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The psychonutritional unit

An out-patient clinic for eating disorders – the first five years

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History and background

Before 1977 there was little work done with eating disorders in the psychiatric unit at Burnley General Hospital. The hospital dietetic department was aimed mainly at special diets for medical, surgical, and paediatric patients and services for the obese. Many patients with anorexia nervosa were treated on paediatric or medical wards, until in the early '80s, following the establishment of a clinical psychology department, a principal-grade psychologist was appointed.

The district is a mixed urban and rural area of north-east Lancashire based on what was a thriving cotton mill industry but which has now become rather run down. The catchment population is around 230,000 and stretches roughly from the Greater Manchester boundaries in the south to the Yorkshire Dales in the north and east. The nearest medical school is at Manchester University, about 30 miles away.

Early discussions between the adult psychiatrist, principal psychologist, and the district dietician, which were stimulated by the early descriptions of bulimia nervosa (Russell, 1979), identified the need for joint working to avoid duplication, and to develop new skills that would not be otherwise available.

At that time we were developing, alongside more conventional skills, a form of out-patient refeeding for anorexics using supplemental products mixed by the dieticians from Forceval protein and flavourings. These were supplied in sachets and supplied free of charge to the patients as there were few palatable preparations on the market then, and they could not be prescribed for anorexia nervosa (although they could be prescribed for metabolic and other disorders).

In July 1982 I wrote to the *British Medical Journal* about the absence of prescribable food supplements for anorexic patients (Launer, 1982), and after submitting evidence to the DHSS it was agreed that a limited number of products (about five at that time) would be identified for this purpose.

Building on this cooperation with the dietetics department and the rather small numbers of restricting anorexics, and taking into account the increasing numbers of bulimic and binge-eating overweight patients that were being referred, we made a decision in 1984 to establish the psychonutritional unit to function on an out-patient basis one session per week.

The patients

General practitioners and hospital consultants both within the district and in close extra-district proximity were invited to refer cases of primary eating disorder in adults for assessment including anorexia nervosa, bulimia nervosa, and obesity where there was thought to be a psychological element.

As a result, 84 patients in the first year were referred, of whom 60 were assessed and 18 had a body mass index (BMI) of 25 or less and were classified as normal weight or underweight, and 42 had a BMI of over 25 and were classified as overweight or obese. This works out at 30% underweight or normal weight and 70% overweight or obese.

Subsequently there was an average of 47 referrals per year, of which of the patients assessed and accepted for treatment 55% were either underweight or normal weight and 45% were overweight or obese.

The team

The team involved a consultant adult psychiatrist, a principal clinical psychologist and the district dietician. None of us had any experience of running a similar unit. Over the years, help was enrolled from occupational therapists, physiotherapists, psychiatric nurses, secretary/typists, trainees, and in particular psychology technicians. The venues of the out-patient clinic have varied from an ENT out-patient clinic to the present setting in a health centre, as we found that patients preferred not to attend the psychiatric out-patient clinic because in many cases they did not connect their problem with psychiatric illness.

The patients were seen on arrival individually by the team and assessed and weighed, as well as being asked to fill in the General Health Questionnaire and

the Eating Disorder Inventory. After the assessment there was a team meeting at which it was decided what action was to be taken and who was to be the key worker.

The therapies

A wide range of options was available, either individual or group based. Relaxation training was offered and also, where appropriate, cognitive work (Fairburn, 1981), involving the keeping of eating diaries and appropriate psychotherapeutic input.

The dietician contributed education and meal plans. The consultant provided medication like fluoxetine and also, where appropriate, prescribable food supplements, together with other therapeutic manoeuvres.

Many patients were involved either jointly or individually with one or more therapists and body image work was introduced, together with assertion therapy.

Beds were available either on an acute DGH psychiatric ward for the more disturbed patients or on a general medical ward under the nominal care of a gastroenterologist, and small numbers of patients were admitted either for nasogastric feeding or for more intensive therapy for short periods.

Outcome

The overall results of patients' progress were classified as 'poor', 'no change', 'moderate' or 'good'. Of the 72 patients treated in 1986–89, four were classified as poor, 26 were classified as no change, 28 were classified as moderate, and 14 were classified as good. Of the 14 good patients, 10 were either anorexic or bulimic, whereas of the 26 no change patients, 18 were obese. The numbers of anorexic, bulimic, or obese patients were evenly distributed among the poor and moderate categories.

Conclusions

In the early part of the 1980s there were few, if any, facilities for eating disorders in the north-west of England. As far as we could ascertain, there were no units nationally that offered treatment for the whole range of eating disorders, namely anorexia nervosa, bulimia, and overweight. From the initial referrals we identified a need to offer some help to all these cases and we organised an out-patient service based on a multidisciplinary model, using the whole range of conventional treatments and incorporating some unique adjuncts like prescribable supplements.

The psychonutritional unit is unique within the district and now offers its services to patients from 30 miles or more outside the district.

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