BODYWHYS
The Eating Disorders Association of Ireland

Eating Disorders A Resource for Pharmacists

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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With sincere thanks to
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&
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The Pharmaceutical Society of Ireland (PSI),
The Pharmacy Regulator

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an Australian source for eating disorders
information and research.

National Eating Disorders Collaboration

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Introduction

Bodywhys - The Eating Disorders Association of Ireland - has developed this information resource to assist pharmacists to identify and support people with an eating disorder and to encourage them to seek help. Further information on Bodywhys can be found on page 21.

Pharmacists are often the first healthcare professional that a person with an eating disorder will come in contact with. The typical image that comes to mind in relation to an eating disorder may be a severely emaciated frame of a young woman. Although this is one way a person with an eating disorder may present, there may be other symptoms which are less obvious. Eating disorders are extremely complex and when a patient is entrenched in the disorder, the complexity can increase and make the diagnosis and management more difficult. Pharmacists can play a vital role in the detection of eating disorders by monitoring the use of prescription and non-prescription medications/products and complementary weight loss aids, as well as being alert to other signs and symptoms that could indicate an eating disorder. As a pharmacist, you are in a key position to detect the presence of an eating disorder, encourage the person to seek help and assist them with referrals.

NOTES

1. About Eating Disorders

An eating disorder is a serious and complex mental illness. It typically features severe disturbances in a person's thought processes and their relationship with food, their body and weight. This may lead to significant complications for a person's quality of life, and in their physical and mental health. There are a variety of eating disorders, with different causes and characteristics. A common feature of an eating disorder is low self-esteem and an attempt to deal with psychological distress through a self-destructive relationship with food.

According to the Department of Health and Children, up to 200,000 people in Ireland may be affected by eating disorders with 400 new cases emerging each year, representing 80 deaths annually.[1] In 2016, 12% of all admissions for under 18s to Irish psychiatric units and hospitals had a primary diagnosis of eating disorders.[2] For anorexia nervosa, the peak incidence of onset is 14-18 years and for bulimia nervosa it is 14-22 years.[3] Binge eating disorder most commonly presents in the late teens or early 20s.

Understanding Eating Disorders as a Coping Mechanism

An eating disorder is not a diet. It is a serious psychological illness. It develops as a coping mechanism that a person uses to manage how they are feeling. The behaviours and thought processes around food, weight and the body become a way of dealing with distress. For many complex reasons, an eating disorder provides someone with a sense of safety and feeling of control. Disordered eating behaviours can bring a sense of relief, and this may initially 'work' for a person for a period of time, because it allows them to feel okay. However, once trapped within an eating disorder, people often feel a need to maintain it in order to manage other parts of their life which may feel overwhelming. They don't know how they could cope without it. They may feel ashamed and frightened in discussing it. The longer an eating disorder continues the more entrenched it becomes and the greater the impact on a person's health and quality of life.

- Eating disorders are, in some cases, fatal.
- Denial and resistance to talking about it are common.
- Contrary to the misconception, eating disorders are not unique to young people or girls.
- No one single cause has been associated with the development of eating disorders.
- People directly affected may feel stigmatised due to negative stereotypes or misconceptions.
- Mental illnesses often require medical/physical and/or psychological intervention to promote recovery.

Presenting Signs and Symptoms [4]

Eating disorders are often accompanied by a range of warning signs, symptoms and complications. Symptoms range from cardiorespiratory, neuropsychiatric, oral and dental, to gastrointestinal, endocrinological and dermatological. Examples may include:

- Frequent changes in weight/weight loss
- Failure to gain expected weight in a child or adolescent who is still growing and developing
- Wanting to lose weight when normal or underweight
- Dry, discoloured skin or fine hair growing on their face and body
- Poor circulation, fluid retention
- Difficulty sleeping, or concentrating
- Calluses
- Enlarged salivary glands
- Digestive problems such as cramps, wind, constipation, diarrhoea, a sore throat or mouth ulcers
- Loss of, or irregular periods
- Unexplained infertility
- Feeling weak, dizzy or tired
- Erosion of tooth enamel, tooth decay
- Muscle weakness
- Cardiac arrhythmias

All of these may be signs or symptoms of disordered eating behaviours, including restrictive eating, frequent purging and nutritional deficiencies or starvation. If you observe any of these signs, initiating a discussion with the patient to determine the cause of the problems is essential.

In anorexia nervosa, the medical complications are a consequence of weight loss and malnutrition[5]. In bulimia nervosa, the medical complications are associated with the mode and frequency of purging[6].

Patients with eating disorders may also present with depression,[7,8,9] anxiety[10,11,12] and suicidal ideation.[13,14]

Common Myths

Myth No. 1 - Eating disorders are a female issue. *FALSE.* Eating disorders can occur in men and women, boys and girls. It is estimated that one in every 10 cases of an eating disorder is male, while for Binge Eating Disorder it is 1 in every 2 cases.

Myth No. 2 - Eating disorders are a teenage issue. *FALSE.* An eating disorder can occur at any age from under 10 to over 70 years. The average age of onset is commonly during the teenage years or early adulthood. When you think about the life changes a person may undergo this stage of their life, you can understand why onset may occur during this time. Some people may experience an eating disorder for over 10 years whilst for others, an eating disorder can develop later in life.

Myth No. 3 - An eating disorder is a faddy diet. *FALSE.* An eating disorder is not a type of diet that somebody uses to lose weight. An eating disorder is a **serious mental illness that has the highest mortality of all psychiatric disorders**. It is a mistake to think that eating disorders are only about food and weight. They are about the person's sense of themselves, their self-esteem and self-worth.

Myth No. 4 - An eating disorder is a lifestyle choice. *FALSE.* A person does not 'choose' to have an eating disorder, and certainly living with an eating disorder is not about adhering to a certain type of lifestyle. A person becomes trapped in an eating disorder, and in a similar way to an addiction, feels compelled to continue engaging in the disordered eating behaviour in order to feel safe and secure. This compulsion replaces the conscious choice a person has, and they need help and support to be able to choose a different way of coping and living.

Myth No. 5 - An eating disorder is a phase. *FALSE.* An eating disorder is not a phase, it is not something that a person 'will grow out of'. It is much more serious than that and should be taken as such by all medical and treatment practitioners involved.

Common Presentations and Key Characteristics*

Anorexia Nervosa (AN)

For someone with AN, first contact with a General Practitioner (GP) is often made by a concerned family member, rather than the patient. Concerns expressed may be related to weight loss, food-related behaviours such as skipping meals, hiding food or adopting a restrictive diet. There may be a change in mood, sleep patterns and increased activity such as excessive exercise.

Typical psychopathological features:

- A persistent restriction of energy intake (food) leading to a person becoming significantly underweight (for what is expected for their age, sex, developmental stage, and physical health).
- Alongside this energy intake restriction and significant low weight, there must be (for diagnosis) an intense fear of gaining weight or of becoming fat, or a persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation or persistent lack of recognition of the seriousness of the current body weight.

These features may not all be present, easy to elicit or they may be denied. Denial of the seriousness of the weight loss or consequences, both physical and psychological is not unusual.

Established anorexia nervosa with signs of emaciation is usually obvious. However, patients may present initially in primary care with non-specific physical symptoms such as abdominal pain, bloating, constipation, cold intolerance, light headedness, hair, nail or skin changes. Amenorrhoea, combined with unexplained weight loss, in the population at risk should always prompt further enquiry.

Apparent food allergy/intolerance and chronic fatigue syndrome sometimes precede the development of an eating disorder and may cause diagnostic confusion. In children and young people, growth failure may be a presenting feature.

In anorexia nervosa, although weight and body mass index (BMI) are important indicators of physical risk they should not be considered the sole indicators (as on their own they are unreliable in adults and especially in children).[15]

**For full diagnostic criteria, please see Appendix 1*

The effective management of anorexia nervosa depends on a full assessment of physical status, psychological features, risk and capacity to consent to treatment.

Other presenting features may include:

- Altered eating or dietary behaviour
- Excessive exercise
- Amenorrhoea
- Depressed mood and/or social withdrawal
- Self-harm
- Suicidal ideation

A patient may also present with physical complaints related to undernutrition including dizziness, fatigue and headache, or abdominal symptoms such as nausea or bloating, unexplained vomiting, lack of appetite and constipation. The patient may deny any problem and offer assurances for concerns.

Bulimia Nervosa (BN)

Typical psychopathological features:

- Repeated episodes of binge eating
- A sense of a lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating)
- Inappropriate compensatory behaviours aimed at preventing weight gain (self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting suppressants or excessive exercising)
- Self-evaluation is unduly influenced by body shape and weight

In contrast to someone with anorexia nervosa, the patient with bulimia nervosa is more likely to be older and to consult a GP or pharmacist without the involvement of a family member. There may be a history of previous anorexia nervosa or of unhappiness with previous weight and attempts to diet. Questioning may reveal patterns of restriction, binge eating, purging and psychopathology.

Not infrequently, physical symptoms are presented which may be related to or consequences of purging or laxative use. These are parotid enlargement, Russell's sign (callus formation on the dorsum of the hand) and dental enamel erosion.

Where the patient does not disclose bulimia nervosa, a range of symptoms may present which should raise the index of suspicion. These include requests for help

with weight loss, menstrual disturbance and the physical consequences of vomiting and laxative and diuretic use. Non-specific symptoms may include fatigue and lethargy.

Gastrointestinal disorders may be present including bloating, fullness, abdominal pain, irritable bowel syndrome type symptoms, constipation, diarrhoea and rectal prolapse as well as oesophagitis and gastrointestinal bleeding. Oropharyngeal symptoms may include a sore throat, parotid swelling and dental enamel erosion.

Binge Eating Disorder (BED)

Typical psychopathological features:

- Repeated episodes of binge eating
- A sense of a lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating)

Many people overeat from time-to-time, and many people often feel they have eaten more than they should have. Some people, however, feel distressed by their overeating They feel out of control and binge on food in order to manage their negative mood or other feelings. There is a powerful craving for food which is experienced as overwhelming. They eat what most people would think is an unusually large amount of food.

Research indicates the men and women who binge eat experience comparable levels of clinical impairment.[16] Effects of binge eating may include depression, stress, obesity and absence from work due to illness.[17]

A person with BED will most commonly present with a weight issue (overweight or obese), and associated problems that occur with being in the overweight / obese category. The person affected by BED may diet frequently, however, they will not engage in purging behaviour after a binge. Over time this can, but may not always, result in significant weight gain.

Binges almost always occur in secret, and an appearance of 'normal' eating is often maintained. The food that is eaten is usually filling and high in calories. It tends to be food that people regard as fattening, and which they are attempting to exclude from their diet. The food is usually consumed very quickly, and is seldom tasted or enjoyed. While in BED there is no purging, there may be sporadic fasts or repetitive diets, and often feelings of shame or self-hatred surface after a binge. A person affected by BED may find themselves trapped in a cycle of dieting, bingeing, self-recrimination and self-loathing. They can feel particularly isolated which can contribute to the prolonging of their experience.

Other Specified Feeding or Eating Disorder (OSFED)

Individuals who do not meet the criteria for AN, BN or BED may be diagnosed with Other Specified Feeding or Eating Disorder (OSFED), previously known as Eating Disorder Not Otherwise Specified (EDNOS).

Individuals affected by OSFED may experience clinically significant symptoms that are problematic and distressing. This may include disordered eating similar to other eating disorders or eating behaviours that are associated with distress, impairment and risk of pain, death or disability.

It is important to emphasise that OSFED is no less serious of an issue than other eating disorders. Individuals affected by OSFED may present with emotional distress and impairment compared with those who do not have an eating disorder.

Avoidant/Restrictive Food Intake Disorder (ARFID)

In ARFID, a person may experience food disturbances to the point that they do not meet their appropriate nutritional and/or energy needs. This may be underlined by factors such as avoidance due to the sensory characteristics of food, a lack of interest in eating or food, or worries about the consequences of eating.

Individuals affected by ARFID may present with:

- Clinically significant restrictive eating leading to weight loss, or a lack of weight gain
- Nutritional deficiencies
- Reliance on tube feeding or oral nutritional supplements
- Disturbances in psychosocial functioning

Research has also identified behaviours and difficulties such as: [18,19,20]

- Food avoidance
- Restrictive eating
- Selective eating since childhood
- Decreased appetite
- Abdominal pain
- A heightened fear of vomiting and/or choking
- Possible food texture issues
- Generalised anxiety
- Gastrointestinal symptoms

To learn more about the characteristics of eating disorders, visit www.bodywhys.ie

Hidden Problem

Some patients may not be open or honest about their disordered eating behaviour. A person with disordered eating issues will often go to great lengths to disguise or hide their problem. They may be afraid to ask for help, and in some cases, they may not realise they have a problem. For many people, speaking about an eating disorder may feel terrifying and shameful.

Patients may commonly present for weight loss medications or interventions. Recognising the signs and symptoms will assist you in providing appropriate advice to the patient. Encouraging the patient to disclose or discuss their problem and seek help is vital.

Risks and Risk Factors

Individuals affected by eating disorders are at risk in terms of their own safety.[21] This may include medically, psychologically, psychosocially and their capacity for insight and motivation.[22] Eating disorders can also involve risks in terms of mortality and suicide.[23]

Risk factors associated with the development of eating disorders include genetic and environmental issues. In addition, shape and weight-related concerns, dietary restraint, and a family history of an eating disturbance may contribute to the development of an eating disorder.[24,25] Dieting attempts, stressful life events, low self-esteem and perfectionism may also be factors.[26,27]

2. Medication and Eating Disorders

Key Messages

- Medication has a limited role in the treatment of eating disorders
- Pharmacists can support people using medication for co-morbid physical and mental health problems
- Some medicines can be misused by people who are experiencing eating disorders
- The physical and psychological impact of the eating disorder may have implications for the safe use of medicines

If a patient has a known diagnosis of an eating disorder, as with other health conditions, it may be appropriate to note this on their Patient Medication Record (PMR) so pharmacists can be alert to potential side effects and additional healthcare needs.

Treatment of Eating Disorders

Serotonin-augmenting antidepressants are effective in the initial treatment stage of BN, and may be effective in treating the bulimic or obsessive symptoms of BED. Antidepressants are not effective in AN until normal body weight has been restored.

Pharmacists should discuss with the patient the importance of taking prescribed medicines as directed by their doctor as well as relevant potential side effects, and address any concerns that they may have at each dispensing.

Management of Co-morbidities

Some patients with eating disorders are prescribed medications to treat psychiatric co-morbidities, such as depression or anxiety or physical co-morbidities such as osteopenia and electrolyte imbalances. Pharmacists can support adherence to these medications and ensure that potential adverse effects or interactions are taken into consideration and discussed with the patient. All antidepressant medicines carry an increased risk of suicidal thoughts and behaviours in the early stages of use for younger patients. It is also worth noting that certain psychiatric medicines, such as olanzapine, can increase weight, which may be troubling for people affected by eating disorders.

Commonly Misused Medicines

Many prescription and over-the-counter products can cause weight loss, and may be misused by a person with an eating disorder. These include laxatives, diuretics, anti-obesity medications such as orlistat and nutritional supplements.

Some individuals may misuse laxatives with little awareness of the potential health implications, and due to the misperception that such products are suitable for weight control. [28,29,30,31,32]

Misuse of laxatives may increase and prolong the severity of eating disorder presentation and psychopathology.[33,34] For people affected by BN, research indicates that stimulant laxatives may be the most commonly abused form of laxatives and they are also associated with the most medical complications.[35] Complications include effects on the gastrointestinal system, along with the systemic effects of hypovolemia and those due to electrolyte disturbances.[36]

Currently, there are no studies which indicate what quantity of stimulant laxative is dangerous or over what duration of usage.[37] It is therefore important to encourage the patient to cease their usage completely rather than adopt an approach of gradual reduction. [38] Surreptitious laxative abuse should be suspected in those patients complaining of chronic diarrhoea without an obvious source.[39]

Some patients may misuse orlistat as a purging mechanism following bingeing.[40,41] Potential side effects such as flatulence and faecal urgency may lead to the avoidance of social situations.[42]

Impact of Eating Disorders on Medication Safety

Pharmacists should be attentive to the possibility for altered pharmacokinetics in people with eating disorders. Pharmacokinetics may change as a result of nutritional deficiencies, starvation, vomiting, fluid disturbances and dehydration, and may include reduced absorption or an increased sensitivity to intended or unintended effects of medicines.

Pharmacists should be aware of the cardiac risks associated with medicines that prolong the QTc interval (e.g. antipsychotics, tricyclic antidepressants, macrolide antibiotics and some antihistamines). Patients with AN are at an increased risk of cardiac complications, and medicines that may compromise cardiac functioning should be avoided.

3. The Role of Pharmacists in Supporting Patients with Eating Disorders

Pharmacists may be amongst the first health professionals to observe the consequences of an eating disorder in a patient. Pharmacists can play a key role in the detection of eating disorders by being alert to the inappropriate use of prescription and non-prescription products and medication. This can be an important initial interaction, encouraging the patient to seek help is a vital step towards recovery. Providing a non-judgemental, comfortable environment for the patient is an essential part of discussing the issue. Use of the Pharmacy Patient Consultation Area may be important to conduct a conversation, in private.

It may be appropriate to inquire about the person's health if they are visibly unwell. It may be useful to keep some fact sheets or information packs about eating disorders on display so customers and patients can read them in their own time, raising awareness of Bodywhys as a support organisation for both the patient and their family.

Engaging and Responding to Patients

Due to the nature of eating disorders, individuals may express intense ambivalence about change, recovery and seeking help. Some patients may seem defensive. A patient's level of self-criticism, though not necessarily apparent to others, may be high. Attempting to force an action plan on them may not be effective, at the outset. You can help them to talk to you if you ask around the issue, and communicate an understanding that, letting it go, and change, is difficult. Useful ways to engage include:

- Communicate concern and empathise.
- Remain calm.
- Raise the issue in a non-judgemental and non-pressurising manner.
- Avoid letting common myths cloud your perceptions.
- Show that you understand that there may be something other than food or weight troubling the person. Understanding an eating disorder as a coping mechanism should inform your initial approach.
- If the person is willing to talk about it, ask questions about the duration and severity of the disorder such as the frequency of bingeing or purging, and any current medical treatment the patient is engaged with.

- Do not focus on specific behaviours any longer than you need – move the focus from specific behaviours to ask how the person is feeling or whether there is something going on for them they would like to talk about.
- Avoid criticism or suggesting quick fixes.
- Discuss referral to other health professionals such as a GP, dietitian, psychiatrist, psychologist or other specialist may be advisable.
- For those aged under 18, it may be advisable to raise any concerns with the patient's parents and refer to a clinician for expert opinion and support.
- Encourage the patient to consider seeking professional health care advice and treatment.
- If the patient denies they have an eating issue, accept their answer and focus on providing them with information they require to use their medication(s) as safely as possible. Encourage the patient to return if they experience adverse effects from medication.
- Train relevant staff members on how to approach these conversations with patients in a respectful and considerate manner, and refer to the pharmacist where appropriate.

Suggested phrases and questions to help you engage with patients

- *I am concerned for you and it seems that there is an issue here that needs to be addressed.*
- *Do you have help available to you at the moment?*
- *Have you spoken to your GP?*
- *Is there someone you might feel comfortable talking to?*
- *What do you feel would be helpful for you right now?*
- *I think you need some help to address this. Can we talk through the options?*
- *I hear what you're saying…*
- *What do you see the problem as?*
- *I appreciate this is difficult to talk about*
- *It is important to seek professional advice, so that your health is monitored and that you have some additional support.*

Being Alert to Inappropriate Requests for Laxatives or other Non-Prescription Medicines

Consideration should be given to the frequency, quantity and reasons for purchase[43] of over-the-counter products such as laxatives or orlistat, in addition to being vigilant for the signs and symptoms of eating disorders.[44] However, it is important to note that restricting the sales of these products may not prevent eating disorders in the long term.[45]

Inappropriate requests may be an opportunity for early intervention. Pharmacists should inform those with a suspected eating disorder about the risks associated with laxative misuse. Individuals should be encouraged to discuss these issues with a GP and signposted to local support services for further information. The GP can focus on the patient's support network and provide a clear picture of what this support network is for the patient. Support options, for example, could include family, partner or a friend. Bodywhys should be mentioned as an option for information and support.

NOTES

4. Referrals and Treatment Pathways

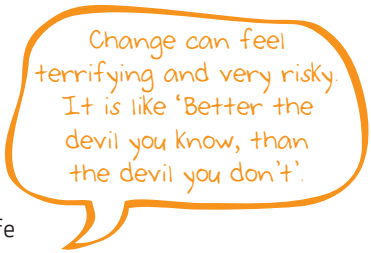
Early intervention is an important part of addressing the issue of eating disorders and in order to promote recovery. For many people, the first port of call is to attend a GP. The GP may carry out an assessment and refer to a specialist or psychiatrist for further support and treatment. Depending on a person's needs, patients may be offered psychotherapy, support from a dietitian, hospital or specialised treatment.

For an overview of treatment pathways please visit www.bodywhys.ie

What are the goals of treatment?

An eating disorder is comprised of different aspects: physical, psychological, behavioural and emotional. While treatment and recovery will address these different aspects, this does not always happen at the same rate and change is not always obvious to those supporting the person. Overall, the goals of treatment need to include:

- Stabilisation of the medical and physical consequences of the eating disorder
- A strengthening of a sense of self, due to working on increasing low self-esteem, minimising clinical perfectionism, appropriate processing and dealing with emotions, and/or dealing with underlying trauma in some cases
- Cessation of the cognitive distortions and ideation around body image and eating behaviours
- Normalisation of eating habits / behaviours and restoration of nutritional wellness
- In women and girls, the resumption of regular menses
- Normalisation of weight
- Re-engagement in a full social life including family life



It is crucial to understand that **an eating disorder is not a choice** that a person makes. As the disordered eating patterns increase, the person's sense of self outside of this diminishes, and they become imprisoned by the need to maintain the eating disorder. **The person feels compelled to continue with it due to a fear of not being able to cope without it.** This is why recovery can take a prolonged period of time and different aspects of the disorder change at different rates during the recovery process.

Remember - ***There is no 'one size fits all' when it comes to treatment. In order to engage the patient in treatment, they must feel that they have a voice in the decision making process.***

Helpful hints for friends and family

- There is no one single cause that has been identified for eating disorders. Often parents feel that the eating disorder is their fault, that they have caused it, and it is important to help them to understand that we do not know why a person develops an eating disorder, and for the most part it is due to multiple factors.
- However, parents have a responsibility to ensure that their child gets the care and treatment they need, and they can help by trying to understand what is happening to their child.

Free Information and Resources

Bodywhys offers a range of leaflets and resources including, but not limited to the following:

- Eating Disorders - A Resource for Parents
- Eating Disorders - A Resource for General Practitioners
- Eating Disorders - A Resource for Pharmacists
- Binge Eating: Breaking the Cycle. A self-help guide towards recovery

These resources can be obtained free of charge from **Bodywhys, P.O. Box 105, Blackrock, Co. Dublin** or email **info@bodywhys.ie**

5. Bodywhys Services

Bodywhys – The Eating Disorders Association of Ireland – is the national voluntary organisation supporting people affected by eating disorders.

PEOPLE CAN AND DO RECOVER

Our Services

Bodywhys provides **SUPPORT GROUPS** for those affected by eating disorders. We also run groups for friends and family members who may be in need of support. The groups are facilitated by trained volunteers and are free to attend.

The Bodywhys **LOCALL HELPLINE 1890 200 444** is a listening service operated by trained volunteers who provide support and information to people affected by eating disorders and to their friends and family members. For up-to-date times of operation, see our website **www.bodywhys.ie**.

BodywhysConnect for adults (19+), and **YouthConnect** (13-18), are online support groups, which are particularly popular with those who wish to maintain anonymity or are living in an isolated area. The online groups operate 4-5 evenings per month and are based on our website at **www.bodywhys.ie**

"Like a helpline call in an email", the Bodywhys **EMAIL SUPPORT SERVICE**, **alex@bodywhys.ie**. People email for support, a listening ear, information and signposting. This allows for increased anonymity and flexibility while providing the optimal level of support.

The Bodywhys **PiLaR PROGRAMME** is a free four week education and skills programme for family members supporting a person with an eating disorder. Bodywhys runs these programmes in different locations nationally. Please email **info@bodywhys.ie** to put your name on the waiting list, and when one is near you you will be contacted. See **www.bodywhys.ie** for upcoming programmes.

www.bodywhys.ie

The Bodywhys website provides a wide variety of information on eating disorders, treatment options and support services.

Also accessible from the site:

- Directory of service providers, searchable by location
- Links to other relevant eating disorder and mental health websites
- Reading list
- SeeMySelf, free online psychoeducation programme

Bodywhys services are available to carers as well as to those affected by eating disorders.

Mental Health First Aid Ireland

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 with an eating disorder.

Information about Mental Health First Aid Ireland is available on **www.mhfaireland.ie**

6. Appendix 1

DSM-5™ Diagnostic Criteria for Eating Disorders[46]

ANOREXIA NERVOSA

Core Features

Deliberate weight loss.

Fear of weight gain and fat.

Body image disturbance.

Diagnostic Criteria (DSM-5™)

- Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory and physical health.
- Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

SUBTYPES

Restricting - during the last 3 months the person has not engaged in recurrent episodes of binge-eating or purging behaviour (self-induced vomiting or the misuse of laxatives, diuretics or enemas).

Binge-eating / purging - during the last 3 months the person has engaged in recurrent episodes of binge-eating or purging behaviour.

Severity Scale

For adults this is based on BMI, for children and adolescents this is based on BMI percentile.

Mild	BMI > 17 kg/m^2	**Severe**	BMI 15-15.99 kg/m^2
Moderate	BMI 16-16.99 kg/m^2	**Extreme**	BMI < 15 kg/m^2

BULIMIA NERVOSA

Core Features

Pattern of dietary restriction broken by binges and then purges.

Diagnostic Criteria (DSM-5™)

- Recurrent episodes of binge-eating characterised by:
  - *Eating, 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.*
  - *A sense of lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating).*
- Recurrent inappropriate compensatory behaviours in order to prevent weight gain (self induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise).
- Binge-eating and compensatory behaviour both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Severity Scale

Mild	Average 1-3 episodes of inappropriate compensatory behaviours per week.
Moderate	Average 4-7 episodes of inappropriate compensatory behaviours per week.
Severe	Average 8-13 episodes of inappropriate compensatory behaviours per week.
Extreme	Average 14 or more episodes of inappropriate compensatory behaviours per week.

BINGE EATING DISORDER

Core Features

Recurrent episodes of binge eating which are not followed by compensatory behaviours, hence the person gains considerable amounts of weight.

Diagnostic Criteria (DSM-5™)

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both the following:
  - *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 in a similar period of time under similar circumstances.*
  - *A sense of lack of control over eating during the episode (e.g. feeling that one cannot stop eating or control what or how much one is eating).*
- The binge episodes are associated with three (or more) of the following:
  - *Eating much more rapidly than normal.*
  - *Eating until feeling uncomfortably full.*
  - *Eating large amounts of food when not feeling physically hungry.*
  - *Eating alone because of being embarrassed by how much one is eating.*
  - *Feeling disgusted with oneself, depressed, or very guilty after overeating.*
- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behaviours as in bulimia nervosa, and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

OTHER SPECIFIED EATING DISORDER (OSFED)

Core Features

This category applies to presentations in which symptoms characteristic of an eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the eating disorders diagnostic class.

Examples are:

1. **Atypical Anorexia Nervosa:** A person develops all of the criteria for anorexia, except that, despite significant weight loss, a person may be within or above the normal weight range.
2. **Bulimia Nervosa of low frequency/limited duration**: A person may meet the criteria for bulimia, though binge eating or compensatory behaviours may occur, on average, less than once a week and/or for less than 3 months.
3. **Binge Eating Disorder of low frequency/limited duration**: A person may meet the criteria for binge eating disorder, though binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging Disorder:** A person may use purging behaviours to change their weight or shape, in the absence of binge eating.
5. **Night Eating Syndrome:** A person may experience recurrent episodes of night eating. This may occur following excessive consumption of food following an evening meal. The night time eating is not explained by external factors (medication, sleep cycle, other medical disorders) in a person's life and may cause significant distress and impairment in functioning. The disordered pattern of eating is not better explained by binge eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

Core Features

An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

Diagnostic Criteria (DSM-5™)

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.

The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

NOTES

7. References

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