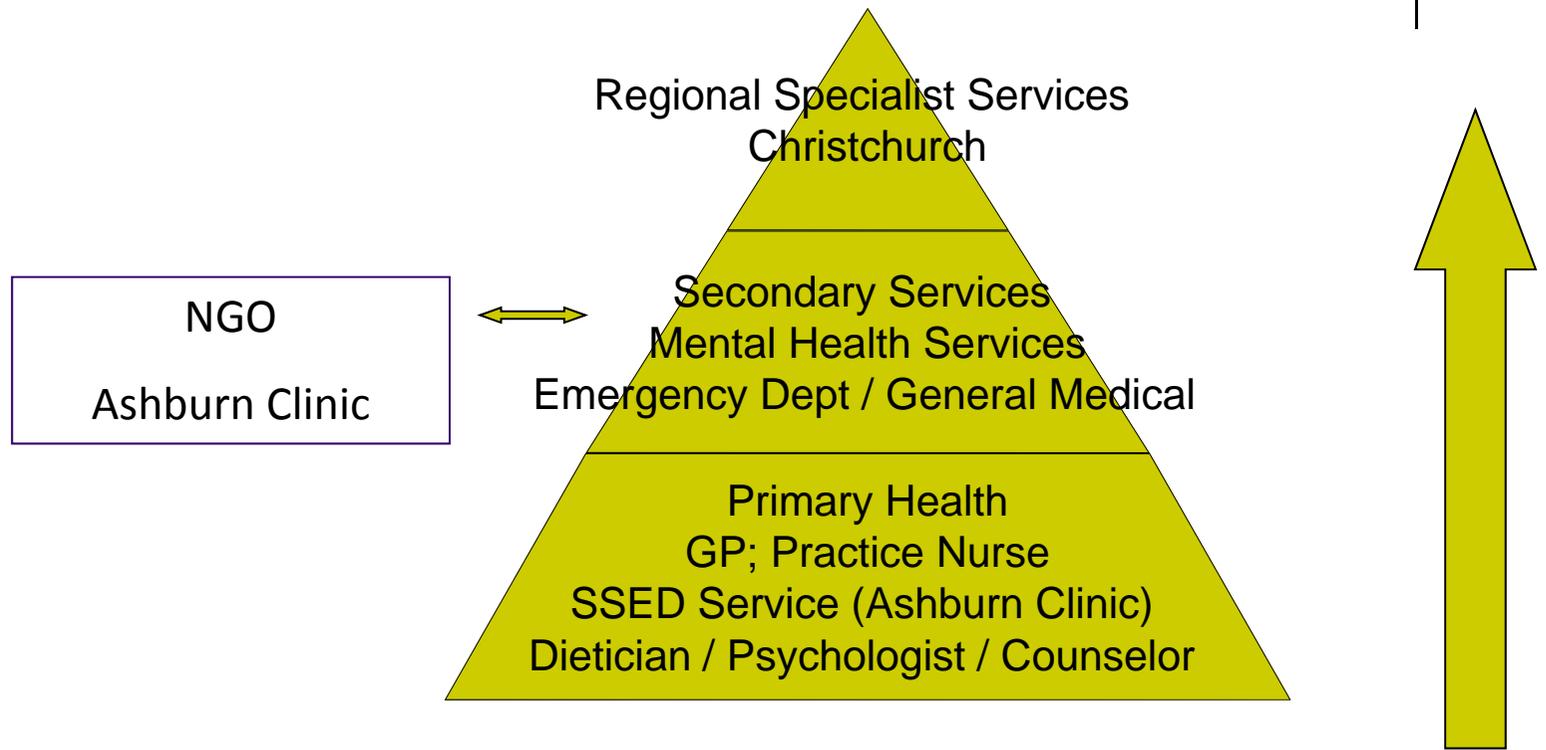




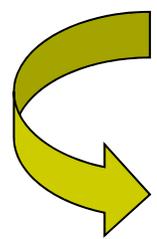
# **Southern Support Eating Disorders (SSED) Service**

GP CME September 2011

# Treatment in South Island



Referral  
Pathways



Southern Support Eating Disorders (SSED) Service for support networks; clinical advice; education.  
Liaison with DHB to access Regional Service telemedicine for case review.  
Liaison with the Regional Service for short term 'Inpatient Assessment' & access to the 'Weight Restoration Programme.'



## ● Referral & Clinical Assessment Pathway

People who present with symptoms & /or behaviours consistent with ED / Disordered Eating

- Initial identification & Assessments (1-3 sessions)
- Brief interventions (6 - 8 sessions)
- Recommendations – to client & referrer
- Education & Support (families / whanau)
- Referrals for specialist interventions
- **NB:** Assessments usually conducted in referrers practice & clinical responsibility remains the responsibility of referrer.

## ● Education & Professional Networking Pathway

Health Organisations, professionals, schools & other community groups

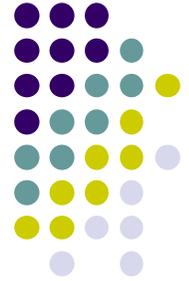
- Consultation & Clinical Support
- Networks for Health Professionals
- Education
- Resources

## Future Directions for ED Services (Ministry of Health, 2008): Recommendations



- Development of clinical pathways & guidelines for early intervention in primary services in NZ context.
- Evaluate the effectiveness of initiatives & interventions (including peer support) at any level in the continuum.
- Develop outcome measures that establish service user and carer satisfaction.
- Collect data: incidence & prevalence of ED in NZ.
- Investigate, develop effective, evidence-based ED awareness & prevention in schools.
- Evidence Based Guidelines in the **NZ context** to assist with early intervention in primary health & criteria for referral to specialised services.
- Investigate feasibility, effectiveness of mobile ED teams to work with primary & secondary care services - care close to homes of children & adolescents.

# SSED Service: Projects



- GP: Information Pack - Electronic Resource.
- Nursing: Guidelines for Practice Nurses / Public Health Nurse.
- Developing client resources (eg: Links to self-help websites; access to books; handouts).
- Research: Pilot Study / Questionnaire.
- Research: Joint research with Otago University Dept of Psychological Medicine.
- Family Support Network: October Family Forums - Psychoeducation
- Southland: Working on a Consumer support network.
- Health professionals: Liaison Referral pathways
- Education: GP CME; Practice RN Forums...
- National Networks: National ED Forum: Pilot e-learning project.

# Research: Pilot Study



**Sample Group: 10 (GPs) 1 (RN)**

- **Q2: Years of Experience:** 15 - > 25 years
- **Q3: Identification:** Seldom ... 1/year...probably missing some... "I'm male"
- **Q4: Confidence in Early Identification:** Likert scale (Low = 1) (5 = High) 2-3
- **Q5: Confidence in use of Assessment/Screening Tools:** No knowledge or rated Low 1-2
- **Q6: Tx Models or Approach:** (a) No use of tx models (b) Would like to know about them...Know more post education.
- **Q7: Management Plan:** No use / knowledge of specific management plan
- **Q8: Referral:** Anyone or first available; dietician, paediatrician, MH services, Auckland
- **Q9: Barriers:** Lack of services; cost; difficult to tx.
- **Q10: Comments on Prevention:** The media; Primary care needs to get more involved; is obesity an ED?
- **Q11: (a) Information: Nursing plans/Guidelines (b) Education:** Early diagnosis; best management; private tx v public for AN
- **Q12: How:** CME education sessions; Check list; links to regional/national education; website links; work collaboratively.
- **Q13: What can the service provide:** Support; coordination; education; availability/access.

# Identification: Diagnostic Issues for Primary Health



- **AN:** Publicly visible, physical / medical consequences . “ego-syntonic” (accepted as part of the self), sufferers rarely see the need for treatment, rarely seek it.
- **BN:** Private, medical manifestations hidden, ‘ego dystonic’ (not accepted as part of self), sufferers reluctant to seek treatment, embarrassed...
- **BOTH:** Serious psychiatric & medical conditions - avoid “rule out” approach to diagnosis.
- **Risk:** > by time medical causes of symptomatology fully excluded & DSM criteria are met – early intervention is a misnomer.
- **Binge Eating Disorder:** Common; obese or normal weight; hidden; compulsive overeating; emotional eating; food addiction.

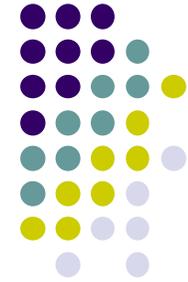
**Research:** *People with ED are shown to present to GPs more frequently*

# Common misdiagnosis



- Intermittent diarrhoea and constipation (laxative abuse / starvation) often diagnosed as lactose intolerance or irritable bowel syndrome
- Abdominal pain
- Hypoglycaemia
- Premenstrual Syndrome
- Systemic candidiasis (Yeast Infections)
- Food allergies
- Chronic fatigue syndrome

# Physical Signs & Symptoms with AN include



## General

- Precipitous weight loss
- Emaciation, often concealed with clothing.
- Failure to > weight in proportion to height.
- Preoccupation with additional weight loss despite thinness
- Hypothermia and cold intolerance.

## Neuro psychiatric

- Memory loss-poor concentration
- Insomnia
- Depression/Anxiety/Obsessive behaviour
- Self-harm
- Suicidal ideation/attempt

## Cardio respiratory

- Chest pain
- Bradycardia; hypotension

## Gastrointestinal

- Constipation; abdominal pain
- Early satiety, delayed gastric emptying

## Endocrine

- Secondary Amenorrhea
- Low bone mineral density
- > risk for fractures & osteoporosis
- Infertility

## Dermatologic

- Lanugo hair (fine downy hair) face, neck, arms.
- Hair loss

# Anorexia Nervosa (age-adjusted)



- Any **clinically significant degree of weight loss** not due to medical illness in the context of reported excessive dieting and exercise for a period of more than **1 month**.
- Verbalisation of **fear of weight gain** is **not** required
- Disturbance in the way in which one's body or shape is experienced.
- Influence of body weight or shape on self-evaluation.
- Denial of the seriousness of the current low weight doesn't require verbalisation but can be ascertained by either **behavioural observation** or professional / parental report.
- Amenorrhea would not apply to children or adolescents  
**NB:** Investigate failure to >weight / height or delayed pubertal development.

# BN: Physical signs & symptoms include



## General

- Fluctuating weight patterns

## Oral & Dental

- Oral trauma / lacerations
- Dental erosion / tooth sensitivity; caries
- Swollen / tender parotid glands

## Cardio respiratory

- Chest pain; palpitations; arrhythmias

## Dermatologic

- Calloused knuckles (Russell's sign)

## Gastro intestinal

- Abdominal bloating
- Constipation
- Gastro esophageal reflux
- Haematemesis

*NB: Questioning of specific s/s highlights the effects. General questioning usually has the person stating they feel fine.*

# EDNOS



- Currently includes Binge Eating Disorder (BED)
- Meets criteria for AN and/or BN **BUT** Females have menses.
- May have significant weight loss but in general weight is in the normal range
- Binging and purging occur less frequently than in BN
- **Prevalence:** More than 1/2 clinical samples; Lack of studies.

# Associated features: BED



- Depression or anxiety (Approx 30%)
  - Non specific tension (relieved by binge)
  - Dissociation or numbing
  - Obesity
  - Marked weight fluctuations
  - Restriction (varies)
  - Low self esteem
  - Relationship problems
  - Substance abuse / dependence
- NB: Mostly females...Common ...Chronic...

# Prognostic factors: Good



- Young age/first episode/short duration
- Relatively preserved body weight / BMI
- Intact family
- Established other roles
- Absence of co-morbidity

Ref: Treasure & Russell, 2011 (Ref: Dr R Morgan)

# Prognostic Factors: Bad



- Purging anorexia
- Chronicity > 6 years
- Alcohol and drug use
- Psychiatric co-morbidity especially personality disorder NB: Suicide rate for women with ED 58x greater than for women without ED. Hertzog et al, 2000).
- Unrelenting lack of insight  
(Ref: Dr R Morgan)

# CBT Model of an Eating Disorder



## **RISK FACTORS: FAMILY**

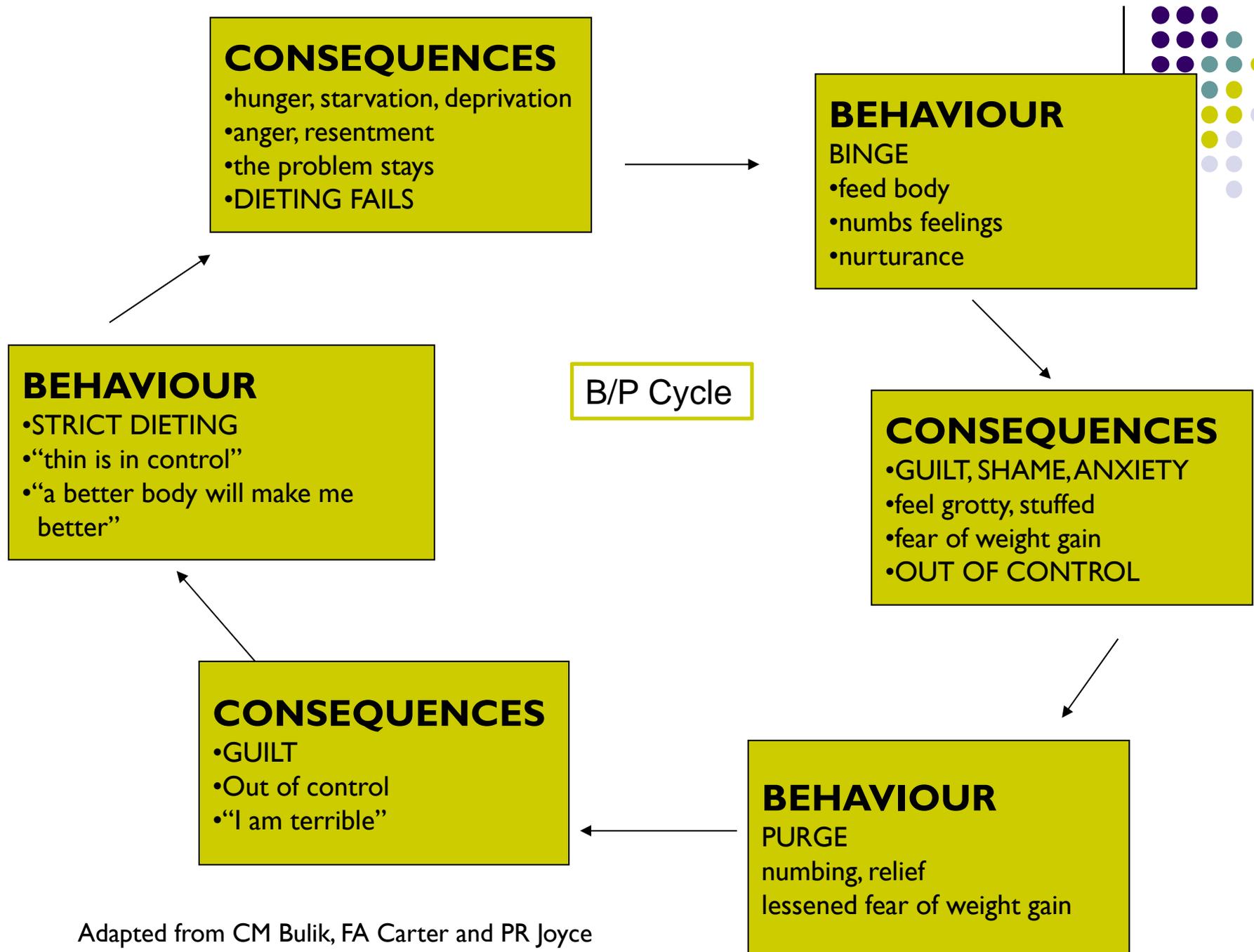
- family history of depression
- family history of alcoholism
- family conflict or trauma
- parental deprivation
- sexual abuse
- physical abuse
- emotional abuse

## **RISK FACTORS: SOCIETY**

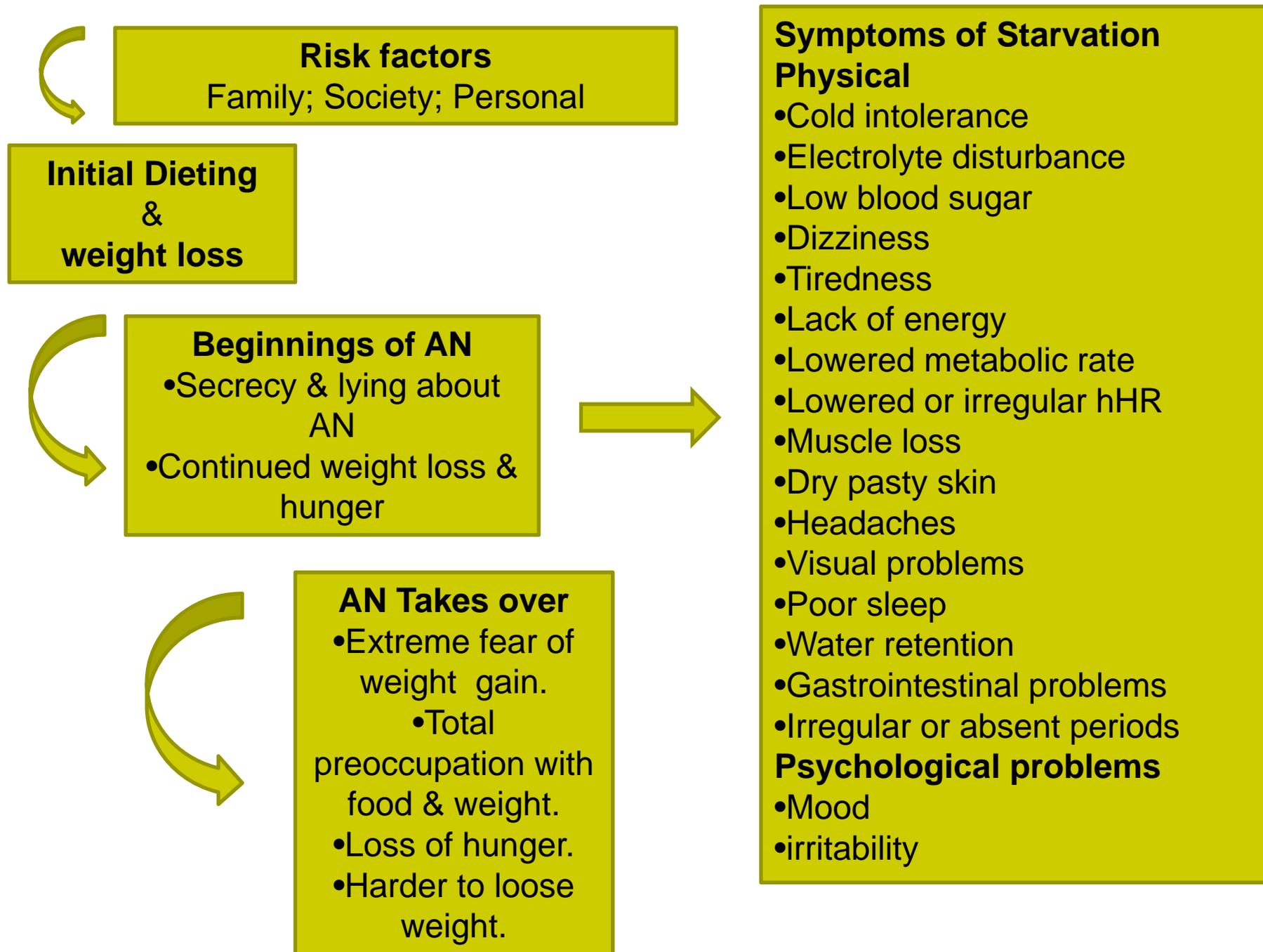
- social pressures on women
- emphasis on thinness
- role confusion
- mixed messages for woman

## **RISK FACTORS: SELF**

- poor problem solving skills
- low self-esteem
- low mood, depression
- high anxiety, nervousness
- perfectionism
- self-critical
- impulsivity
- fears about sexuality
- fears about relationship problems



Adapted from CM Bulik, FA Carter and PR Joyce



**SSCM Model of Anorexia Nervosa:** (Adapted from McIntosh & Jordan, 2010, ANZAED)

# Screening



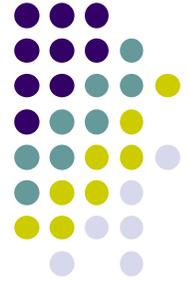
- Screening is not the same as the formal diagnosis process against the DSM-IV.
- “Early recognition and intervention is vitally important...ways need to be found to engage treatment resistant patients...overcome barriers to help-seeking within health services...early recognition in schools and [provision of] family support may reduce delay...correcting malnutrition and secondary consequences of brain starvation are essential in parallel with psychosocial help”  
(Ref: Treasure & Russell, 2011)

# Early Recognition: Warning Signs of an Eating Disorder



- Diet books, pondering over labels, evidence of visiting pro-anorexia or eating disorder websites, dieting behaviours (eg: diet pills; artificial sweeteners; gums...).
- Extreme calorie counting: Refusal to eat non diet foods.
- Sudden decision to become vegetarian, increased picky eating, especially eating only “healthy foods”.
- Fasting and skipping meals regularly.
- Refusing to eat with the family or friends
- Multiple showers in a day / Always going to the bathroom immediately after eating.
- Unusual number of stomach flu episodes.
- Excessive exercise.

# Simple Screening in Primary Care

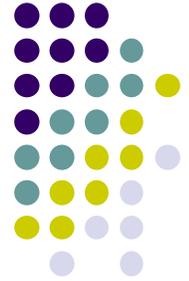


- How many diets have you been on in the past year?
- Do you think you should be dieting?
- Are you dissatisfied with your body size?
- Does your weight affect the way you think about yourself?  
A positive response to any of these questions warrants further evaluation
- EDE-Q ( Eating Disorders Examination) Assessment of BN

Fairburn, C.G., Cooper, Z. (1993). The Eating Disorders Examination (12<sup>th</sup> ed). In C.G. Fairburn & G. T. Wilson (eds), Binge Eating: Nature, assessment, and treatment, New York, Guilford Press.

# SCOFF Questionnaire

Morgan, Reid, & Lacey (1999)



- **S-** Do you make yourself sick ( induce vomiting) because you feel uncomfortably full?
- **C-** Do you worry that you have lost control over how much you eat?
- **O-** Have you recently lost more that (one stone) 6.4 kg in a three-month period?
- **F-** Do you think you are too fat, even though others say you are too thin?
- **F-** Would you say that food dominated your life?
- One point for every yes answer, a score >2 indicates further follow up required

# Assessment and Screening Questions



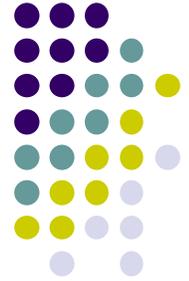
- Has there been any change in your weight?
- What did you eat yesterday?
- Do you ever binge?
- Have you ever used self-induced vomiting to lose weight or compensate for overeating?
- Have you ever used laxatives, diuretics or enemas to lose weight or to compensate for over-eating?
- How much do you exercise in a typical week?
- How do you feel about your appearance?
- Are your menstrual periods regular?

# Nursing: Simple Physical Screening



- Height and weight
- Hydration
- Temperature
- Squat test
- Lying and standing pulse and BP
- ECG; DXA if amenorrhea >6months
- Arrange Blood tests: Full blood count; serum metabolic profile, electrolytes, enzymes, Thyroid function. ([WWW.AEDWEB.ORG](http://WWW.AEDWEB.ORG))

# BMI



- Normal range is 18.5-24.9 kg/m<sup>2</sup>
- Underweight: <18.50
- Severe thinness <16.00
- Overweight: >25.00
- Obese: > 30.00

<http://www.moh.govt.nz/moh.nsf/index/how-obesity-measured>

**NB: Importance of the Weight / Height Centile**

# Treatment: Management Plan



## **Assessment**

- Physical/psychiatric/psychological/ nutritional

## **Who needs to be involved**

- Health professionals (physical assessment) / others... Family / whanau / support networks / referral to dietician; psychologist ...

## **Contract Setting**

- Indications for hospitalisation; follow-up agreements; food diary; exercise log; record binge/purge; agreement on how to manage weight

## **Goal Planning**

- Restore weight (AN)
- Reduce binge eating / purging (BN)
- Correct biological & psychological complications
- Normalise eating patterns
- Provide education – alternative coping strategies
- Role of Psychopharmacology

## **Relapse prevention**

# AN: Specialist Supportive Clinical management (SSCM)



## Phase 1:

- Identify target symptoms
- Set goal weight range
- Set goals for normalising eating
- Psycho-education

## Phase 2:

- Focus on target symptoms
- Normalise eating
- Address other issues raised by person

## Phase 3:

- Prepare for end of therapy relationship
- Plan for maintaining Changes

**Ref: (SSCM Model of Anorexia Nervosa: McIntosh, Jordan & Luty et al., 2006.)**

# Referral to Specialist Services: Maudsley Family Therapy for AN



- Endorsed by NICE Guideline (grade B )
- Good long-term outcome in young patients with short duration of illness.
- > than 3 years recovery rate is low
- “What causes inadequately treated AN to persist? ...**starvation & stress**” (Treasure & Russell, 2011, p. 6)

## SSED Service Perspective

- Motivational Interviewing: During initial phase of treatment to guide towards change.

(Price-Evans, & Treasure, 2011)



# Treatment options BN

Self help books:

Getting better bit(e) by Bit(e): A survival kit for sufferers of bulimia nervosa and binge eating disorders Schmidt. U., & Treasure, J.

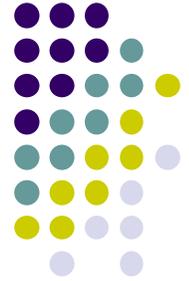
Crave: Why you binge eat and how to stop  
Cynthia Bulik

Strategies... Mindfulness... “Pathological Critic...”

Internet resources:

[www.smart-eating.com](http://www.smart-eating.com) & [www.bulimiahelp.org](http://www.bulimiahelp.org)

# Core Functions of an ED



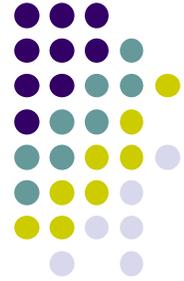
- Specialness
- Virtue
- Control
- Emotional regulation.
- Identity

“Even though anorexia nervosa is sustained by malnutrition and predisposing biological traits, the disease state becomes further entrenched because it is existentially ‘needed’ for its protective and compensatory elements”.

(Strober, 2004, p. 249-250)

## Response..

Communicate beliefs and values that foster client self-acceptance and opportunities for change



- Acknowledge that the ED exists for a reason-explore how the ED functions for the person.
- Self perception: Work together consolidating and elaborating aspects of identity and self concept that are independent of the eating disorder.
- Recognise the wisdom of the clients readiness to change.
- Accept that meaningful change takes time.

The Use of Motivational Interviewing in Anorexia Nervosa. Price-Evans, K. and Treasure, J. (2011)

# Cognitive Distortions



- All or none thinking
- Over generalisations
- Filtering
- Discounting or disqualifying the positive
- Jumping to conclusions
- Magnifying / catastrophising
- Emotional reasoning
- Personalising
- Superstitious thinking
- Should Statements
- Denying

# Challenging Automatic Irrational thoughts

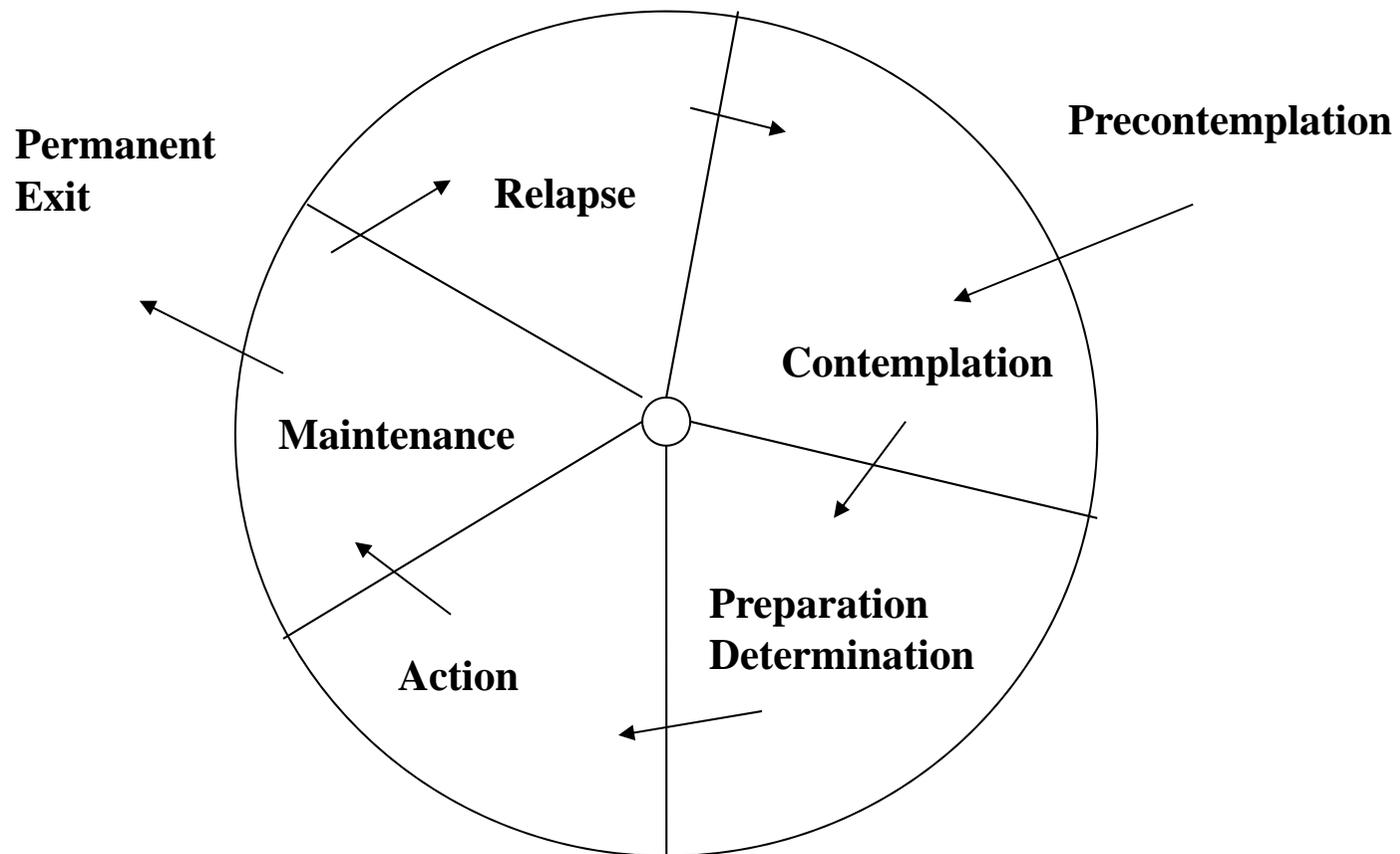
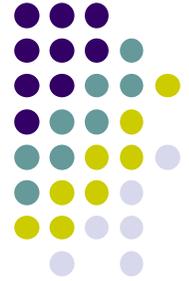


How to..

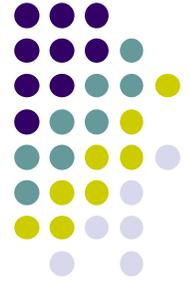
- Examining problematic thoughts
- What is the evidence?
- What alternative views might there be
- What is the worst that could happen
- What would I advise a friend if he/she were in the same situation
- What is the effect of believing in my automatic thought
- What are the thinking errors
- Find a rational alternative

# Stages of Change

(Prochaska & DiClemente, 1983)

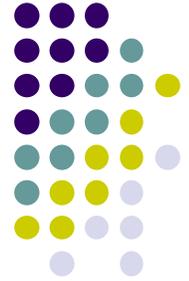


# Helpful Hints: Families



- Separate the person from the disorder.
- Encourage person to seek help.
- Remind person about other skills & attributes.
- Focus on the positive behaviours rather than the destructive ones.
- Keep communication positive & open.
- Take focus off food & weight when possible.
- Plan for / contract about meals.
- Set boundaries.

# SSED Service



- Identification
- Assessment & Screening
- Tx Models
- Management Plan
- Referral
- Barrier...
- Prevention....
- How & what the SSED Service can provide....

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