Title: Eating Disorders: How to recognise, respond and promote recovery

Abstract

This continuing professional development article aims to raise awareness of eating disorders, how they are experienced and some approaches to assessment and treatment that will help the practicing mental health nurse to provide evidence-based care. National guidelines and relevant research are presented to aid understanding of the phenomena of eating disorder. Eating disorders are considered across the age span, and a simple mode of assessment is offered. Case studies are used to highlight the use of therapeutic interventions and treatment plans in both in-patient and community care and provide a starting point for informed practice.

Overall aim

To raise awareness about eating disorders and consider contemporary practice guidelines for the care of a person experiencing an eating disorder.

Learning Outcomes

- Define what is meant by 'eating disorder',
- Identify a range of eating disorders and the way that they are experienced,
- Learn about the importance of establishing, a therapeutic relationship with a person with an eating disorder,
- Outline some nursing interventions and approaches recommended for those experiencing a range of eating disorders.

Introduction:

This continuing professional development article aims to raise awareness of eating disorders, how they are experienced, and how intervention can improve quality of life and lead towards recovery. We draw on national guidelines and research to help you understand the phenomena of eating disorder, and case studies highlight the application of interventions and treatment plans, how to conduct a basic assessment and establish a therapeutic relationship provide a starting point for informed practice to enable recovery and hope. The case studies focus on Anorexia Nervosa and Bulimia Nervosa illustrate the issues raised through the lens of lived experience and facilitate the application of theory and research. These are not based on any individual patient, but rather the collective experience of both authors. Table 1. includes a broader spectrum of experience is provided for ease of reference:

Table 1. : Summary of eating disorder and recommendations

<Insert table >

Background:

The NHS define an eating disorder as 'a mental health condition where you use the control of food to cope with feelings and other situations.' (NHS, 2022). Anybody who has suffered from an eating disorder or been close to them professionally, or personally, will know that it is much more than that. Ask the man on the street to name any eating disorder and the chances are that they will say

'anorexia', the disorder that '*crystalised out as a separate and distinct disorder'* in the last century (Mount Sinai, 1965). This is completely understandable; it is the most visible and the most life-threatening eating disorder of them all, and many diagnosed in childhood or adolescence will remain affected for many decades, or, sadly, will die (Royal College of Psychiatrists,2012a ; Fichter et al, 2017). Nonetheless, early intervention and informed practice can make a huge difference and offer hope to individuals and families. The National Institute for Health and Care Excellence (NICE) guidance (2017) offers recommendations for treating AN, Bulimia Nervosa (BN) and Binge Eating Disorder (BED). Avoidant Restrictive Food Intake Disorder (ARFID) , pica, Orthorexia and rumination disorder are not covered in the NICE guidance, but have been included in the table for reference.

Whilst the majority of the estimated 1.25 million people experiencing eating disorders in the UK (RCPsych 2021) are female (around 90%), (Hindley et al, 2021) many will never seek treatment due to their reluctance to change, shame and stigma. Men and boys are even less likely to seek treatment, so it's challenging to establish an accurate impression of numbers (Manzato et al 2019, NICE, 2017; RCPsych, 2019). Getting access to treatment is challenging, since low body weight and malnourishment are deciding factors for referral, due to the associated risks despite people experiencing BN and BED often being at a healthy weight (NICE, 2022).

Eating disorders are never a choice but develop due to a range of factors such as social learning, experiences of bullying or abuse as well as physical factors, such as illness in childhood (NICE, 2017). There is some uncertainty about the genetic influences in eating disorder, (Mitchison and Hay, 2014), although the risk of developing AN is eleven times higher if you have a first degree relative with AN (Trace et al, 2013).

The article will refer to the '*suffering*[1]' of people who experience eating disorders, since many feel that their suffering is not understood, nor taken seriously (Corral-Liria et al 2021). Conversely, we have to recognise that although not all who experience eating disorders will accept that they are 'ill', many will 'suffer' feelings of shame, despair and self-loathing (Musby , 2022).

Time out 1

> When conducting a study with women who were being treated for anorexia nervosa in an in-patient service, Wright, (2012) asked the women how they wished their experience to be described. For example, would they like it to be called 'eating disorder', 'eating distress', 'anorexia nervosa, ' and if they would like it to be said that they 'experienced' or they 'suffered' the disorder. The women were unanimous in their request that they be described as 'suffering' from 'anorexia nervosa', and that anything else was insufficient. How do you describe the lived experience of a person carrying a diagnosis of anorexia nervosa? How important are the words that we use? And why?

Common eating disorders and how they are explained and experienced

It is important to note that eating disorders are not merely about eating or physiology, there is always a psychological and social impact on the quality of life of the individual (Corral-Liria et al, 2021; Jenkins et al., 2011) and of their 'carer' (Coomber and King, 2012). Portela de Santana et al (2012) refer to eating disorders as biopsychosocial diseases ad call for a biopsychosocial response. Indeed, therapy that considers the whole person, within the context of their family is especially important for children and young people (Treasure and Todd, 2016) to meet their multifaceted

[1] Note to editor: please retain the word 'suffering' as we have used it deliberately. We realise that the house style would be 'experiencing' or 'people who have'.

experience which includes low self-esteem, body dysmorphia, depression, persistent thoughts and behaviours related to food and weight, and a wide range of physiological complications. More broadly, experience of an eating disorder includes educational and social impacts such as loneliness and unemployment. The educational achievements of those who experience AN are frequently lower than the individual's potential for academic success (Maxwell et al, 2011), although people diagnosed with AN are often high achievers, competitive, perfectionists with good work ethics, but absences from school or college prevent them from thriving academically and may cause avoidance of social or learning situations for fear that they will not meet the expectations of others (Masoumeh, 2019).

Eating Disorders across the lifespan

It is widely accepted that eating disorders often start in childhood or adolescence, and that factors influencing eating behaviours and body image are affected by social learning, peer support, and culture (RCPsych, 2012a). Sadly, eating disorder presentations across all ages have increased in the UK, Australia, US and Canada during the recent Covid-19 pandemic (Toulany et al, 2022). This is especially true for AN and BN, and, although an eating disorder can emerge at any age, it may be triggered by life events, trauma and BED is commonly experienced in mid-life (Brandsma, 2007; Fairburn, 2013). BED and BN can be hidden for years, as secret eating and purging are private activities not immediately obvious. The symptoms can also peak and trough, but may be 'triggered' by external influences, low mood, and anxiety (Masheb and Grilo , 2006). '*Old age anorexia'* is also gaining recognition, although it is disputable if this aligns with the criteria of AN, or if it is related to a deterioration in eating habits and loss of appetite (Lapid et al, 2010).

The experience of men and boys

It is estimated that only 10% of those diagnosed with an eating disorder are male, (RCPsych, 2019), and it has long been a concern that we need to pay better attention to the possibility of eating disorders in boys and men (Langley,2006).

A concerning issue for men is stigma, attributable to a perception that they have a typical female disease, leading to shame, isolation, and delay in help-seeking (Arnow et al, 2017; Sangha et al, 2019). However, Sangha et al (2019) describe the preoccupation of the man's body not being lean or muscular enough might align better to 'body dysmorphia' or 'muscle dysmorphia' which are not classified as eating disorders but exist in the context of eating distress and body image disturbance, which may trigger eating disorder (Arnow et al, 2017).

Assessment of eating disorder

Diagnosis can be made if a person aligns to the criteria set out in the *Diagnostic and statistical manual of mental disorders* (DSM-5) and *International classification of diseases* (ICD-11) (American Psychiatric Association 2013, World Health Organisation 2019). Not all sufferers will meet the criteria for admission to a specialist community team, hence, referrals can be aided by good assessment informed by accurate, objective observations using specific assessment tools and scales. There are several validated assessment tools, such as the Binge Eating Scale , a 16 item self-report questionnaire (Gormally et al. 1982) and the Eating Attitudes Test© (EAT-26) (Garner et al 1982) and a simple and accessible one, 'SCOFF':

SCOFF (Morgan et al, 1999) is an easy to use, 5-item questionnaire (Perry et al, 2002):

> ***S*** *– Do you make yourself* ***S****ick because you feel uncomfortably full?*

C *– Do you worry you have lost* ***C****ontrol over how much you eat?*

O *– Have you recently lost more than* ***O****ne stone (6.35 kg) in a three-month period?*

F *– Do you believe yourself to be* ***F****at when others say you are too thin?*

F *– Would you say* ***F****ood dominates your life?*

If the individual answers 'yes' to 2 or more of these questions, it is recommended that a referral is made. Additionally, if you are suspicious that the person may be experiencing BN there are 2 further questions that can be asked:

1.Are you satisfied with your eating patterns?

2. Do you ever eat in secret?

Although simple, in tests the SCOFF questionnaire has been shown to be reliable for screening for AN and BN, and '*designed to raise suspicion of a likely case rather than to diagnose'* (Morgan et al 1999 :1468).

Establishing a therapeutic relationship

The therapeutic relationship is fundamental to all nursing practice (Peplau, 1952; Wright, 2021). Research into the therapeutic relationship with women with anorexia and their workers revealed that the establishment of a good therapeutic relationship is possible, even in the absence of agreed goals and tasks (Wright & Hacking, 2012). It is important to be *with* the person, not simply to *do,* to connect, to listen and be accessible. This is not a new phenomenon, both Benner (1984) and Shipton (2004) also purported that the relationship is about **being** rather than **doing** enabling the nurse to act as a therapeutic agent.

A person's sense of value may be measured by the time that nurses spend with them, and a kind and nurturing approach can help to establish an empowering sense of security, provided that it is within the context of healthy, professional attachment and is fair and consistent (Wright and Hacking, 2012).

Therapeutic approaches to recovery

Eating Disorder care and treatment are guided by the NICE guidance (NICE, 2017) and the 'MEED' guidance which focuses on the medical emergencies related to AN and updates the 'MARSIPAN' guidance . (RCPsych, 2012b, 2014, 2022). It was published following the 'Ignoring the Alarms' report (Parliamentary and Health Service Ombudsman (2017) and the death of 3 service users with eating disorders, including a 19 year old woman, Averil Hart, who had anorexia nervosa. At age 14 she was discharged from an inpatient ED service, she later went to university where she deteriorated and was admitted to a medical ward, where she died. The Ombudsman declared that her deterioration and death was avoidable. Recommendations rested largely on the provision of education and training, and the document goes some way to providing this.

Despite this, the threshold for admission to a specialist service is such that only a small percentage of people experiencing an eating disorder will ever reach a specialist team. Hence, this article offers some therapeutic approaches that can be adopted by nurses working in generic services, community and in-patient units.

Time out 2.

Read the "MEED" guidance (RCPsych 2022) and reflect upon its utility. Is this widely used or discussed in your experience?

Two case studies are presented. Firstly, 'Fred' who is considered within the context of in-patient care and treatment, and secondly, 'Elisa', who is in the community.

In-patient: Anorexia and weight restoration care and treatment

Anorexia, and specifically, Severe and Enduring Anorexia Nervosa (SE-AN) has the highest mortality rate of any psychiatric disorder due to the significant weight loss, malnutrition, and subsequent physical complications (Roux et al, 2013). Hence in-patient care, weight restoration and the reestablishment of physical functioning are priorities (NICE, 2017). Fairburn (2008) and Waller et al (2019) propose therapeutic approaches which include diet protocols and weight monitoring, which, although successful, are often barely tolerated by the patients. Dining rooms need to be therapeutic environments which support the patient to be nourished and where they can address the challenge of tackling their refusal to eat. It is a skilful nurse who compassionately manages the resulting distress experienced and it can be tough for everybody in the room (Wright and Schroeder, 2016). Nevertheless, Waller suggests that we "Maintain a stance of "no excuses—you can do this and can rise to the challenge" (Waller et al, 2020: 1137).

Time out 3. Reflect on the challenge of providing a weight restoration programme for SE-AN i.e. working in partnership to develop trust in the nursing team, acknowledging the person's reluctance and ambivalence to treatment and communicate in a sensitive and non-confrontational way. Refer to section 4 of the MEED guidance (RCPsych 2022) where a guide to re-feeding is presented.

Please consider *Fred,* who is presented to illustrate good practice and enable you to consider the lived experience of a man suffering from anorexia, his nutritional plan and the potential for re-feeding syndrome.

> *Fred has been referred to an in-patient eating disorder unit due to a relapse of his anorexia, having lost more than 20 kg in six months ,resulting in a BMI of 13.8. He can think only of diet and is deeply ashamed that he has lost control over the anorexic voice, an intrusive and commanding internal voice that comments on his appearance and eating. He feels he that is not able to be a 'normal' husband to his wife Jenny, and daddy to their little girl, Millie. He has convinced himself that he will be fine, but is disgusted by his body, still believing that he is fat. He can't bear to see himself in the mirror, which leads him to vomit, and avoiding mirrors. He desperately wants to stay at home, and not be separated from his wife and child, but has been informed that he is at threshold of serious malnutrition. He reluctantly agrees to admission.*

A dietician will agree a safe re-feeding protocol for Fred that will gradually increase his daily calories and replenish vitamins, provide rehydration, and include a series of blood tests. Then the correction of electrolyte imbalances commences coupled with a diet of 35 cals/kg per day (e.g. 1,400 calories per day) which is increased by 5cals/kg every 2 days. This will protect against refeeding syndrome, a serious complication which can be fatal. Refeeding syndrome can occur when a diet is re-introduced after prolonged starvation and can be life threatening because electrolytes such as phosphate, potassium, and magnesium can plummet resulting in multi-organ failure (RCPsych, 2022)

Once Fred has gained sufficient weight to improve cognitive function, psychoeducation increases motivation and will aid recognition of his triggers and fear of weight-gain (Masheb and Grilo , 2006). This is the restoration phase where food and sufficient rest is still important to relieve the brain of its starvation state (Fairburn, 2008).

No matter how good in-patient care is, the 12 months following discharge is the time when relapse is most likely (Khalsa et al., 2017). Care and treatment offered in the community focusses on quality of life and things that can help Fred to keep well. For example:

1. Avoid 'healthy eating' sites and diet plans
2. Preparing meals with another person
3. Eating with trusted others
4. Going for quality over quantity, including fats, carbohydrates, protein, vegetables and fruit
5. Eating in places that feel secure and happy
6. Planning for eating snack times and mealtimes
7. Shopping with a weekly meal plan in mind
8. Choosing personal rewards and activities that boost self esteem

Time out 4.

> Think about the list above and consider this in relation to an individual that you have encountered within your work. Consider how you might discuss pragmatics of the suggestions to improve their quality of life and how you might instill hope.

Community Care: Bulimia

Bulimia Nervosa (BN), whilst not as visible as AN, is a serious condition. The cycles of bingeing and purging, often accompanied by the overuse of diuretics or laxatives, can cause complications such as electrolyte imbalances, sleeplessness, irregular menstrual periods, gastrointestinal disturbances, mood swings and tiredness (Roux et al, 2013).

The NICE guidance for treating eating disorders (2017: 17) states that we are required to *" Assess the impact of the home, education, work and wider social environment (including the internet and social media) on each person's eating disorder."*

Please consider the case study of Elisa, a young adult diagnosed with co-occurring bulimia and depression, and how you might support her to access credible self-help resources:

> *Elisa is a 19-year-old woman who is of healthy weight, who has hidden her eating disorder for many years. She tends to eat compulsively in secret, especially when under stress, which is followed by a feeling of hatred for herself and induced vomiting (purging). She feels ashamed of herself, unattractive and out of control. Her GP has prescribed her antidepressants and referred her to self-help resources.*

Self-help resources are combined with support from a community nurse or a therapist. The NHS website and the charity 'Beat' offer such support and well evidenced approaches in workbooks hat can be completed at home, for example McCabe et al (2004). Worksheets can be useful for

tracking binges and identifying how thoughts influence behaviours. The NHS guidance (NHS 2022) focuses on:

1. Self-monitoring diet and fluids
2. Making realistic meal plans
3. Identifying your triggers
4. Recognising the cause of your bulimia
5. Finding other ways to cope with distressing emotions

Time out 5:

Specialist mental health services for people experiencing BN are scarce and tend to be reserved for those who have significant, physical complications. Hence, many are sign-posted to self-help intervention such as those available on the internet. How could you best support somebody engaging in using a self-help resource ?

As soon as the person is willing to engage in talking proactively about change and recovery, Cognitive Behavioural Therapy (CBT) for eating disorders (CBT-ED) is recommended as the key evidence-based treatment for non-underweight adults (not children) (Mulkens and Waller, 2021; Waller et al, 2019, 2020). Whilst CBT-ED therapists are scarce there are many elements of such therapy that can be adopted by nurses. Here, we give some examples of CBT-ED interventions, from Waller et al's work (Waller et al 2020; Mulkens and Waller, 2021), that can be implemented by nurses:

1. An active attitude which is underpinned by the possibility of change.
2. Positive reinforcement for changes that the patient does make, to stress how well they are learning.
3. Monitoring of food intake and weekly weighing.
4. Helping the person to challenge the 'anorexic voice' by using imagery.
5. Self-monitoring of food intake and weekly open weighing.
6. A "here and now" approach to the cognitions, emotions, behaviours, and physiology present in the moment.
7. Recognising small changes and working with these.
8. Historical review, and how the past connects to current maintaining factors.

Family interventions:

Family-based methods have the strongest evidence for successful eating disorder treatment for children (NICE, 2017) of which the Maudsley method, is best known (Lock et al, 2015). It is largely focused on AN and effectiveness measured by weight restoration and the improvement of eating habits. Additionally, Eva Musby's text, written from a mother's perspective adds a valuable and accessible resource that emphasises a compassionate holistic approach and the need for family and carer education (Musby, 2022).

When a child in the family has an eating disorder, the impact on the whole family is significant (Musby, 2022). Natenshon (1999) provides a step by step workbook to assist them to recognise

signs of an eating disorder, understanding treatment options , recovery processes and dealing with setbacks. Dealing with an eating disorder at school or college can be a particular challenge.

Time out 6:

> Children who struggle with their eating at school can sometimes be teased or 'picked on'. How would you support a child who said that that they were being teased at school mealtimes?

Conclusion

Eating Disorders are complex and multifaceted. They are under recognised, and there is limited pre-qualifying education to assist the registered nurse to intervene appropriately. National guidelines, relevant research, case studies and possible therapeutic approaches are presented, as well as a summary table to help you understand the phenomena of eating disorder and interventions. This article has provided an overview to enhance understanding of the person, their experience, and what approaches and interventions might make a difference for them and their families. Whilst there are no 'quick fixes', an understanding of the person, and evidence-based approaches to ameliorate suffering can go a long way towards making a difference to their quality of life and to their families in gaining appropriate support.

Time out 7.

> Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account

Time out 8.

> Identify how recognising, responding and promoting recovery for patients with eating disorders applies to your practice and the requirements of your regulatory body

Helpful resources

National Centre for Eating Disorders (NCED) https://eating-disorders.org.uk/

Support Line (UK): 0845 838 2040

The UK's Eating Disorder Charity - Beat (beateatingdisorders.org.uk)

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Eating Disorder	**Characterised by**	**Treatment recommendations**	**Therapy recommendations**	National Institute for Health and Care Excellence G**uidelines ?**
Anorexia Nervosa (AN)	Controlled food restriction Over exercise	Weight restoration Monitoring weight, mental and physical health, risk factors. Multi-disciplinary approach Dietary advise	Psychoeducation ED focused cognitive behavioural therapy (CBT-ED) Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) Specialist supportive clinical management (SSCM). ED focused focal psychodynamic therapy (FPT). AN focused family therapy for children and young people (FT-AN),	✓
Bulimia Nervosa (BN)	Loss of control overeating habits Binging and Purging	Psychological treatment only recommended (NICE, 2017) No specific treatment for BM, but malnourishment, cardiac complications or depression treated if co-existing.	Psychoeducation BN guided self-help for adults with bulimia nervosa. CBT self-help materials for eating disorders with: 4-9 Brief supportive sessions (20 min). BN focused family therapy for children and young people (FT-BN)	✓
Binge eating disorder (BED)	Compulsive overeating	Refer to the NICE guideline on obesity identification, assessment and management: NICE (2022)	Psychoeducation BED focused guided self-help programme to adults with binge eating disorder. CBT self-help materials Focus on adherence to the self-help programme CBT-ED if required	✓
Other Specified feeding or eating disorder (OSFED)			Use treatment for the eating disorder it most closely resembles	✘
Avoidant restrictive food intake disorder (ARFID)	Avoids or limits certain foods Certain foods create negative		Psychoeducation CBT Dialectical Behavioural Therapy (DBT)	✘

	or distressing connotations		Family therapy Exposure therapy	

Table 1. : Summary of eating disorder and recommendations