MRCPsych course

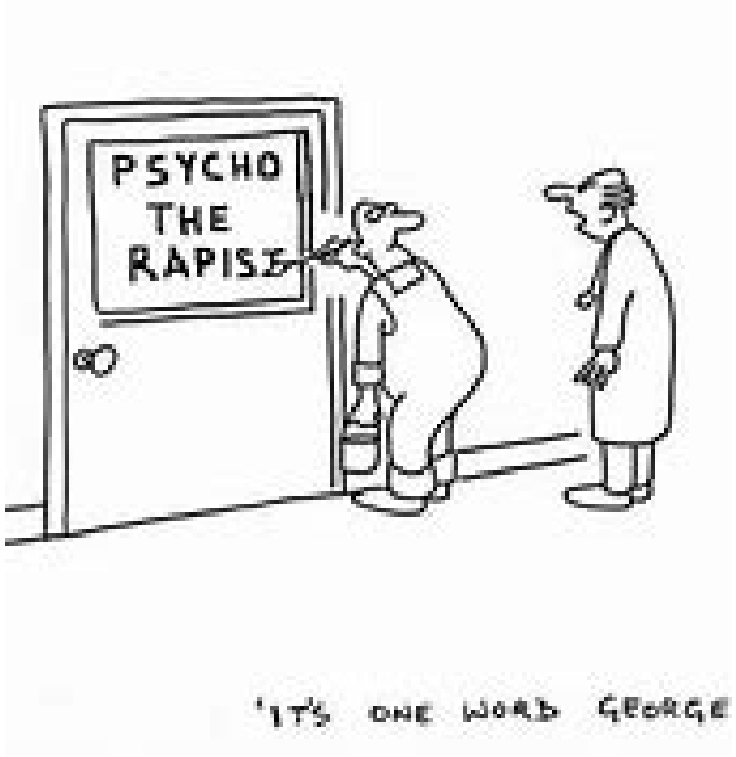
October 2020

Dr Michelle Evison

EATING DISORDERS

Introductions: Me

- Consultant medical psychotherapist 2014, Gaskell House, Manchester, required:
  - 900 hours of therapy
  - 700 dynamic, individual and group
  - 100 hours CBT (DBT)
  - 100 hours family therapy
- Consultant psychiatrist 2018



Introductions: Eating Disorder Service

CWP (Cheshire and Wirral Partnership)

- 3 consultant psychiatrists
  - Dr Jessica Morgan
  - Dr Matthew Cahill
  - Dr Michelle Evison

- Our 14 bed inpatient unit is based in Clatterbridge.
- Community clinics in
  - Macclesfield, Crewe, Chester, Birkenhead, Warrington, Trafford and Bolton.


Southport
Chorley
Rochdale
Bolton
Wigan
Warrington
Oldham
Leigh
Manchester
Ashton-under-Lyne
St Helens
Liverpool
Stockport
Birkenhead
Widnes
Runcorn
Frodsham
Northwich
Knutsford
Alderley Edge
Macclesfield
Chester
Winsford
Middlewich
Sandbach
Crewe
Nantwich
Congleton
Leek
Stoke-on-Trent
Newcastle-under-Lyme
Ellesmere Port
Mold
Buckley
Broughton
Ruthin
Wrexham

Service provision

- 18+
- GP referral (no self referral)
- Moderate to severe eating disorders
- Care pathways
  - AN / BN / EDNOS / Binge eating
- Carers workshop

Service

- Warrington / Halton

(pop 200,000 + 120,000)

- Trafford

(pop 230,000)

Service: Warrington/ Halton and Trafford

- Secretaries 2 – Wendy / jane
- Eating disorder practitioners 3 – Karen / Laura Ray (CPN, SW and OT background)
- Psychologist 3 (1 full time equivalent) – Laura / Caroline / Katy (CAT training / family work)
- Team leader 1– Paula (IPT) (CPN background)
- Dietitian 1 – Jade (part time 3/7)
- Medic 1- Michelle (part time 2.5/7)

Other ED services

- Salford (The willows)
- Stockport (Oakwood house)
- Central manchester (Gaskell house)
- Liverpool
- North wales

- NO consultant psychiatrist
- Some models of care have GP with special interest to review bloods / ecg.

Overview of Programme Today

- 1) ASSESSMENT (9.45-11)
  - ICD-10 and DSM 5 Diagnoses – AN / BN / EDNOS / binge eating
  - ED Assessment – history, Physical examination, investigations
  - Medical management

- 2) Disorder specific TREATMENTS (11.15-12.30)
  - NICE GUIDELINES – psychological therapy
  - CWP treatment pathways

- 3) Case studies: (1.15-3.00)

- 4) Complex cases (3.15-4.15)

Anorexia - ICD 10 DIAGNOSIS:

ANOREXIA - diagnosis

DSM V

- a. restriction of energy intake relative to requirements leading to significantly low body weight in the context of age / sex / development / physical health

(DSM VI removal of word refusal)

ICD 10

- a. Body weight is maintained at least 15% below that expected (body-mass index is 17.5 or less).

- .The weight loss is self-induced by avoidance of 'fattening foods'. One or more of the following may also be present:
  - self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.

Anorexia - diagnosis

DSM V

- b. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

ICD 10

- b. Intense fear of gaining weight or becoming fat, even though underweight.

- There is body-image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.

Anorexia - diagnosis

DSM V

- *(DSM VI removed:. In postmenarcheal females, amenorrhoea the absence of at least three consecutive menstrual cycles).*

ICD 10

- c. A widespread endocrine disorder involving the hypothalamic – pituitary – gonadal axis is manifest in women as amenorrhoea and in men as a loss of sexual interest and potency. There may also be elevated levels of growth hormone, raised levels of cortisol, changes in the peripheral metabolism of the thyroid hormone, and abnormalities of insulin secretion.

Anorexia - Diagnosis

DSM IV

- **Restricting type:** During current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour.

  Binge-eating/purging type: During the current episode of Anorexia Nervosa the person has regularly engaged in binge-eating or purging behaviour.

Anorexia - Diagnosis

DSM V

- ATYPICAL ANOREXIA
- Includes individuals who meet criteria who are not underweight despite significant weight loss.

BULIMIA - Diagnosis

DSM V

- Recurrent episodes of binge eating.

(1) eating, in a discrete period of time (e.g. within any 2-hour period),

(2) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances;

(3) a sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

ICD 10

- There is a persistent preoccupation with eating, and an irresistible craving for food; the patient succumbs to episodes of overeating in which large amounts of food are consumed in short periods of time.

BULIMIA - Diagnosis

DSM V

- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting or excessive exercise.

ICD 10

- The patient attempts to counteract the 'fattening' effects of food by one or more of the following:
- self-induced vomiting; purgative abuse, alternating periods of starvation; use of drugs such as appetite suppressants, thyroid preparations or diuretics. When bulimia occurs in diabetic patients they may choose to neglect their insulin treatment.

BULIMIA - Diagnosis

DSM V

- The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.

ICD 10

Bulimia - Diagnosis

DSM V

- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

ICD 10

- The psychopathology consists of a morbid dread of fatness and the patient sets herself or himself a sharply defined weight threshold, well below the premorbid weight that constitutes the optimum or healthy weight in the opinion of the physician.
- There is often, but not always, a history of an earlier episode of anorexia nervosa, the interval between the two disorders ranging from a few months to several years. This earlier episode may have been fully expressed, or may have assumed a minor cryptic form with a moderate loss of weight and/or a transient phase of amenorrhoea.

Binge eating - diagnosis

- ICD-10 – F50.9 eating disorder unspecified
- DSM5 – Binge Eating Disorder (BED)
  - Recurrent and persistent episodes of binge eating
  - Binge eating 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
  - Absence of regular compensatory behaviours (such as purging).

Other Diagnoses

- **DSM 4**

- EDNOS
  Eating disorder not otherwise specified

- **DSM-5**

- OSFED

Other Specified Feeding and Eating Disorders (who are presenting with some or most of the symptoms of anorexia nervosa, bulimia nervosa or binge-eating disorder)

Other Diagnoses

- Despite being an eating disorder service we do not see any form of disordered eating eg
- Paranoia re food being poisoned
- Loss of appetite with depression
- Food phobias

ASSESSMENT

History

- Weight:
  - Current weight / height / BMI
  - Weight history (previous highest / lowest weight), rate of weight loss.
  - Goal for weight
  - Attitude and feelings to weight / shape / size

  (Normal BMI 18.5 – 25)

History

- Eating behaviours
  - Typical day (snacks / timings / calorie limit?)
  - Range of foods
  - Banned foods? / dietary preferences (vegan), onset, religious beliefs.
  - Fluid restrictions? / drinking to fill stomach
  - Cutting up food
  - Subjective / objective binge (where, when, what, feelings)

(Normal calorie intake 2000 female 2500 male)

History

- Compensatory behaviours
  - Exercise (compulsive)
  - Non exercise activity (standing / jigging / chewing). Sit still?
  - Chew and spit
  - Purging (fluid load / rinse)
  - Medications (laxatives / diet pills / diuretics / prescribed meds / insulin)

History

- Mood
  - Concentration
  - Energy
  - Motivation
  - Anhedonia
  - Sleep

  - Self harm

History

- Social
  - impact on relationships / work
    - e.g. going out with friends, avoiding food
    - Routines with timing of meals / snacks
    - Routines with exercise
  - Eat in front of others?

History

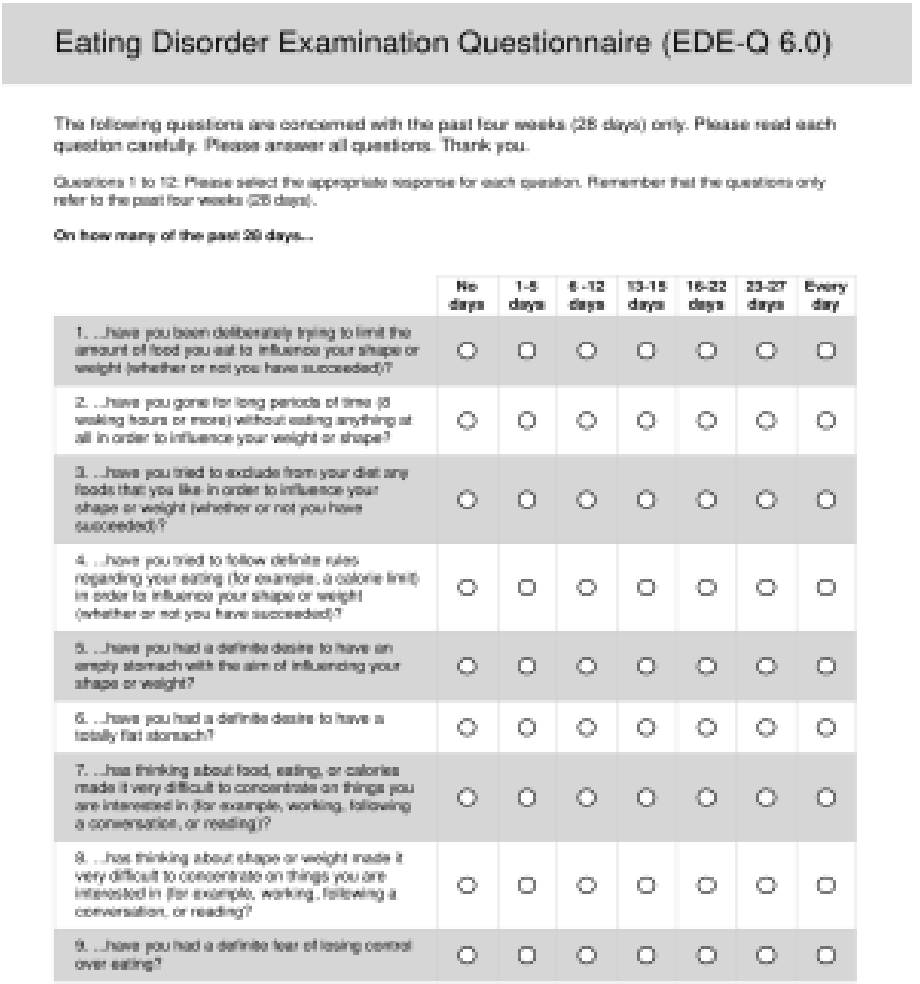
- Drugs / alcohol
- Smoking
- Past medical history
- Past psychiatric history
- Medication (OTC e.g. raspberry tea etc)
- Family history

History

- ROS
  - CVS: palpitations / chest pain / dizzy
  - RESP: SOB
  - GI: indigestion / reflux. Bloating
  - Gynae: periods
  - Urinary: incontinence / nocturia
  - Musculosk: weakness / cramps /pain
  - Neuro: pins / needles
  - Other: dry skin / hair loss
    - : cold extremities

ED ASSESSMENT

- OUTCOME MEASURES
  - Dass 21
  - Rosenberg Self esteem
  - EDEQ
  - CIA



Eating Disorder Examination Questionnaire (EDE-Q 6.0)

The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all questions. Thank you.

Questions 1 to 12: Please select the appropriate response for each question. Remember that the questions only refer to the past four weeks (28 days).

On how many of the past 28 days...

	No days	1-5 days	6 -12 days	13-15 days	16-22 days	23-27 days	Every day
1. ...have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	○	○	○	○	○	○	○
2. ...have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your weight or shape?	○	○	○	○	○	○	○
3. ...have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	○	○	○	○	○	○	○
4. ...have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	○	○	○	○	○	○	○
5. ...have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	○	○	○	○	○	○	○
6. ...have you had a definite desire to have a totally flat stomach?	○	○	○	○	○	○	○
7. ...has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	○	○	○	○	○	○	○
8. ...has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	○	○	○	○	○	○	○
9. ...have you had a definite fear of losing control over eating?	○	○	○	○	○	○	○

Physical examination

- Weight (one layer of clothing, no shoes) / height / BMI
- BP (sitting & standing) / pulse / temp
- Squat test
- Abdominal examination (?constipation)

- SIGNS
  - Parotid glands (hypertrophy)
  - Skin – dry /cold / red hands and feet
  - Skin – lanugo hair (fine hair on back / abdo and arms)
  - Skin – integrity i.e. pressure sores
  - Petechial haemorrhages
  - Russell's sign (calluses on back of hand)
  - Dependent odema

Investigations

- Bloods
  - FBC
  - U&E
  - LFT
  - Vit D
  - Bone / Phopshate / mg
  - TFT (? Sick euthyroid syndrome-low T4/ T3, TSH N)
  - Haematinics
  - CK
  - Gonadotrophins (fsh / lh)
- Bone scan
- ECG

Medical management

- Dental advice
- Abnormal U&E's: Hypokalaemia /Hyponatraemia
- Haematological complications
- Deranged lft's
- Hypoglycaemia
- Refeeding
- Refeeding syndrome
- Wernickes / Korsakoffs
- Cardiac complications
- Osteoporosis
- Decision to admit

SYSTEM	TEST* OR INVESTIGATION	CONCERN	ALERT
Nutrition	BMI	<14	<12
	Weight loss/week	>0.5kg	>1.0kg
	Skin Breakdown	<0.1cm	>0.2cm
	Purpuric rash		+
Circulation	Systolic BP	<90	<80
	Postural drop (sit-stand)	>10	>20
	Pulse rate	<50	<40
Musculo-Skeletal (Squat Test and Sit Up Test)	Unable to get up without using arms for balance (yellow)	+	
	Unable to sit up without using arms as leverage (red)		+
	Unable to sit up without using arms as leverage	+	
	Unable to sit up at all		+

Temperature		<35C <98.0F	<34.5C <97.0F
Bone Marrow	WCC	<4.0	<2.0
	Neutrophil count	<1.5	<1.0
	Hb	<11	<9.0
	Acute Hb drop (MCV and MCH raised – no acute risk)		+
	Platelets	<130	<110
Salt/Water Balance	K+	<3.5	<3.0
	2. Na+	<135	<130
	3. Mg++	0.5-0.7	<0.5
	4. PO4-	0.5-0.8	<0.5
	5. Urea	>7	>10

Liver	Bilirubin	>20	>40
	Alkpase	>110	>200
	AST	>40	>80
	ALT	>45	>90
	GGT	>45	>90
Nutrition	Albumin	<35	<32
	Creatinine Kinase	>170	>250
	Glucose	<3.5	<2.5
Differential Diagnosis	TFT, ESR		
ECG	Pulse rate	<50	<40
	Corrected QT interval (QTC)		>450msec
	Arrhythmias		+

Dental

- Erosion of enamel from acid as a consequence of self inducing vomiting
  - Dental review (little white lie if helpful – suffer from acid regurgitation if too embarrassed to disclose self induced.)
  - DO NOT BRUSH TEETH IMEDIATELY AFTER
  - Rinse with water / alkali (beware mouth washes can be acidic)
  - Fortified toothpaste

Hypokalaemia

- Most common electrolyte disturbance. From purging and / or laxative abuse

WHAT SHOULD I DO?

- Monitoring protocol (give to GP's)
  - i. Above 3.5 monitor levels monthly
    ii. Above 3.0 ensure compliance and monitor levels weekly
    iii. Between 2.5 and 2.9 need to increase supplementation and monitor weekly, and repeat ECG
    iv. Below 2.5 needs to attend A&E

Hypokalaemia

- Replace with Sando-K supplements two tablets 1-4 times daily
  - In AN compliance generally not a problem can be difficult if severe anorexia and they fluid restrict. Also due to reported / perceived fluid shifts.
  - In EUPD low potassium can generate anxiety in others and validate difficulties. Management relies on capacity to take potassium supplements. Can be accompanied by refusal to have blood tests / refusal to attend A&E.

Hypokalaemia

- Discuss and document with patients symptoms of low potassium (they will know how often they have purged / changes in laxative use etc)
  - Weakness / tiredness / numbness / tingling
  - Cramps / spasms / twitching
  - Constipation
  - Chest pain and palpitations / SOB (this can be difficult to differentaite from anxiety)

Hyponatraemia

- Normal values 135-145

- Causes
  - Low volume (**diarrohea / vomitting / diuretics / fluid restriction** / sweating)
  - Normal volume, dilute urine (hypothyroidism / **excess water**)
  - Normal volume, concentrated urine (SIADH)
  - High Volume (heart failure / liver failure / kidney failure)
  - FALSE POSITIVES (high blood sugar etc)

Hyponatraemia

- What should I do?
  - Repeat test
  - Check medication, ?stop / reduce medication (SSRI's common cause of SIADH by their action on the hypothalamus and ADH production– hyponatraemia starts within first few weeks of starting treatment and resolves within 2 weeks of discontinuing)
  - Check urine / serum osmolality
  - Fluid restriction

Haematological complications

HB

- Anaemia of deficiency of vit b12 / folate / iron. (Check MCV / MCH). Treat with supplements.
- Anaemia of chronic disease (sideroblastic anaemia)

WCC

- Low WCC (low neutrophils), evidence of malnutrition causing bone marrow failure.
- If neutropenia severe (>0.5) may need to consider prophylactic antibiotic cover (discuss with haematologist)

Creatinine

- Often mildly deranged and ‘appropriately’ low as proportional to body muscle mass

- Can be ‘normal’, but actually should be low due to low weight, reflecting effects on kidney of chronic low K / dehydration / chronic use of stimulant laxatives

Hypoglycaemia

- Common
- Normally, after eating a meal, rise in glucose, causing secretion of insulin, that moves glucose into cells. To stop glucose levels from falling too low, glucagon released from pancreas causing liver glycogen to be broken down releasing glucose into the blood.
- But in Anorexia liver glycogen stores are depleted.
- Frequently measure levels and treat with glucotabs.

Refeeding

- Almost patients with Low BMI who increase dietary intake will develop **‘refeeding signs**’ i.e.
  - Dependent odema
  - Aches / pains (especially in the legs)

- This is different from **‘refeeding syndrome’,** which is potentially fatal

Refeeding Syndrome

- First recognised after second world war prisoners were starting to eat after prolonged period of starvation – often suffered cardiac failure.
- Noticed that those given chocolate better survival….

Refeeding syndrome

- Hallmark biochemical feature is hypophosphatemia.
- Phosphorus is largely an intracellular mineral, it is essential for energy storage in the form of ATP
- When a patient is in a starvation state insulin decreased and fat / protein are catabolised to produce energy, this depletes intracellular phosphate (though serum levels can be normal). When they are given nutrition, glycaemia leads to increased insulin production which causes a greatly increased uptake and use of phosphate in the cells, which leads to a deficit of phosphorous.

Refeeding syndrome

- Potassium can be affected in a similar way, a sudden shift in metabolism from catabolism to anabolism leads to potassium being taken up into cells causes drop in serum levels, risks of arrhythmias.
- Magnesium is linked to phosphorous movement, and so can also become deficit when metabolism changes in refeeding.

Refeeding syndrome

- Who is at risk
  - Anorexia
  - Alcoholics
  - Malnourished – (intake) dysphagia / stroke
  - Malnourished – (absorption) inflammatory bowel disease
  - Increased metabolic needs – cancer / post op

  - Negligible food intake for 5 days
  - Poor physiological reserve / Low BMI

Prevention of refeeding

- Bloods – daily 10 days, most at risk time within 4 days of refeeding starting.
- Cautious increase in calorie intake, diet high in milk based products – milky drinks / yoghurt.
- Additional supplements (phosphate / potassium) as required.

Deranged lft's

- ALT – routinely raised in refeeding
    - Released from hepatocytes when damaged.
- AST – routinely raised in refeeding
    - Released from hepatocytes and muscles when damaged (can use CK to differentiae)
- ALK PHOSP
    - Elevated if obstruction to liver ducts or increased bone formation (use GGT to differentiate)

	REFEEDING PATHWAY (PATIENT AT RISK OF REFEEDING SYNDROME)	BMI <15 PATHWAY	BMI 15-17.5 PATHWAY	PURGING PATHWAY
		PATIENT NOT AT RISK OF REFEEDING SYNDROME		
INITIAL SCREEN	FBC U+E LFT TFT CK PHOSPHATE MAGNESIUM	FBC U+E LFT TFT CK	FBC U+E LFT TFT CK	U+E
ONGOING BLOODS	TWICE WEEKLY U+E LFT PHOSPHATE MAGNESIUM	3 MONTHLY FBC U+E LFT	NIL (UNLESS CLINICAL NEED)	U+E 3.0 – 3.5– REPEAT IN 1/52 2.5 - 2.9 – PRESCRIBE SUPPLEMENT, REPEAT IN 1/52 THEN USE CLINICAL JUDGEMENT
ONGOING INVESTIGATIONS	INITIAL ECG THEN CLINICAL JUDGEMENT	ECG -CLINICAL JUDGEMENT	ECG - CLINICAL JUDGEMENT	ECG - CLINICAL JUDGEMENT
		BONE SCAN EVERY TWO YEARS UNLESS NOT INDICATED		
ITAMIN / MINERAL / POTASSIUM UPPLEMENTATION	SANATOGEN A-Z ONE DAILY CALCICHEW D3 FORTE TWO DAILY THIAMINE 100MG TWICE DAILY VITAMIN B CO STRONG TWO TDS	SANATOGEN A-Z ONE DAILY CALCICHEW D3 FORTE TWO DAILY	SANATOGEN A-Z ONE DAILY CALCICHEW D3 FORTE TWO DAILY IF AMENORRHEA	POTASSIUM SUPPLEMENT ACCORDING TO HYPOKALAEMIA PROTOCOL

Wernickes encephaolpathy (acute stage)

- Ocular abnormalities
  - Nystagmus
  - opthalmoplegia
- Ataxia
- Confusion

- (impaired hearing, apathy / irritability / drowisness memory impairment)

Korsakoff's syndrome (chronic stage)

- Amnesia
- Confabulation
- Personality change

- (peripheral neuropathy)

Wernicke's / Korsakoffs

- Thiamine deficiency (B1)
- Thiamine involved in glucose metabolism and other processes.

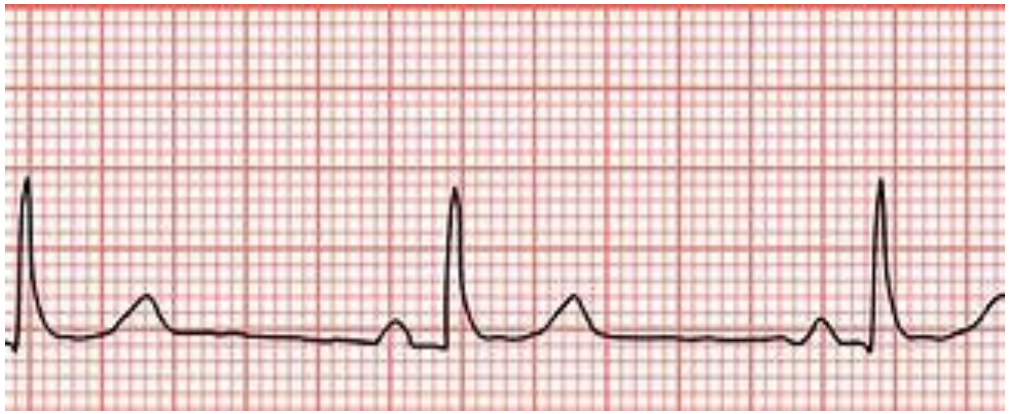
- Treatment
  - IV pabrinex (vit c / Vit b 1/2/3/6)
  - Oral Thiamine 100mg tds

Thyroid

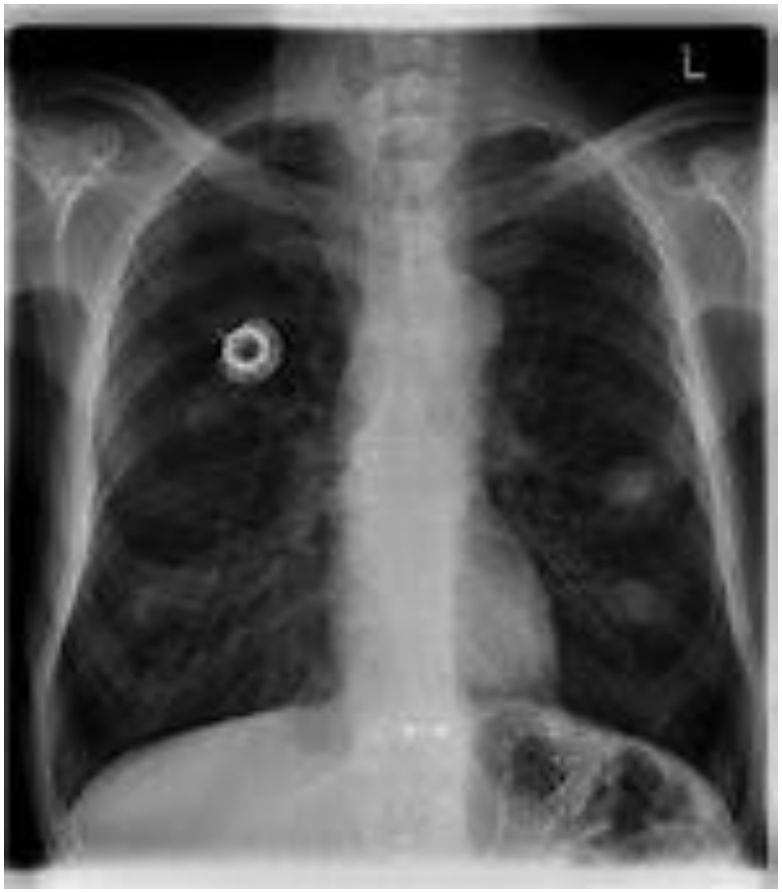
- Sick euthyroid syndrome
- Abnormal levels of T3 / T4, but no specific abnormally of thyroid gland, linked to starvation.
- Does not require thyroid treatment, will resolve with weight restoration.

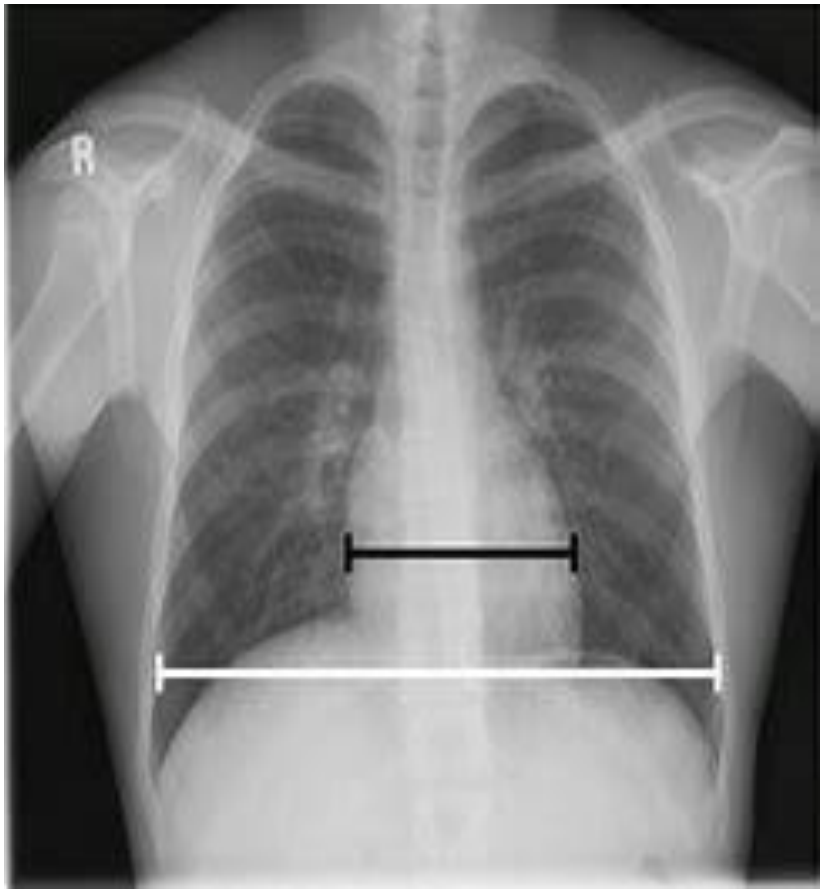
Cardiac complications
Low BMI

- Low BP, bradycardia
- Prolongation of QTC



Cardiac complications





Cardiac Complications: hypokalaemia

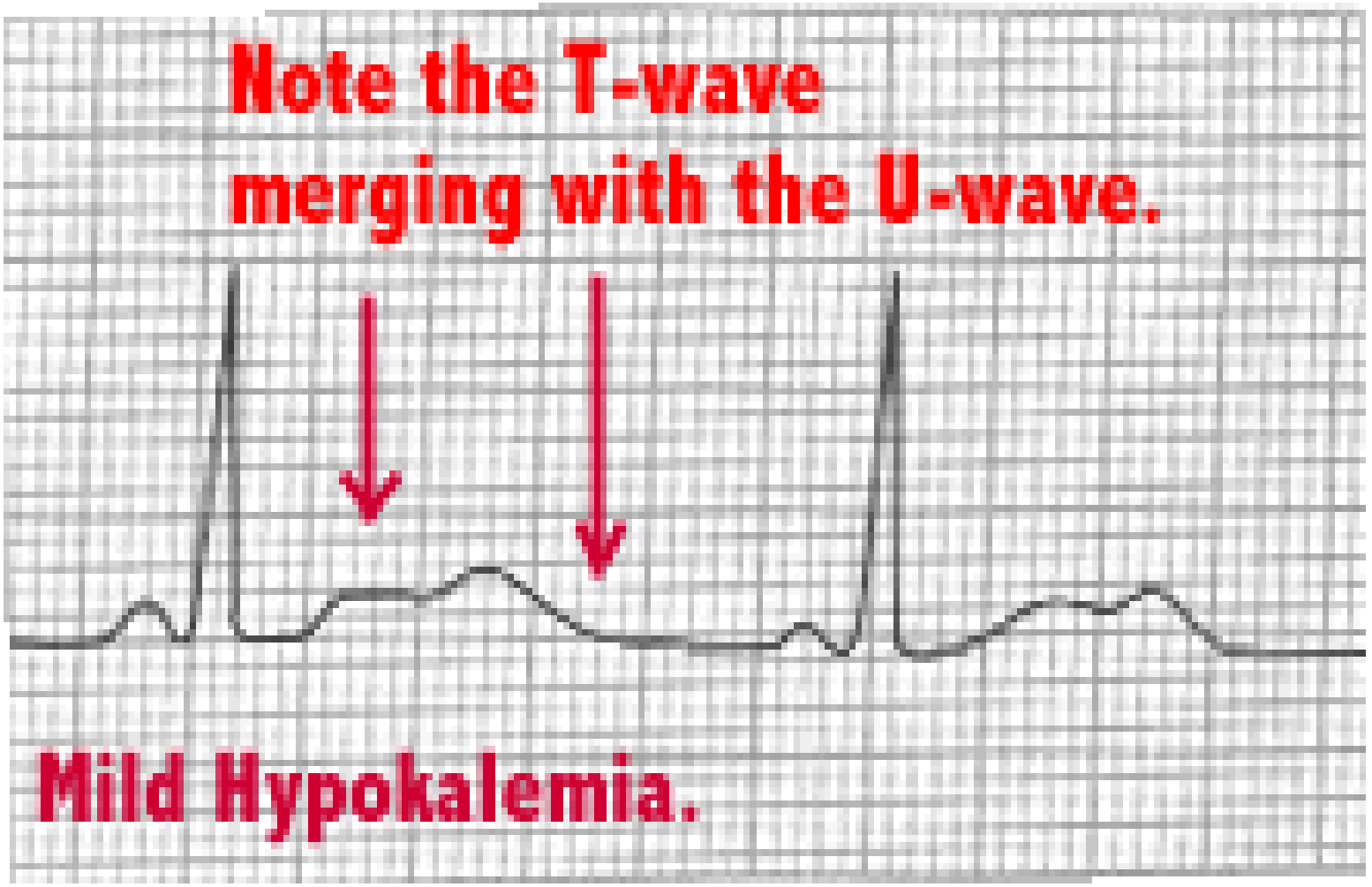
EARLY ECG CHANGES

- Increased amplitude and width of p wave
- T wave flattening and inversion
- ST Depression
- Prominent U waves / biphasic t wave. (seen in precordial leads)
- Apparent prolongation of QT actually due to t wave merging with u wave)

LATE ECG CHANGES

- Prolongation of pr interval
- Decreased voltage of QRS
- Widening of QRS
- Ventricular arrhythmias

hypokalaemia



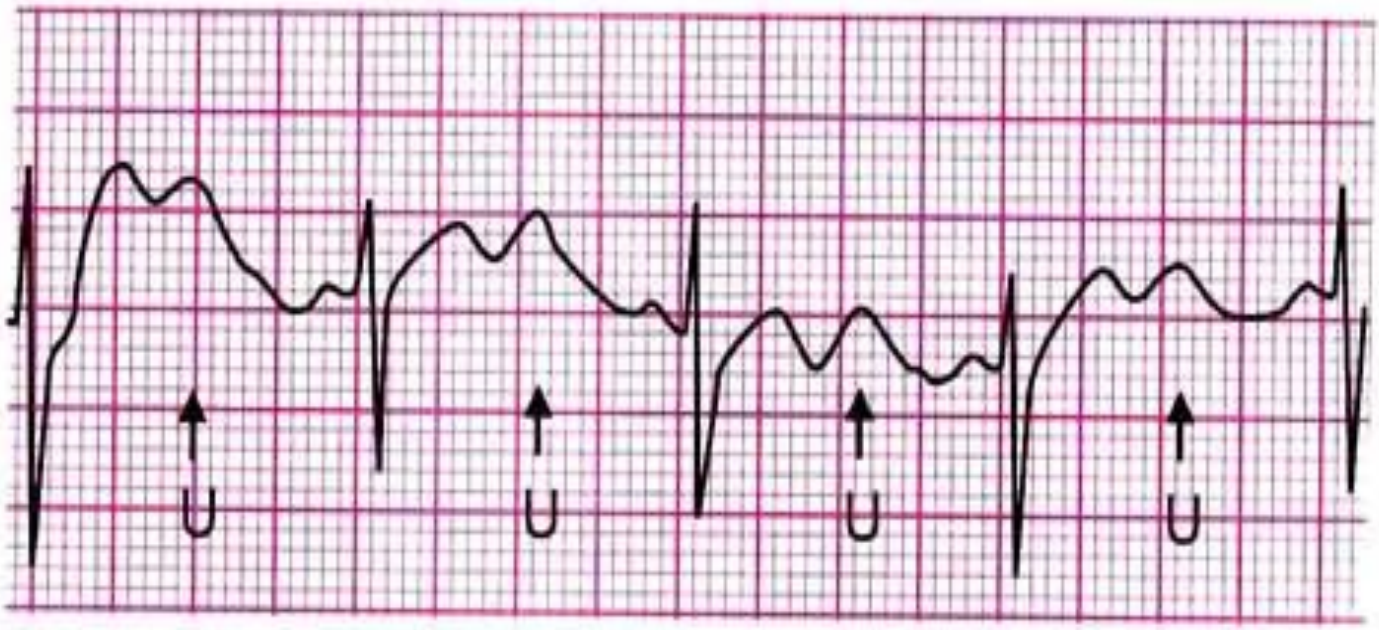
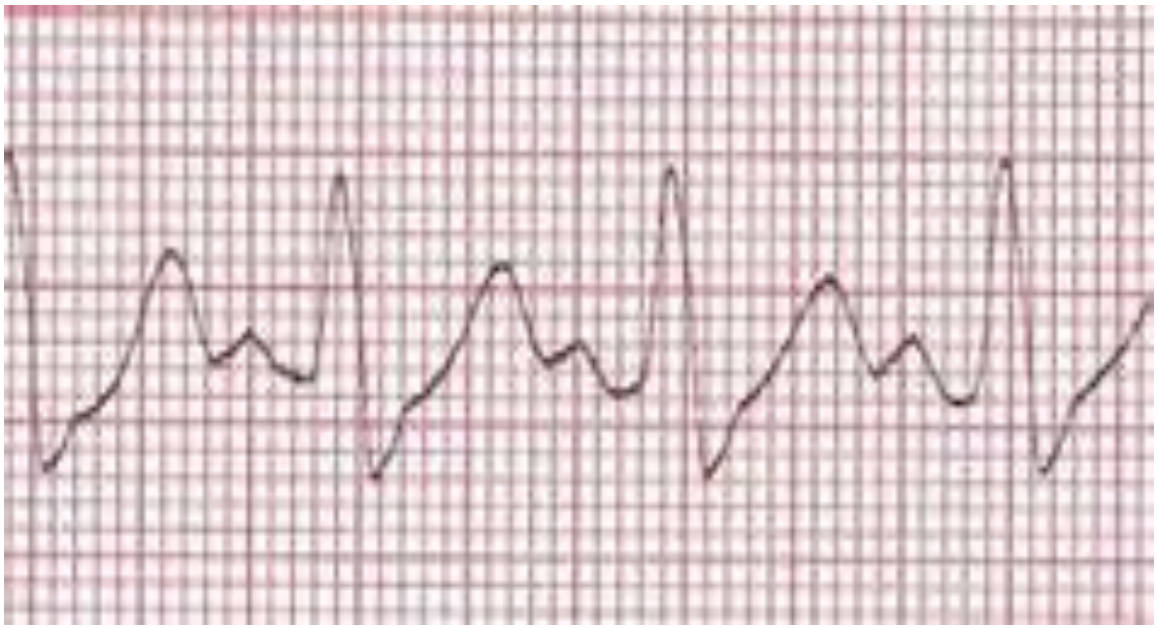


Fig. 9.5 Hypokalaemia.



Purging / laxative abuse

- Dehydration
- Stimulates renin-angiotensin-aldosterone system
- Conserves water

- REDUCTION IN purging / laxatives
- Hyperaldosteronism
- Oedema
- Anxiety, return to ED behaviours

Sodium Balance

The renin-angiotensin-aldosterone pathway

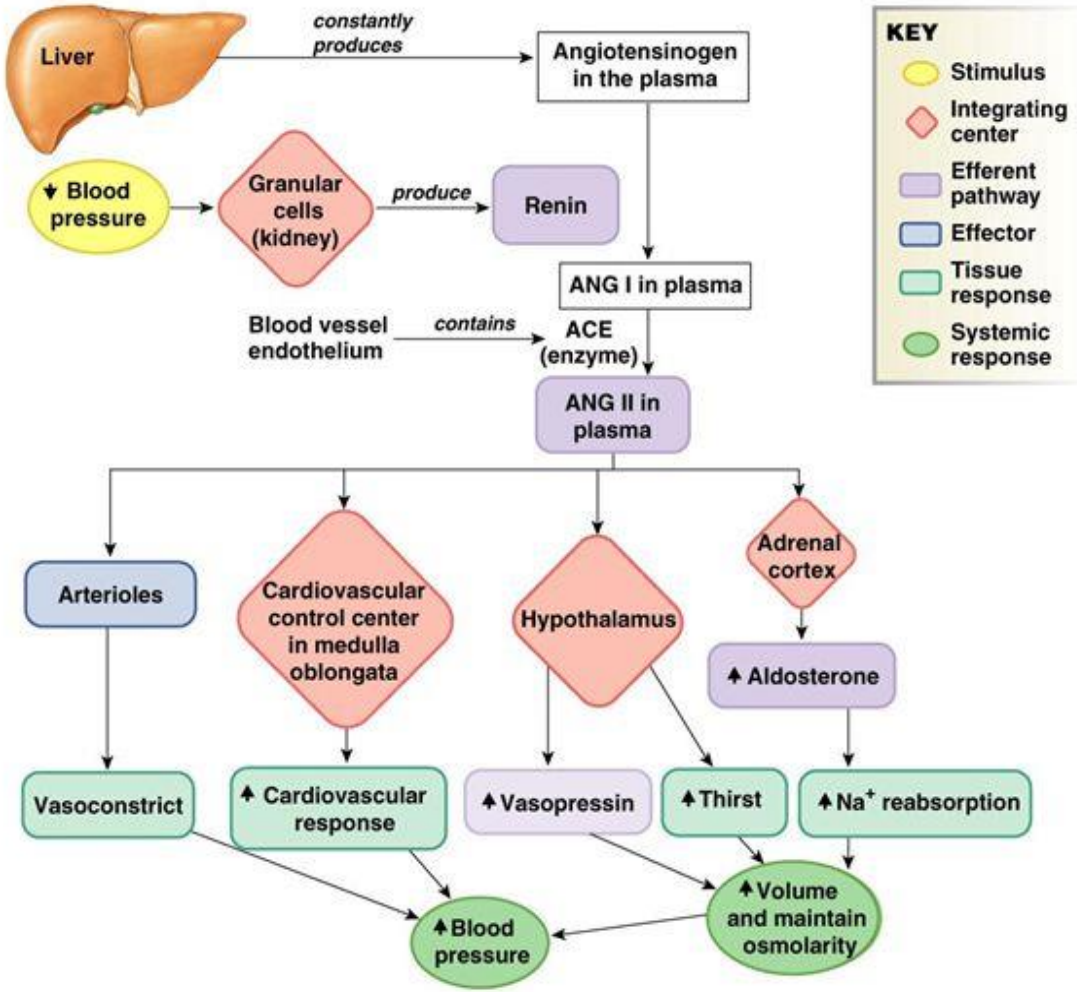
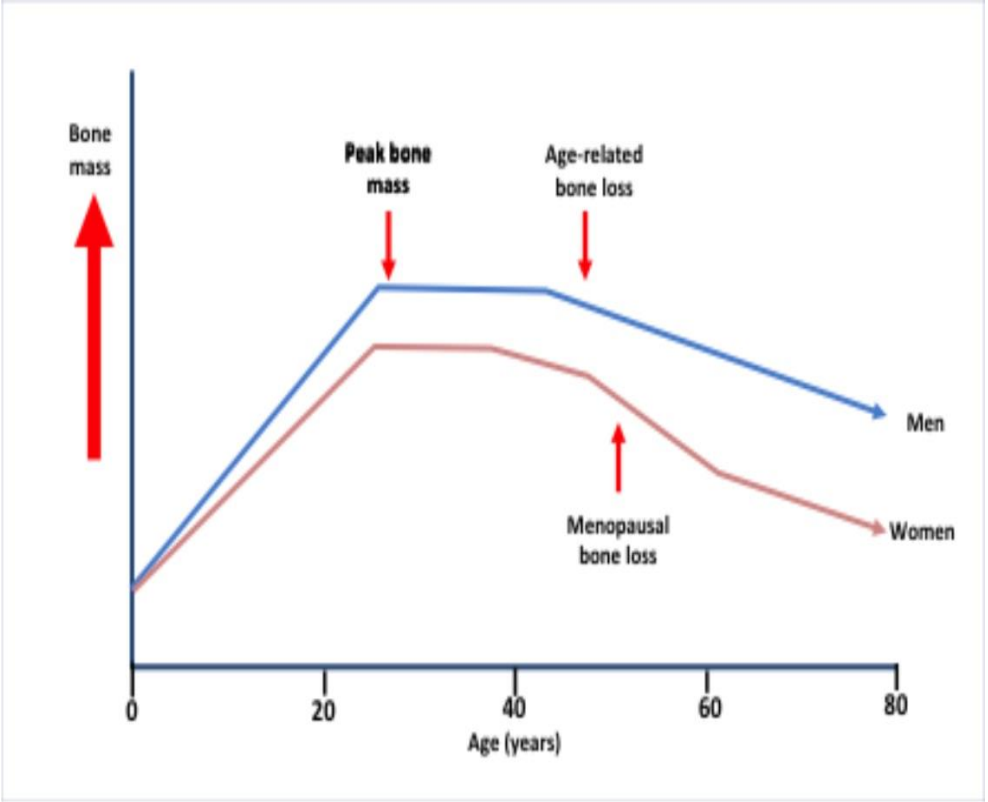
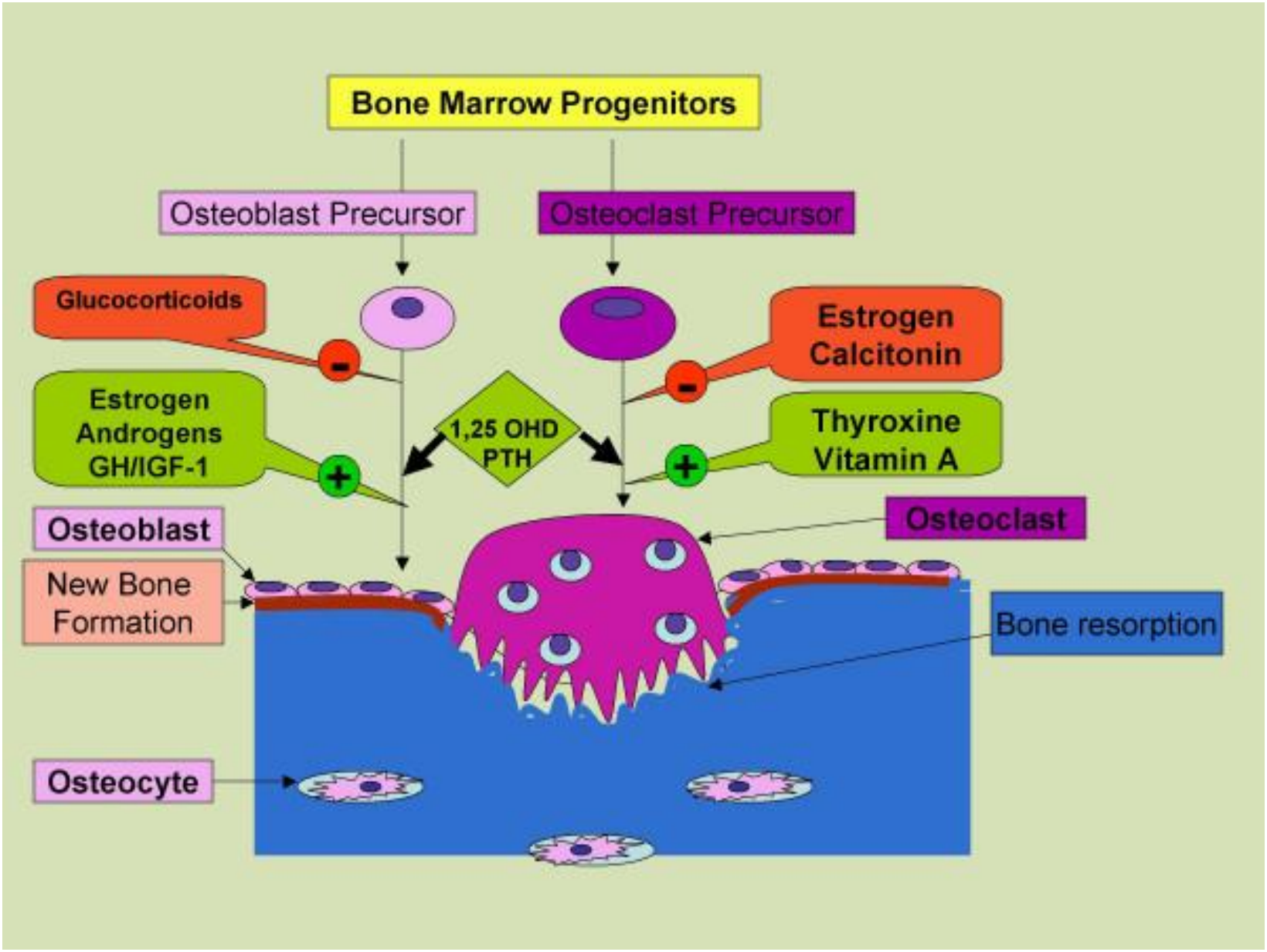


Figure 20-14

Bone health

There is a gradual increase in bone density during childhood and early adulthood, with an accelerated acquisition of bone in puberty with peak bone mass aged 18-23, window of opportunity closing by late 20's. Anorexia stops normal bone development.



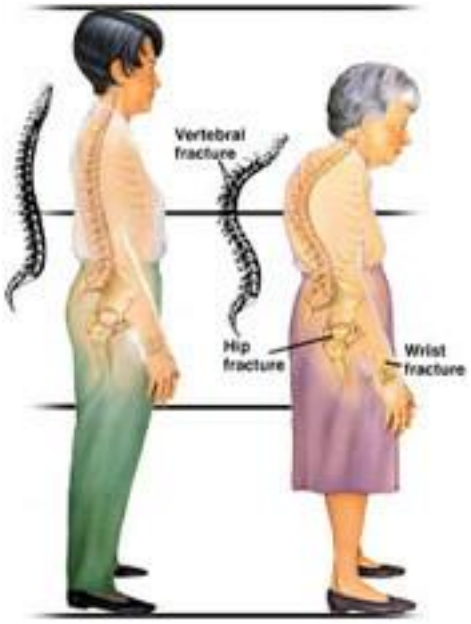

Bone Marrow Progenitors
Osteoblast Precursor
Osteoclast Precursor
Glucocorticoids
Estrogen
Calcitonin
Estrogen
Androgens
GH/IGF-1
1,25 OHD
PTH
Thyroxine
Vitamin A
Osteoblast
Osteoclast
New Bone
Formation
Bone resorption
Osteocyte

Osteoporosis

Primary type 1 (Postmenopausal)

Primary Type 2 (Senile Osteoporosis)

Secondary Osteoporosis



Primary Osteoporosis: treatment

- **Lifestyle advice (stop smoking / alcohol 2 or less units daily**
- **Adequte calcium and vit D intake**
- **Regular weight bearing exercise**

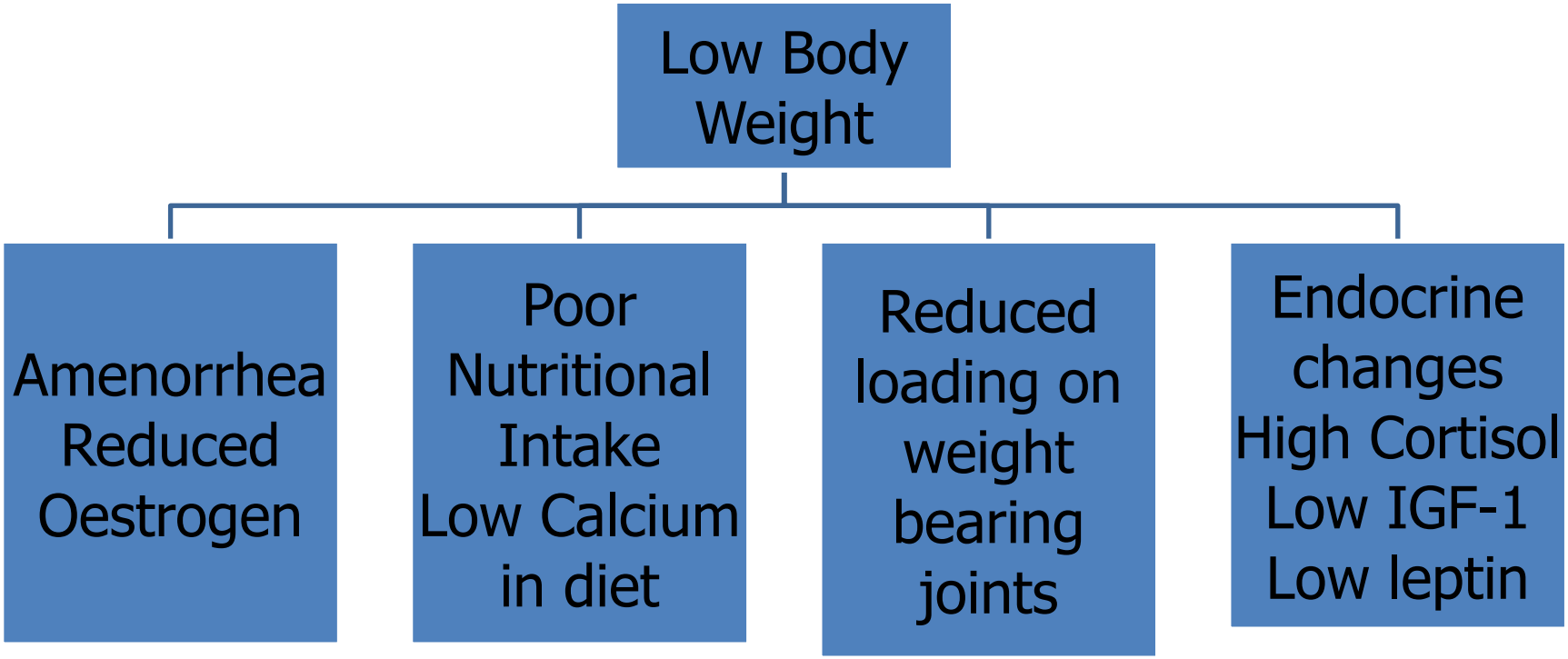
- **Biphosphonates (alendronic acid / risedronate sodium)**

Bind to the surface of bones and slow down the breakdown / resorption of bone i.e. the osteoclasts, this slows down the rate of bone loss as bone formation, the osteoblasts, can work more effectively.

This increases bone density and reduces the risk of fractures.

NICE advises stopping bisphosphonates after 3 years.

Secondary osteoporosis: Proposed Mechanisms



Secondary Osteoporosis

- What should we **not** do?
  - ? Oestrogen (as OCP can reduce IGF-1), small study re transdermal patches may be a more effective form.
  - Studies looking at bisphosphonates, (?safety in women of child bearing age) not recommended.
  - Exercise : only beneficial in context of normal BMI, restoring weight a greater priority.

- What should we do?
  - Best treatment, weight restoration including return of menstruation. The effectiveness of weight restoration diminishes after attainment of peak bone density in the mid-twenties.
  - Calcium and Vit D replacement (actually little evidence, but this is the current recommendation)
  - Ensure not smoking / excessive alcohol…(very unlikely)

Osteoporosis: Diagnosis

- DEXA Bone scan considered if low weight for significant period of time, no periods, psychologically may help shift motivation (evidence of damage can help with denial of consequences)
- Do not repeat more than every 3 years.
- Osteoporosis is defined by a T score of –2.5
- Osteopenia is defined as T score below -1.0

Decision to admit

- Not made on any one parameter (e.g. weight)
- Overview of weight in context of bloods / other physiological parameters / symptoms / viability of community treatment.
- Majority of in patients are voluntary

Treatments

BAM!!!

- PURPOSE
  - Reduce drop out rate / Protect staff time
  - Improve early engagement and build therapeutic alliance
  - Explore ambivalence
  - Develop clear goals / aims

Assessing Motivation

1.	I ***want*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I ***could*** make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	There are ***good reasons*** for me to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I ***have*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I ***intend*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I am ***trying*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I ***hope*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I ***can*** make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	It is ***important*** for me to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I ***need*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I am ***going*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely
1.	I am ***doing things*** to make this change	0 1 2 3 4 5 6 7 8 9 10 Definitely Not Probably Not Maybe Probably Definitely

Building motivation: current vs past

My happiness with:	Rate current happiness (0-10)	In the past (0-10)	Reasons for change in happiness	Importance of improvement
My physical health				
My social life				
My job				
My school and/or education				
How I manage money, finances and legal issues				
My relationship with food				
My emotional health				
How much exercise I get				
My relationship with spouse/partner				
My relationship with children				
My relationship with my parents				
My relationship with closest friends				
My relationship with the world & environment and/or with God				

	In five year's time still with the eating disorder, the following will have happened in these areas
My physical health	
My social life	
My job	
My school and or education	
How I manage my money, finances and legal issues	
My relationship with food	
My emotional health	
How much exercise I get	
My relationship with spouse/partner	
My relationship with my children	
My relationship with my parents	
My relationship with my closest friends	
My relationship with the world & environment and/or with God	
Happiness generally	

Building Motivation:

Getting to know your AN, to then make decisions to change or not

ED as Friend

- Makes me feel safe
- Numbs feelings
- Consumes thoughts, nothing else matters, narrows focus
- Makes me feel powerful
- Communicates to others, buffers demands from others
- Provides an escape

ED as Enemy

- Thinking, concentration, decision making impaired
- Hard to read own emotions
- Hard to read others emotions
- Depression / anxiety
- Impact on relationships
- Impact on health
- Impact on work / education
- finances

Dear AN,

The past years seem like a blur of tiredness and hunger and getting through each day. You have taken away my health, but also my dream to become a vet. I was smart at school, but you made my head fuzzy, my passion to go to university has gone. I have one friend left, one poor soul who visits me at home. I have osteoporosis and am told I should do the sports I used to enjoy like climbing and skiing. I sometimes feel angry towards you anorexia for all the misery you have caused, but then at the same time I cannot imagine life without you. I feel trapped and bad about myself for not seeing a way out of this. You have ruined my life and will continue to do so unless I do find a way out. You have taken away my younger years, you have made me an old and anxious man too soon…..

- *Dear AN,*
- *I am so lucky to have you as my friend, thank you for always being there and not letting me down. When I started my new school I struggled to make friends and the loneliness nearly engulfed me. The anxiety of not fitting in was too much, and having you to focus on made it all manageable. You give me something to be good at, something I can master. You enable me to stop caring if others like me or not, if I am honest you also help me show my family that not everything is so wonderful, they want me to smile and get on with it, but you make them take note and get real. Thank you for being there when I felt like I was sinking….*

Building Motivation

- Finding Support
  - **Jellyfish** (overwhelmed by own emotion, transparently emotional, unable to support)
  - **Ostrich** (ignoring problems, can support ED)
  - **Kangaroo** (overprotective, too accommodating)
  - **Rhino** (overly directive / forceful not experienced as helpful)

  - **Dolphin** – side by side, nudging in a helpful manner

Janet Treasure, Grainne Smith and Anna Crane

Skills-based Learning for Caring for a Loved One with an Eating Disorder

THE NEW MAUDSLEY METHOD

Anorexia - treatments

- NICE GUIDELINES
- individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)

  up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)

  - 20 sessions, with: weekly sessions for the first 10 weeks, and a flexible schedule after this, up to 10 extra sessions for people with complex problems
- specialist supportive clinical management (SSCM).

Anorexia –Treatments: CBT-ED

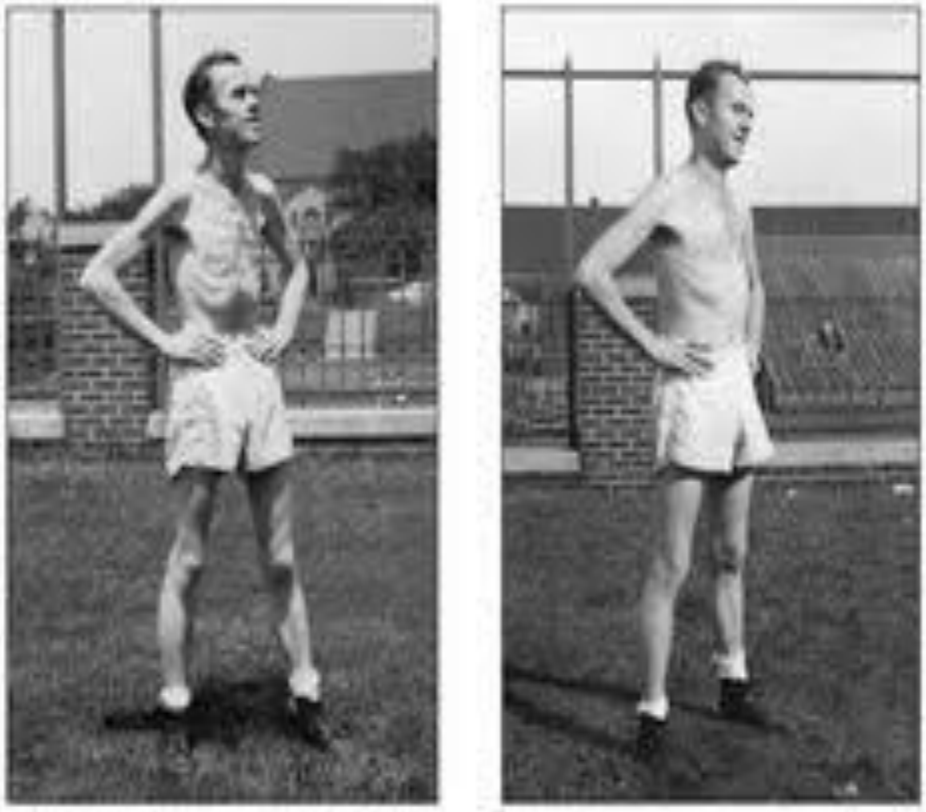
- CBT- ED (Glenn Waller)
  - Exposure therapy to eating and weight
  - Behavioural experiments to change cognitions
    - e.g. weight gain will be uncontrollable, small increase in calories will lead to disproportionate amount of eating)
  - Cognitive restructuring
    - Reduce overvaluation of one's appearance
  - Emotional eating
  - Body image treatment
  - Relapse prevention

- EARLY CHANGE GIVES BEST OUTCOMES

Anorexia – CBT-ED

- Early sessions, focus on eating (behavioural change) food diaries. Weight at each session.
  - Improves cognitive rigidity
  - Improves emotional stability (carbohydrates needed for tryptophan synthesis which is needed for serotonin production).
  - Overcome anxiety (through exposure work).
  - Improve quality of life

Anorexia – CBT-ED



Dan Miller during the twenty-fourth week of starvation, and during the recovery period. Miller's 24.5 percent weight loss was typical. *Courtesy of Henry Schollberg*

- MINNESOTA EXPERIMENT

- depression, severe emotional distress,
- preoccupation with food, both during the starvation period and the rehabilitation phase.
- social withdrawal and isolation
- decline in concentration, comprehension and judgment capabilities
- Sexual interest was drastically reduced

- Conclusion: the profound social and psychological effects result from undernutrition, and recovery depends on physical re-nourishment as well as psychological treatment. Food is medicine!
- There maybe psychological causes, but treatment is food.

Anorexia - MANTRA

Treatment is centred around patient-manual

- Work-book style

– Patient & therapist deciding collaboratively which parts might be relevant

Based on motivational interviewing

- Draw out the client's ideas

– Avoid persuasion or giving opinions without being asked. Be curious and patient

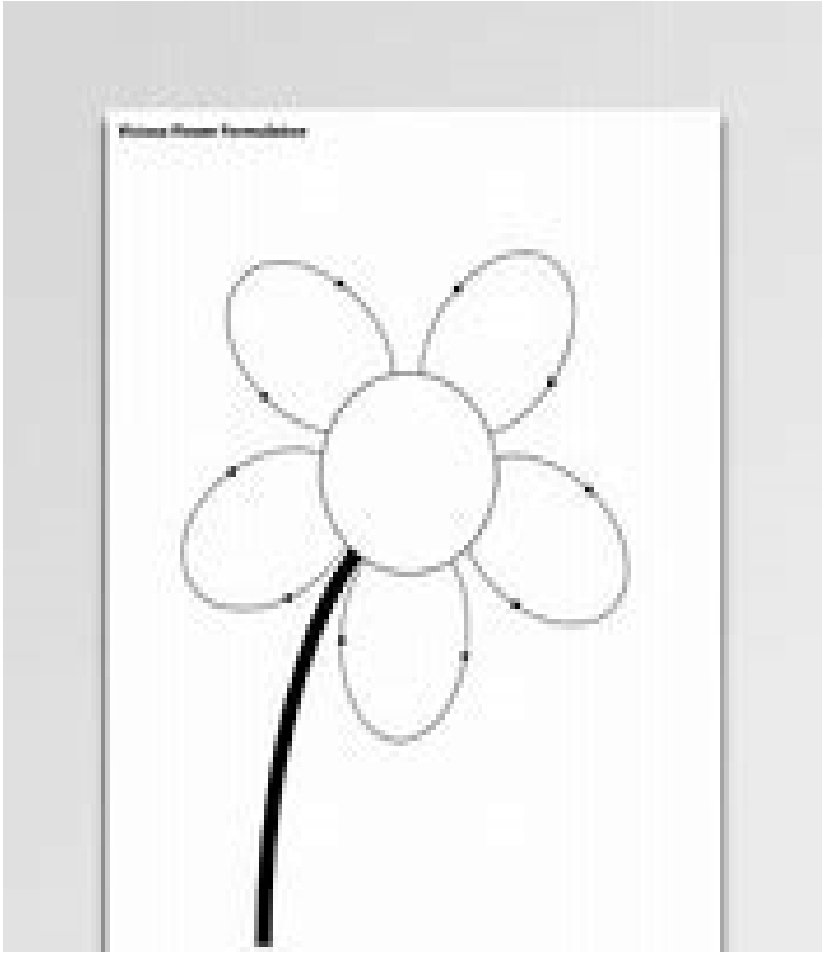
MANTRA - Modules

- Working with support
- Nutrition
- Case formulation
- Goals and experiments
- Thinking styles
- Emotional and social mind
- Identity
- Relapse prevention

Mantra Formulation

- ‘Vicious’ Flower

- Personality type -inflexible / detail focused / perfectionist
- Emotional difficulties - sensitive to rejection, hard to show emotions
- Positive beliefs about AN - keeps me safe / in control
- Enabling behaviours of others – over involved / facilitating



Anorexia - SSCM

- assess, identify, and regularly review key problems
- aim to help people recognise the link between their symptoms and their abnormal eating behaviour
- aim to restore weight
- provide psychoeducation, and nutritional education
- allow the person to decide what else should be included as part of their therapy.

Mantra	CBT - E	SSCM
To facilitate change through examination of patient's values, aspirations, goals and traits Focus on intra and inter personal maintaining factors	To address cognitive and behavioural maintaining mechanisms	To provide a supportive context in which client can make changes
Therapist style: motivational, patient centred	Therapist style : collaborative, active, challenging	Therapist style: warm, supportive, reassuring
Sessions patient directed, prescribed content with patient manual	Session set by agenda, prescribed content	*Sessions patient directed, no prescribed content.*
Self monitoring of eating / symptoms possible	*Self monitoring of eating / symptoms essential*	Self monitoring of eating / symptoms possible
Teach specific problem solving	Teach specific problem solving	Possible

Prognosis in AN

- Anorexia nervosa has the highest mortality of all psychiatric conditions. This is due to medical complications, and the increased risk of suicide.

- Approximately 50% of those with anorexia nervosa make a full recovery (although they will on average, be ill for 6-7 years), 33% improve and 20% have a chronic eating disorder. Full recovery can happen even after 20 years of severe anorexia.

- Relapse is common but estimates of relapse rates vary due to non-consistent definitions. There is said to be a more than 50% relapse rate within a year of successful inpatient treatment

- Poor prognosis is predicted by a long duration of illness prior to presentation, the need for hospitalisation and onset in adulthood

- There is a high risk of comorbid or subsequent psychiatric conditions, such as anxiety disorders, obsessive-compulsive disorder (OCD), depression, substance abuse, EUPD.

- As long as the heart and other organs have not been damaged, most of the complications of starvation seem to improve slowly once a person is eating enough. (osteoporosis can be irreversible)

Anorexia Outcomes

- Recognised that outcomes are poor in anorexia, irrespective of treatment (in comparison to other ED diagnoses).
- ? A lot of shame involved in bulimia / Binge eating (both individual and society) which motivates change, but anorexia there is a denial of consequences and a reinforcing 'buzz' of weight loss / control.
- Anyone felt good about being on diet and losing weight?? (again both individual experience and society values)
- Hard to avoid food as a coping mechanism - Can avoid alcohol / drugs etc..
- CBT techniques harness the ability to use cognitive challenges to overcome emotional problems eg phobia / anxiety / negative thoughts. However in anorexia, cognitive challenges cannot be 'harnessed' as the difficulty lies in the mind not allowing the body a voice, i.e. denying the body's need for energy / nutrition and denying the body's experience of emotions.

BULIMIA

Bulimia - Treatment

- NICE GUIDELINES

- Bulimia-nervosa-focused guided self-help programmes
- use cognitive behavioural materials

- brief supportive sessions (for example 4 to 9 sessions lasting 20 minutes each over 16 weeks,

- If unacceptable, contraindicated, or ineffective: trial

- individual eating-disorder-focused cognitive behavioural therapy (CBT-ED).
- establishing a pattern of regular eating
- Emotional eating
- Body image

- 20 sessions over 20 weeks, and consider twice-weekly sessions in the first phase

.

Bulimia - treatment

- Medication
  - Fluoxetine up to 60mg has an evidence base for reducing urges to binge,

Prognosis in BN

- About half of sufferers recover, cutting their bingeing and purging by at least half. This is not a complete cure, but will get back some control
- The outcome is worse if you also have problems with drugs, alcohol or harming yourself.
- CBT and IPT work just as effectively over a year, although CBT seems to start to work a bit sooner.
- Recovery usually takes place slowly over a few months or many years.

BINGE EATING

Binge eating – Treatment NICE

- guided self-help programme
- cognitive behavioural self-help materials

- brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks,

- group eating-disorder-focused cognitive behavioural therapy (CBT-ED).
- psychoeducation, self-monitoring of the eating behaviour , a daily food intake plan and identifying binge eating cues
- include body exposure training and helping the person to identify and change negative beliefs about their body

- 16 weekly 90-minute group sessions over 4 months

- individual CBT-ED
- develop a formulation
- eat regular meals and snacks to avoid feeling hungry
- address the emotional triggers, using cognitive restructuring, behavioural experiments and exposure
- monitoring of binge eating behaviours, dietary intake and weight
- address body-image issues if present

- typically consist of 16–20 sessions

Compassion Focused group for binge eating

- Based on Ken Goss model – CFT for overeating
- Assumptions: high shame and self criticism interfere with ability to make use of standard CBT / self help approaches
- Considering and developing compassion:
  - allows people to focus on other ways in which they can soothe themselves rather than binge

Our format

Seven sessions: each 2 hours, mix - theory /practice

1) Introduction to compassion/ 3 emotion systems
2) Compassionate formulation / letter writing
3) Dietetics session / Meal planning
4) Distress tolerance
5) Mindfulness
6) Compassion for the self exercises
7) Relapse prevention

Feedback from group

- “I’ve spent a lifetime bashing myself with criticism and it hasn’t worked. It’s time I tried some compassion instead”
- “analysing why we binge and hearing others’ experiences has helped me not feel so ashamed”
- “it gives a lot to help you work on things you want to change”
- “I find (the compassion focused exercises) soothing”

Feedback continued

- “I struggle because my mind wanders a lot”
- “I was very tired so it was very hard to focus”
- “I am finding this difficult as the focus is on me”
- “what I’m starting to appreciate is the effort needed by myself”
- “ think of more ways to support outside group session”
- “the overarching issue is the inability on my part to put theory into practice in everyday life”
- “good overall but very difficult to be compassionate to myself”
- “it has helped me feel slightly more hopeful”

Our reflections

- Very high level of self criticism and shame in group – consistent with research
- Huge block to viewing selves compassionately
- Very limited ways to self soothe identified
- Food associated with huge threat
- Much time needed considering meaning of compassion – not just “being nice” and saying “it’s fine to do what I’m doing”
- Fear of this approach – if I give up self criticism…. It will all get worse

Case Studies

Anorexia nervosa

- Case C
- 22year old female
- Assessed 2014, bmi 15.2

- PERSONAL HISTORY
- Lives with parents and sibling
- C is the youngest of 2 sisters, and she reports having had a normal upbringing and having good relationships with her close family.
- Completed university degree
- PGCE course to teach sports sciences, interrupted due to her eating disorder.

Case C

- ED HISTORY
- Always a slim child, running regularly at around the age of 11 for enjoyment rather than any concerns about weight or shape. Has competed at county level.
- University at the age of 18. After the end of her first term, at Christmas 2011, she returned home and it was noted that she had put on a little weight, BMI 20.
- Comments from her mother (meant in a flattering way), saying she had become more “shapely” or “womanly”. Upset whilst describing this, though she acknowledged that there had been no malice intended.
- C was quite disturbed by this, and she began to exercise very frequently and restrict her diet, as she had managed before going to university. Over following year, lost weight to BMI around 18.5kgs/m2, which she felt was very healthy for her .

Case C

- ED HISTORY continued…
- It seems that she gained a sense of control and satisfaction from these activities, which she found reassuring, and they seemed to be an extension of her exercise regime and eating behaviour from her adolescence.

- In her second year at university, eating behaviour subsequently deteriorated further following the breakdown of her relationship with new flatmates with whom she did not socialise or eat with to the same degree. This allowed both more time to focus on her ED, and the opportunity to feel a greater sense of satisfaction from weight control and loss.

- She noticed that her exercise and control of meals was taking up a significant amount of her time, and she began to feel a little controlled by the behaviour . At the end of 2013, further weight loss, and her exercise and eating regimes became more extreme.

Case C

- ED BEHAVIOURS at ASSESSMENT
- Exercises for around 2 hours a day (running and cycling).
- Restrictive eating
  - Breakfast: cereals with a small amount of warm milk and orange cordial, have a
  - lunch : salad with a piece or toast, white coffee with sugar
  - evening meal : pasta, vegetables quorn product.

  Additional water.

Case C

- Physical health

  menarche aged 16

  normal menstrual history.

  OCP 3½ years

- Drugs alcohol

  nil

Case C

- Mood

- more tearful of late, and there was some evidence of this in the session.
- broken sleep
- increased anxiety
- feeling ambivalent about life, but denies any suicidal thoughts or plans
- no history of self harm.
- some repetitive and obsessional behaviours, although these are currently exclusively around eating, and seem to be useful in delaying the onset of her eating and controlling her diet more generally.
- previous fear of vomiting, after having a transient illness which caused vomiting, but again she denied that this had any connection to her eating problems.

CASE C

- Treatment plan

- Seemed well motivated to not lose further weight and make modest weight increase to a healthier lifestyle.
  - Dietetic review
  - Support sessions to work with ED thoughts
  - Medical review

CASE C

- Treatment overview:

- Extensive out patient treatment but continued weight loss, informal admission, discharged self around BMI 14-15
- Subsequently lost weight gained on admission back to pre admission levels
- MHA carried out, Parents objected, decided not to displace them
- Family work was attempted; mum was keen and willing, however patient and dad were not on board.
- Entered period of medical monitoring
- Recovery triggered by series of events supporting independence (getting a job, getting a boyfriend and getting her own place)
- Mum commented ‘all she needed to do was move out’
- Discharged, BMI >17.5, periods started.

Binge eating: Case A

- A states that her eating has been problematic from approximately the age of 13. She stated that she remembers being on the bus and having binges of chocolate but she said that she was slimmer at that time because she trained in the morning and the evenings every day.

Case A: Personal History

- She stated that she became poorly, was prescribed steroids and her weight *"ballooned"* from a size 8 to a size 14 very quickly.
- She stated also that the steroids made her feel very hungry but after she finished them she managed to stabilise her weight to around a size 10/12 dress size.

Case A: Personal history

- A met her partner in 2011 and at times never ate in front of him and ate quite a restrictive diet and lost quite a considerable amount of weight down to 7 stone.
- In 2014 they moved in together and she stated that her partner started working longer hours and this gave her more of an opportunity to binge, which she did do, and has struggled from then and her weight has crept up.
-

Case A: Personal History

- However, since November 2017 bingeing episodes have increased and she feels out of control and unable to stop the bingeing. She reports a history of crash dieting and is worried about getting married in 2019 due to feeling *“fat”*.

Current Eating Pattern:

Working days

6.30am- has strawberries, Muller yoghurt

11.00am – 12noon- pasta sauce of 200 calories or a subway salad sandwich

2.30pm – 3.30pm -binge on 6 packets of crisps/chocolate bar.

7.30pm- cooked tea that's freshly made

Non working days

6.3 0am -wakes up

8.00am- plan a binge and the binge can last two hours

3.00pm - possibly have another binge

7.30pm - may have tea or sometimes she will try to avoid this by saying she is not feeling very well or full etc.

Social Situation

Supportive partner, a child that she loves, a home that she wants and a job that she enjoys doing but struggles primarily with her binge eating, which is a major part of her life and is really distressing for her.

Case A: MSE

Presented as low in mood and tearful

She rated her mood at 5 (10 = very depressed). Feels anxious, agitated, irritable and snappy. She Struggles going to sleep and has EMW

Denies suicidal ideation, self-harm. Or misuse of drugs and alcohol.

Case A: Treatment

- Discussed trialling fluoxetine (recommended with binge eating and may also improve her mood and anxiety).
- Attended CFT group

Case M: AN and co-morbidity Personal history

- Born and bred locally
- She had no physical problems as a child and described a happy early childhood.
- Her parents divorced when she was 11 and her mother re-married when she was 12
- She described that from this time onwards her childhood became unhappy. She described her step father as a bully and physically aggressive, mainly focused on her mother and herself and never focused on the other 3 children. As a result of this aggression and his possessiveness towards her mother, she felt victimised throughout the latter part of her childhood but never told anyone as her mother said that she shouldn't.
- Mother and step father subsequently separated but only when she was 18 years old.

Case M: Personal history

- She left school at the age of 18 with 3 A' Levels in B, B, & C.
- She did not want to attend university and as a result took a job in marketing which she really enjoyed but was made redundant after 2 years.
- Was able to find employment subsequently but she said that she was working below a level of her qualification.
- Was on sick leave and did not return, she had taken a grievance out against her boss due to bullying.

CASE M: ED history

- Eating difficulties which began at the age of 14 when she began dieting.

- Prior to this time she had been a gymnast and hence was heavily built and very muscular. From secondary school she was bullied at school,

- She never really felt that she part of a group of friends at school. She has no further contact with any of her school friends and, indeed maintaining friendships has clearly been a difficulty throughout her life.

CASE M : ED history

- At the age of 17 had a break up with her partner and began to diet excessively.
- She lost more than 6stone over a few months reducing from 16½ stone to 9stone and also began to take laxatives around this time.
- On this occasion her eating problems gradually normalised and she got her life back on track forming another relationship for three years

Case M: ED history

- Aged 22 her partner broke up this relationship; she described that at this point she lost everything. They had owned their own home together and many of their friends were friends of them as a couple. She subsequently lost all of her investment in the home and has no further contact with their friends.
- From this time her eating became extremely erratic and she significantly increased her laxative use (reporting occasional bites of food and up to 200 laxatives per day).

Case M: ED history

- She also started involuntary vomiting
- Over 10 months she lost approximately 4 stone.

- Was admitted medically with diarrhoea, weight loss and hypokalaemia but did not disclose her eating problems.

- Presented to ED services: aware that she is underweight and needs some help but currently places extremely high value on maintaining a low weight and hence eating, shape and weight are one of the main ways that she boosts her self esteem.

- Mood: feeling sad much of the time and that she does not want to live however does not have any active plan or intent to harm herself.

Case M: First IP ED Admission

- Admitted– BMI 14.2
- Discharged– BMI 18.3
- **Progress on ward:**

  There was a rapid degree of weight gain within 2 weeks (nearly 10kgs), due to fluid retention , likely secondary to chronic laxative abuse and dehydration.

  Required transfer to medical ward initially and renal cause for the fluid overload was excluded. Her fluid retention continued for several weeks and at its worse level her weight reached 63kgs which is likely to be due to approximately 20-25 kgs of fluid overload.

Case M: OPD treatment:

- Disengaged after 18 months (unable to sustain helpful / therapeutic relationship)
- Following discharge she began to use laxatives again and described using between 140 and 300 Ducolax tablets per day.
- With increases in weight and fluid retention, started to restrict diet
- 2 further medical admissions with dehydration

Case M: Acute Admission

- Began to experience an acute episode of hearing loss, tinnitus, dizziness, unsteadiness on her feet, poor vision, double vision, vomiting and her mother described that she could not look in one direction but kept flicking to the side (nystagmus).
- Able to walk for 5 – 10 minutes only at a time.
- admitted for investigation .

Case M: Acute Admission

- During the first 2 weeks as an inpatient she developed
  - memory loss
  - Marked weakness particularly in her lower limbs which developed over the first 7 days of admission and has led to her having to use a wheelchair.
  - Persistent unsteadiness on her feet and a tendency to fall to the right hand side.
  - Hyperesthesia (with a glove and stocking distribution) in her lower limbs up to her knees and in her hands up to her wrists such that being touched in these places can feel like “electric shocks” and very unpleasant.
  - Impaired sensations to touch in a number of areas of her body.
  - Tremulousness of her voice and a feeling that her whole body is shaking.
  - Two episodes of urinary retention such that she has required catheterisation for 1½ weeks -2 weeks on 2 separate occasions
  - Feelings of paranoia which were worst in the early stages of her admission

Case M: Second ED admission

- Admission – BMI 14.9
- Discharge – BMI 16.5

- Transferred from medical ward when medically fit
- Engaged with dietician / OT, engaged less with psychologist; managed to explore the function of the eating disorder as a way she regulates her emotions/copes with her feelings, gives her a sense of achievement as she is so good at controlling her food and is a way of her expressing her distress non-verbally and receiving care she doesn't feel able to ask for.
- She described a tendency to feel overlooked and never good enough – in every way, appearance, personality, achievements (despite evidence to the contrary).

Case M: Transfer to Neuro Rehab

- Rehab halted due to need for surgery to shortened achilles
- Following surgery, readmitted for rehab
- Discharged to parents address. Wheelchair bound.
- Outpatient physiotherapy at the musculoskeletal service
- Occupational therapy
- Review by neuro rehab consultant every 3 months, no further benefit until weight restored to support physio etc.

Case M: Third IP ED admission

- Oct 2016 – BMI 11.8
- Jan 2017 – BMI 14.6

- Admitted following slow decline in weight in OPD.
- During re-feeding, gained a significant amount of fluid in total approximately 5kgs during the first few weeks of her admission.
- She had smuggled laxatives into the ward

- Had been in hospital for the majority of the previous two years; very mindful of her likely institutionalisation and as a result at the onset of her 3rd ED admission we discussed an early date of discharge
- Despite preparations / discussions she admitted that she was concerned and fearful of discharge.
- On occasions she bought benzodiazapines back from home and took these secretly whilst on Oaktrees ward, causing a reduction in her respiratory rate. Reported she took this medication in order to feel less anxious, more happy and relaxed and not as a suicide attempt.

Case M: Acute admission

- Admitted to medical ward Jan 2019
- GP referral for swollen legs
- HPC:
  - c/o fatigue, SOBOE (not when lying flat), tingling in both hands, passing small amounts urine
  - No productive cough, or change in bowel habit
- Dietary intake – 1 tin of weightwatchers soup and approx 1.5L of fluids
- Seen by liaison psychiatry, deemed to have capacity
- Medics discussed Ng feeding, which was refused.

Case M : acute admission -Progress

- Developed UTI and then HAP. Also treated for Staph aureus bacteraemia
- Transferred to ICU for vasopressor support and haemofiltration
- Parenteral nutrition (PN) commenced in ICU (felt able to cope with this better that NG as ‘out of sight’).
- Gradual wean off PN; oral intake encouraged

Case M: Acute admission - progress

- C/o blurred vision with floaters in left eye
- Diagnosed bilateral fungal endopthalmitis
- Unclear source, but likely related to PICC (culture of tip negative). Blood cultures negative
- Referral to Ophthalmology, required repeated surgical intervention (under local).

- Offered ED admission, BMI 13, declined.
- Currently managed in OPD, struggling with fluid retention BMI 14+

Court of protection

W – 2016
Overview:

- W is aged 28 having suffered from an eating disorder for the last 20 years and having been an inpatient for varying lengths of time from the age of 11 to the current period (now some 2 ½ years), mostly in specialist eating disorder units.
- Currently W is detained under section 3 of the Mental Health Act. W had the support of her parents and had a tenancy of her own flat not far from where they lived. The court accepted that none of the periods of inpatient treatment had led to enduring progress. She has had periods when she was detained under the Mental Health Act but again no long standing progress was made in respect of weight.

W-2016
Background

- At the age of seven, she was diagnosed to have obsessive-compulsive disorder and by the age of 10, anorexia nervosa.

- Since the age of 11, she has had six admissions for inpatient treatment, spread between five units around the country and amounting to about 10 years in total.

- In 2006, when (aged 19) she was discharged weighing a relatively healthy 43 kg, but three months later she was detained under the Mental Health Act with a weight of 31 kg. Following this episode, a period of some stability was achieved, during which W was able to spend over a year at university.

- However at the age of 22, she was admitted in an emergency weighing 25 kg, with a BMI of 10.8. After this substantial admission, she was discharged weighing 32 kg.

W – 2016
Background

- The current admission began when W was 25. She was again admitted in an emergency and placed under section. Attempts to build up her strength and return her to the community were unsuccessful. On one occasion of leave, W lost 3 kg in three days. Subsequently she achieved a BMI of 16, her highest in 10 years, but during another period of community leave she had to be readmitted in an emergency after losing 9 kg.

- Her current admission has lasted for 2½ years and yet, despite the most intensive support, she is barely eating and is losing weight at the rate of 500 g – 1 kg per week. She now weighs less than 30 kg and her BMI is 12.6. If she continues to lose weight at this rate, she will die.

W -2016
Case to be decided

Where the person lacks capacity: best interests v preservation of life.

- The application by the Health Board was firstly for W to be re-fed under sedation - this would involve W being rendered unconscious for up to 6 months and fed by tube until she gained a BMI of 17.5. This application was not pursued before the court.
- The second application was that of an immediate discharge to W's parents' home and her flat with a full community support programme.

W-2016
The Law

- There is a strong but not absolute presumption that it is in a person's best interests to receive treatment that helps her to stay alive. There may be circumstances in which the treatment is not in the person's best interests, perhaps because it is futile or unduly burdensome.

W-2016
The Law

"People with capacity are entitled to make decisions for themselves, including about what they will and will not eat, even if their decision brings about their death. The state, here in the form of the Court of Protection, is only entitled to interfere where a person does not have the capacity to decide for herself.

By contrast, where a person lacks capacity, there is a duty to make the decision that is in her best interests.

The first question therefore is whether the person has capacity. The second, which can only arise if she does not, is what decision is in her best interests."

W-2016
The Law

"in considering the best interests

decision-makers must look at welfare in the widest sense, not just medical but social and psychological;

they must consider the nature of the medical treatment in question, what it involves and its prospects of success;

they must consider what the outcome of that treatment for the patient is likely to be;

they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be;

and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

W-2016
The Evidence: patient

- W's wishes and feelings and her beliefs and values.

  – W does not want to die. She would like to return to education and has a career path in mind. Unfortunately she is so far from being fit to resume this course that it is scarcely a realistic one at present.

  – W has provided two documents setting out her position. They are remarkable for their clarity and analytical nature. They also have a detached quality that speaks of W's long years of focusing on the issue of her eating. However, there is no mistaking the sincerity of her description of her current situation:

"Currently I am struggling because I have no control over decisions in my life. I have no focus on things I would like in life that I am being denied. I see no light at the end of the tunnel and am extremely anxious over what is going to be decided."

W- 2016
The Evidence: patient

- I asked her what was the most important thing for her. She replied: *"To make my own decisions and that treatment should not be enforced*".
- She would like to go home and feels that she could *"turn it round"* and that, having been *"rescued"* all her life, she has never tried to manage on her own. She acknowledges that it would be a huge task, carrying the risk of death, and says that if it didn't work after a couple of weeks, she would like to have a short re-admission to the unit or, preferably, to an SEDU.
- On the current unit, she feels that she has failed and that nobody believes that she can succeed. The loss of the prospect of a job hit her hard. She wants support, not a battle. She would like what she described as a collaborative plan.

W-2016
The Evidence: patient

- I asked W about the nature of anorexia. Does she feel that it is a mental disorder or, as some have suggested, a condition in the nature of an addiction? Her insightful response was that some aspects of her behaviour, notably exercise, was like an addiction, but that the overall condition was more a way of life.

W-2016
The Evidence: psychology

- W associated the eating disorder with the means of keeping people close and receiving care. She was fearful that others wouldn't care about her as much without it.

- There were very difficult feelings associated with the actual process of eating. W said she feared these feelings which is why she resisted eating. The feelings chiefly seemed to be those of guilt and remorse. Clearly then, the process of eating had become something almost sinful.

- She told me that she wanted a future without anorexia… Having had problems with food since she was 10 years old, anorexia had become a huge part of her identity. It was not only difficult for her to imagine a life without it, it was also a little scary. Take away the anorexia and what was left?

W- 2016
The Evidence : psychology

- *W was very similar in presentation to the last time I saw her over 2 years ago. She has entrenched anorexia nervosa thoughts and behaviours that seem to be virtually impossible for her to fight…*
- *sadly my opinion is that it is very unlikely W is going to make a significant recovery… In my view, over the years some iatrogenic factors could have potentially crept in, in terms of W's relationship with services and others around her… NHS clinical staff have become her main social connections… Services can become a reinforcing influence by providing an overly protective environment which ensures safety and security while reducing loneliness and isolation. This limits the need for an individual to develop their own sense of responsibility, autonomy and independence. Also, the highly structured environment of inpatient care supports the rigid attention to detail and inflexibility which is characteristic of people with eating disorders, allowing these negative behaviours to thrive…"*

W – 2016
Decision

- The court accepted, having heard the evidence of the Trust, that by reason of her severe anorexia W lacked capacity to make decisions about care and treatment of the condition, although the court accepted she did have capacity to make other decisions which included decisions about physical health.

- The unanimous professional view was that using coercion to get W to eat is no longer appropriate and that a cure is not to be hoped for but what could be achieved would be a limited degree of recovery and the maintenance of that state. A move to an alternative unit was likely to be futile.

W-2016
Decision

- Ultimately the court made the order which was the least worst option from W's point of view, being beyond the power of the doctors, family members or the court to bring about an improvement in W's circumstances or an extension of her life.
- The court found that given that most of W's life had been in an institutional environment, and whilst designed to be therapeutic, for W it was not therapeutic at all.
- The court was clear to stress that services were not being withdrawn from W but that the present treatment was not beneficial to W and therefore it was not right for it to continue .

W-2016
Decision

- It will at first seem counterintuitive that someone so ill should be discharged from hospital. The conventional assumption is that hospital treatment is likely to bring benefits, but the evidence has persuaded me that in this case that is not so. The outcome is to some extent in accordance with W's wishes.
- Accordingly given the professional advice, the court discharged W from hospital to receive a package of support for herself and her family in the community.

CoP Cases So Far…..

- 1) Re E 2012 (JACKSON J)
- 2) Re L 2012 (KING)
- 3) Re X 2014 (COBB)
- 4) Re W 2016 (JACKSON J)
- 5) Re Z 2016 (HAYDEN J)

Case Law – Re E (2012)

- 32 year old
- Severe AN, alcohol abuse, BPD
- Proceedings bought by Local Authority
- Palliative Care in Care Home
- BMI 11.3 and dropping
- Death imminent

Re E - History

- Serious sexual abuse 4-11
- Age 11 began controlling eating, binge eating, vomiting and alcohol
- Age 15 – Admitted 9/12 SEDU
- Four SEDU admissions
- One alcohol rehab admission
- More recently ‘revolving door’
- MHA on 10 occasions

Re E - History

- July 2011 / Oct 2011 – Advanced Directive
- March 2012 fed by NG tube but resisted
- No calories since (case in June 2012)
- April 2012 “All treatment options exhausted”
- Admitted to a community hospital for palliative care

Re E – Different Views

- Parents - Highly sceptical about fresh professional promises
- Do not want E to die, but unless further medical intervention has a real prospect, they respect her decision
- Health authority – neutral position
- Dr Glover – in favour of forced treatment

Re E - Options

- 1) No intervention
- 2) Immediate transfer to SEDU for NG or PEG feeding

Re E – Questions to Answer

- 1) Does E at this point have the mental capacity to make decisions about her treatment?
- 2) If not, did she have when she made the advanced directive?
- 3) If she lacks capacity and has not made a valid advance decision, what is in her best interest in terms of treatment?

Re E - Summary

- Lacked capacity to accept or refuse treatment
- Lacked capacity at the time of advanced directive
- Did not consider further treatment to be futile
- Lawful and in her best interest for her to be fed, forcibly if necessary

Re L (2012)

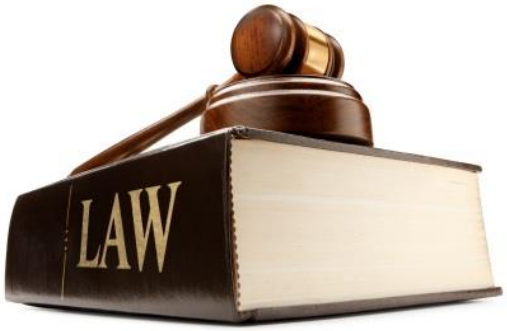
- 29-year old woman with a long history of anorexia nervosa
- 90% of her life over the previous 16 years as an inpatient in various units.
- At the time of the case, L weighed around three stone and had a very poor prognosis.
- L lacked capacity to make decisions in relation to serious medical treatment, including in relation to nutrition and hydration.

Re L

- The question arose as to whether it is in L's best interests to forcibly re-feed her.
- L's family and medical team were all agreed that invasive force-feeding was not in her best interests, given the length of time that L had suffered from anorexia nervosa.
- The medical evidence (provided by Dr Glover) was that the act of inserting a naso-gastric or PEG tube, and the sedation to do this, would lead to almost certain death[13] due to her frail physical condition and severely impaired organ function.
- As such, it was held that force-feeding was not in L's best interests and thus that it was lawful to withhold such treatment.

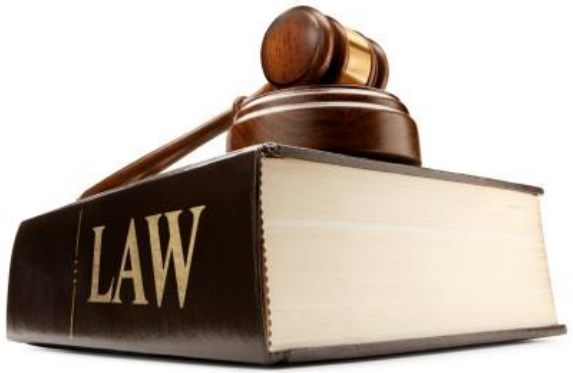
Re X (2014)

- ‘Young woman’
- Lives alone in private bed-sit
- Severe and enduring Anorexia Nervosa last 14 years
- Alcohol dependence syndrome and irreversible liver disease

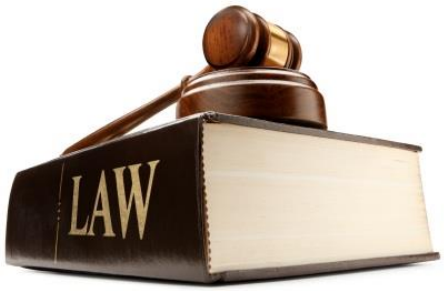


Re X

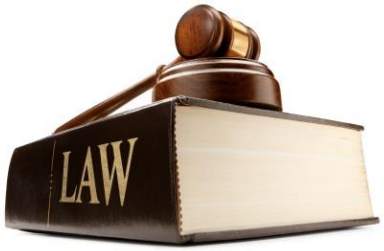
- Harmful childhood experiences suffered under care of parents
- *“The traumas of her childhood have left deep wounds which continue to manifest themselves through her psychological disturbance”*



Re X



- Revolving door
- Forced fed with only short term benefits
- BMI 12.3
- Bottle of vodka a day
- Admission “clinically inappropriate, counter-productive and increasingly unethical”
- Has been on ‘end of life’ pathway twice in recent months



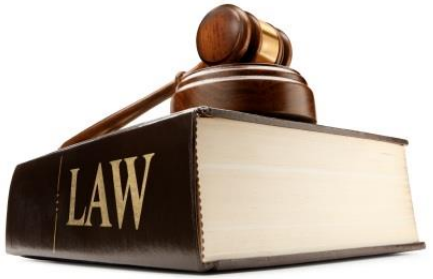
Re X

- Application made August 2014:
  - Not in Ms X's best interest to be subject to further compulsory detention and treatment of AN
  - It is in her best interest, and shall be lawful, for her treating clinicians not to provide Ms X with nutrition and hydration with which she does not comply

Dr B – Ms X

- *"It is my belief that if Ms X did not have anorexia nervosa she would already have died from a complication of cirrhosis. She is alive today because the MHA has provided us with an option to treat her anorexia when her BMI dropped to a dangerous level. The intermittent admissions have allowed us periods of time to break the inexorable cycle of heavy drinking that would otherwise have led to end stage liver failure"*

Re X



- Deemed not to have capacity with respect to decisions around treatment for AN
- Dr Glover – Expert witness – Advised it was NOT in her best interest to be force fed
- Mr Justice Cobb – did not compel treatment for Ms X's anorexia

Re E v Re X

- What are the differences?
  - Chances of success 20-30% v 5%
  - Forced feeding for two years, with Ms X “a 95-98% chance that she will spend a miserable time being forcibly fed before she then dies”
  - “Treatment which might return E to a relatively normal life is available but has not so far been tried, and that she should receive it” v “Ms X has been successfully treated in the past but has then relapsed, there is no untried treatment in the case”

RE Z

- Anorexia: handing back control? – Mental Capacity Law and Policy

https://www.mentalcapacitylawandpolicy.org.uk/anorexia-handing-back-control/

Outcomes

- Re E – Survived
- Re L – Died
- Re X – Died
- Re W – Died
- Re Z – Alive with better quality of life

COMPLEX CASES

Shared Cases - BPD

- DBT understanding of BPD (women with history of chronic parasuicidal behaviour)
- BPD appeared in DSM 3 in 1980. Historically 'borderline' was a psychoanalytic name for group of patients who appeared suitable for analysis, but would deteriorate and could require hospitalisation, and /or whilst in hospital deteriorate behaviourally. Emotional state of both therapist and patient seemed to deteriorate; i.e traditional treatments ineffective / harmful.
- Marsha Linehan (disclosed previous BPD), set out to understand why and design effective treatment.

BPD – DBT perspective

- CBT evidence base in affective disorders.
- CBT sessions and analysed interactions, what worked, what did not.
- Outcome was DBT, remains based on cognitive –behavioural techniques
  - Problem solving
  - Exposure
  - Skills
  - Contingency Mx
  - Cognitive restructuring
- IMPORTANT MODIFICATIONS

BPD – DBT perspective

- Matter of fact exaggerations
- Acceptance of feelings / situations
- Double bind statements
- Rapid changes in style (warm acceptance to blunt irreverence)

BPD – DBT perspective

- MODIFICATIONS TO TREATMENT
  - Balance of change and acceptance / Dialetics (focus in CBT on change through cognitive restructuring, is experienced as invalidating of emotions. Focus in DBT is on synthesis). Acceptance taught through mindfulness and letting go of judgements.
  - Focus on therapy interfering behaviours
  - Combination of group / 1:1. (group reduces tendency for unrelenting crises to dominate sessions and overshadow learning skills)

Consequences of treating ED / BPD

- Focus on weight restoration or stopping purging, but these are maladaptive behaviours used to manage emotional dysregulation, so shifts in ED behaviours mean other (usually maladaptive) coping mechanisms eg self harm increase.

- BPD focused treatment
  - Using more skillful means to manage extreme emotions / impulsivity
  - Need to address underlying emotional sensitivity and dysregulation
  - Using ED behaviours is doing the best they can with current skills

Consequences of treating BPD /ED with CBT…

- Invalidating
- Focuses on change rather than dialetical position – the emotional dysregulation in BPD will not be 'cured', but can be tolerated / managed skilfully.
- Patients report very disappointed that emotionally feel no different (or worse) with weight restoration. Have been 'lied to'; emotional sensitivity /dysregulation are super fuelled with weight restoration.

- BPD focused therapy
  - Balance of acceptance and change.
  - Validation of emotional experience is first step in skilful response

Consequence of treating BPD /ED with SSCM

- Supportive therapy, therapist warm / reassuring.
- Get pulled into being relied upon by patient, reinforcing illness as a means of finding validation for distress.

- BPD focused therapy
  - Mindful of therapist / services reinforcing maladaptive behaviours

  Eg no support from therapist 24hours after self harm /non life threatening ligature not removed by staff, staff support patient to remove ligature.

Consequence of treating BPD / ED with SSCM

- 1:1 therapy, get drawn into repeated interpersonal crises.
- Unable to complete / be effective with problem solving due to new difficulties

- BPD specific
- Use group therapy to focus on task of skill acquisition.
- Work on underlying problems not just symptoms of underlying problems

Summary

- Knowledge of medical management is helpful in those you may come across whilst on call, or who have co-morbid ED, this needs to be about
  - when to admit to medical ward (urgent)
  - what monitoring might be appropriate.
  - when appropriate to refer

- Out of interest, learnt about therapies for ED
- Shared some of the most complex aspects of my job

Questions?

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