with timely intervention and support contributes to the learning and self-discovery process of recovery. More information about relapse and recurrence including risk factors for relapse can be found on the NEDC’s relapse and recurrence page: www.nedc.com.au/relapse-and-recurrence



Where to find more information

A more comprehensive resource is available for GPs from The Eating Disorders Association Inc (Qld) at <http://eda.org.au/wp-content/uploads/Complete-GP-Information-Kit-2013.pdf>

Clinical resources for health professionals

To access clinical resources for health professionals working with eating disorders visit <http://ceed.org.au/clinical-resources/> and <http://cedd.org.au/health-professionals/resources-clinical-guidance/>

Website Resources for GP's

The National Eating Disorders Collaboration (NEDC) has a number of resources available through their website which may meet the professional needs of GPs with eating disorders patients: www.nedc.com.au/health-professionals

Mental Health First Aid

For professionals who do not have a background in working with people with eating disorders, the Mental Health First Aid guidelines may provide a useful starting place to support recognition and safe responses to people who are developing or experiencing an eating disorder. The guidelines provide an evidence based set of general recommendations about how you can help someone who is developing or experiencing an eating disorder: www.mhfa.com.au/cms/

Latest Research and Resources

NEDC provides a single gateway through which healthcare providers can access the latest evidence-based information and resources on the prevention, identification, early intervention and management of eating disorders here: www.nedc.com.au/research-resources

Professional Development

Within Australia there are opportunities for professionals to advance their knowledge and expertise in the field of eating disorders.

Professional development: www.nedc.com.au/proffesional-develop

Upcoming events: http://member.nedc.com.au/events/event_list.asp

Eating Disorders Awareness for Professionals

Appropriate messages can be combined with effective engagement strategies to help health service providers and other professionals educate the community about eating disorders. The NEDC website provides further information on how to communicate about eating disorders, breaking down barriers, preventing eating disorders and eating disorders and obesity: www.nedc.com.au/eating-disorders-awareness

National Support Line: 1800 ED HOPE (1800 33 4673)



References

Key references

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 5th ed. American Psychiatric Association: Washington DC, USA.

Bardone-Cone, A. M., Schaefer, L. M., Maldonado, C. R., Fitzsimmons, E. E., Harney, M. B., Lawson, M. A., Robinson, D. P., Tosh, A. & Smith, R. (2010). Aspects of Self-concept and Eating Disorder Recovery: What Does the Sense of Self Look Like When an Individual Recovers From an Eating Disorder? *Journal of Social and Clinical Psychology*, 29(7), 821-846.

Cotton, M.A., Ball, C. & Robinson, P. (2003). Four Simple Questions Can Help Screen for Eating Disorders. *Journal of General Internal Medicine*, 18(1), 53-56.

Gilbert, N., Arcelus, J., Cashmore, R., Thompson, B., Langham, C. & Meyer, C. (2012). Should I Ask About Eating? Patients' Disclosure of Eating Disorder Symptoms and Help-seeking Behaviour. *European Eating Disorders Review*, 20(1), 80-85.

Luck, A. J., MorganLuck, J. F., Reid, F., O'Brien, A., Brunton, J., Price, C., Perry, L., & Lacey, J. H. (2002). The SCOFF Questionnaire and Clinical Interview for Eating Disorders in General Practice: Comparative Study. *BMJ*, 325(7367), 755-756.

Other useful references

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (DSM-4)*, 4th ed. American Psychiatric Association: Washington DC, USA.

de la Rie, S., Noordenbos, G., Donker, M. & van Furth, E. (2006). Evaluating The Treatment of Eating Disorders from the Patient's Perspective. *International Journal of Eating Disorders*, 39(8), 667–676.

Evans, E. J., Hay, P. J., Mond, J., Paxton, S. J., Quirk, F., Rodgers, B., Jhaji, A. K. & Sawoniewska, M.A. (2011). Barriers to Help Seeking in Young Women with Eating Disorders: a Qualitative Exploration in a Longitudinal Community Survey. *Eating Disorders: The Journal of Treatment & Prevention*, 19 (3), 270-285.

Fursland, A., Allen, K. L., Watson, H. & Byrne, S. M. (2010). Eating Disorders – Not Just an Adolescent Issue? Australia and New Zealand Academy of Eating Disorders (ANZAED) 8th Annual Conference, Auckland, New Zealand.

Goodwin, H., Haycraft, E., Taranis, L. & Meyer, C. (2011). Psychometric Evaluation of the Compulsive Exercise Test (CET) in an Adolescent Population: Links with Eating Psychopathology. *European Eating Disorders Review. Special Issue: Special edition on compulsive exercise*, 19(3), 269-279.

Hart, L. M., Jorm, A. F., Paxton, S. J., Kelly, C. M. & Kitchener, B. A. (2009). First Aid for Eating Disorders. *Eating Disorders: The Journal of Treatment & Prevention*, 17(5), 357-384.

Hay, P. J., Mond, J., Buttner, P. & Darby, A. (2008). Eating Disorder Behaviors Are Increasing: Findings from Two Sequential Community Surveys in South Australia. *PLoS ONE*, 3(2), e1541.

Hill, L. S., Reid, F., Morgan, J. F. & Lacey, J. (2010). SCOFF, The Development of an Eating Disorder Screening Questionnaire. *International Journal of Eating Disorders*, 43(4), 344-351.

Himelein, M. J. & Thatcher, S. (2006). Polycystic Ovary Syndrome and Mental Health: A Review. *Obstetrical and Gynecological Survey*, 61(11), 723-32.

Hudson, J. I., Hiripi, E., Pope Jr, H. G. & Kessler, R. C. (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61(3), 348-358.

Jacobi, C. & Fittig, E. (2010). Psychosocial Risk Factors for Eating Disorders. In Agras, W.S. (Ed.), *Oxford Handbook of Eating Disorders*. Oxford University Press: New York, USA.

Jacobi, C., Fittig, E., Bryson, S. W., Wilfley, D., Kraemer, H. C. & Taylor, C. B. (2011). Who is Really at Risk? Identifying Risk Factors for Subthreshold and Full Syndrome Eating Disorders in a High-risk Sample. *Psychological Medicine*, 41, 1939-1949.

Jones, W. & Morgan, J. (2010). Eating Disorders in Men: A Review of the Literature. *Journal of Public Mental Health*, 9 (2), 23 – 31.

Mangweth-Matzek, B., Rupp, Cl., Hausmann, A., Assmayr, K., Mariacher, E.,

Kemmler, G., Whitworth, A. B. & Biebl, W. (2006). Never Too Old for Eating Disorders or Body Dissatisfaction: A Community Study of Elderly Women. *International Journal of Eating Disorders*, 39(7), 583-586.

Newton, M. S. & Chizawsky, L. L. K. (2006). Treating Vulnerable Populations: The Case of Eating Disorders During Pregnancy. *Journal of Psychosomatic Obstetrics & Gynecology*, 27(1), 5-7.

Pereira, R. F. & Alvarenga, M. (2007). Disordered Eating: Identifying, Treating, Preventing, and Differentiating It From Eating Disorders. *Diabetes Spectrum*, 20(3), 141-148.

Sullivan, P. F. (1995). Mortality in Anorexia Nervosa. *The American Journal of Psychiatry*, 152(7), 1073-1073-1074.

Swanson, S. A., Crow, S. J., Le Grange, D., Swendsen, J. & Merikangas, K. R. (2011). Prevalence and Correlates of Eating Disorders in Adolescents Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 68 (7), 714-723.

Taranis, L., Touyz, S. & Meyer, C. (2011). Disordered Eating and Exercise: Development and Preliminary Validation of the Compulsive Exercise Test (CET). *European Eating Disorders Review*, 19(3), 256-68.



nedc.com.au

The National Eating Disorders Collaboration is a collaboration of people and organisations with expertise in the field of eating disorders, individuals from a range of healthcare and research sectors and people with a lived experience of an eating disorder.

Through the contribution of its members, the NEDC has the resources to lead the way in addressing eating disorders in Australia.

nedc.com.au brings research, expertise and evidence from leaders in the field together in one place.

Become a member

We welcome individuals and organisations to become members of the NEDC. As a member you can get involved in one of the working groups and contribute to project deliverables. You will also be informed on collaboration activities and receive access to the members only area of the website. Join the collaboration: www.nedc.com.au/become-a-member

Sign up for the NEDC Monthly e-Bulletin

If you would like to keep up to date with what is happening in the wider eating disorders sector including the latest evidence based research on eating disorders you can register receive our monthly e-Bulletin. Subscribe to the e-Bulletin: www.nedc.com.au/subscribe

Join our e-Network

If you are an eating disorders expert or other professional with an interest in eating disorders and would like to connect to other professionals about this issue please join our Clinician's e-Network. Find out more about the e-Network: www.nedc.com.au/e-network



The National Eating Disorders Collaboration
103 Alexander Street Crows Nest NSW 2065
Phone: +61 2 9412 4499 Fax: +61 2 8090 8196
Email: info@nedc.com.au

For a downloadable copy of this resource visit:
www.nedc.com.au/health-professionals

The National Eating Disorders Collaboration
(NEDC) is an initiative of the Australian
Government Department of Health