# South Island Eating Disorders Service

# The Service

- Established in the mid 70's – as Christchurch Eating Disorders Service and presently covers the whole of the South Island for the treatment of eating disorders
- Regional – Hub & Spoke model
- Based at PMH
- Managed by Mental Health Division of CDHB

# The Team

Multidisciplinary group of professional

disciplines working across the inpatient and

outpatient areas.

- Consultant Psychiatrist
- Physician
- Paediatrician
- Psychologists

# The Team (cont'd)

- Social Workers
- Dietitians
- Occupational Therapists
- Psychiatric Nurses
- Consult Liaison Nurse
- Physiotherapist
- Secretary

# Referrals

- Accepted from health professionals with GP involvement and support
- 12 years and over
- From within the CDHB
- From the rest of the South Island for Consult Liaison, specialist and inpatient treatment via CMHT
- Tertiary Service

# EATING DISORDERS

- Eating disorders are serious mental illnesses with significant life-threatening medical and psychiatric morbidity and mortality, regardless of an individuals weight. Anorexia nervosa has the highest mortality rate of any psychiatric disorder. Risk of premature death is 6-12 times higher in women with AN compared to the general population.

# Eating disorders and other mental health issues

- A person with an eating disorder will often be diagnosed with another mental health problem. Dual diagnosis or co-morbidity refers to the presence of one or more diseases or disorders in one individual.
  There is a high level of co-morbidity of psychiatric illnesses with eating disorders. Eating disorders are most commonly accompanied by depression and anxiety disorders; however, substance abuse and personality disorders are prevalent in people with eating disorders. In fact, research suggests that approximately 60% of people with an eating disorder will also meet diagnosis for one of these other psychological disorders.

## Classification (DSMV)

- Anorexia Nervosa
- Bulimia Nervosa
- ARFID (avoidant/restrictive feeding intake
- OSFED (other specified feeding/eating disorder
- Binge Eating Disorder

# ANOREXIA NERVOSA:-

Restriction of energy intake relative to requirements leading to a significantly low body weight in context of age, developmental trajectory and physical health.
Intense fear of gaining weight or becoming fat, even though underweight.
Disturbance in the way 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.

Sub types – Restricting
Purging

# BULIMIA NERVOSA:-

Recurrent episodes of binge eating characterised by BOTH of the following:

i Eating in a discreet amount of time (within a 2 hour period) large amounts of food.

ii Sense of a lack of control over eating during an episode.

Recurrent inappropriate compensatory behaviour in order to prevent weight gain (purging).

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

Self-evaluation is unduly influenced by body shape and weight.

- Binge Eating Disorder (BED)

As for Bulimia Nervosa with no compensatory behaviours.

- OSFED

Other specified feeding/eating disorder

- ARFID

Avoidant, restrictive feeding intake disorder

# Demographics

- Anorexia Nervosa

  Lifetime prevalence for women 0.5%

  Point prevalence 15-19 years 0.5%

  Incidence 20/100,000 females/yr

  10% of presentations are males

  Increase in recent decades but now stable

  Younger onset

  20% mortality

# Demographics

- Bulimia Nervosa

  Lifetime for women 1-3%

  Point prevalence 1% young women

  Incidence 30/100,000 females/yr

  Rapid increase in diagnosis since described in 1979

  Most likely a culturally bound syndrome

  Now stable or declining rates but local experience shows an increase in male presentations

# Morbidity

It is timely to remember that patients with Anorexia Nervosa have a 10 fold risk of death compared with healthy controls.

A 50 times risk with concurrent type 1 diabetes

A 20% mortality at 20 years

## Causes of death

Complications of Anorexia Nervosa – malnutrition, methods of weight control 54%

Suicide 27%

Other/unknown 19%

# High Risk Groups

- Adolescents-peak onset for ED 12-25
- Women-weight/shape concerns & history of depression
- Young people with Diabetes or Polycystic Ovary Syndrome
- Athletes
- Family history of an eating disorder
- Those interested in weight loss

# Recognising the warning signs

Physical:

- Rapid weight loss
- Disturbance/loss of menstrual cycle
- Fainting/dizziness
- Tiredness/poor sleep
- Swelling around cheeks/jaw
- Dental problems
- Feeling cold even in warm weather

# Recognising the warning signs

Psychological:

- Preoccupation with eating, food, body shape and weight.
- Feeling anxious around meal times
- Feeling ‘out of control’ around food
- Black and white thinking ie rigid food being good or bad
- Depression,stress, anxiety, irratiblity, low self esteem

# Recognising the warning signs

Behavioural

- Dieting behaviours
- Eating in private/avoiding others
- Evidence of binge eating(hoarding)
- Frequent trips to bathroom during/after meals
- Vomiting/laxatives/enemas/diuretics
- Changes in clothing style (baggy)
- Compulsive exercise

# Detecting an Eating Disorder

**Cues to Anorexia nervosa**

**Hypothermia**

**Peripheral cyanosis**

**Lanugo hair, brittle hair, hair loss**

**Hypercarotenemia**

**Preoccupation with additional weight loss despite thinness**

# Detecting an Eating Disorder

**Cues to Binge-Purge behaviour**

- **Swollen or tender parotid glands**
- **Dental enamel erosion / many new caries**
- **Calloused scarred area on back of hand**
- **Yo-yo weight pattern**
- **Hypokalemia**

# Individual Characteristics

**Low self-esteem (AN / BN)**

**Perfectionism (AN)**

**High achievement (AN)**

**Over-compliance (AN)**

**Excessive exercise (AN / BN)**

**OCD/OCPD traits (AN)**

**Anxiety (AN / BN)**

**Early menarche  (AN)**

# CRITERA DIFFERENCES FOR ADOLSCENTS

- MAY NOT VERBALLY ENDORSE A FEAR OF FATNESS
- MAY ENDORSE ONCE WEIGHT GAIN COMMENCES
- MAY NOT APPRECIATE THE RISKS ASSOCIATED WITH EXTREME WEIGHT LOSS
- MAY SAY STILL HAVING PERIODS BUT MAY ONLY BE LIGHT 1 DAY
- ADOLESCENTS DO NOT RIGIDLY FIT CRITERIA SET DOWN BY DSM-IV

# MEDICAL COMPLICATIONS

- AMENORRHEA – OSTOPENIA – OSTEOPOROSIS adolescence in vital time (33 – 60%) bone mass accrues during this time – due to malnutrition reduced LH and FSH this is not done resulting in lowered bone density.

Cardiac implications:

- Skin/Hair
- Teeth
- Iron
- Hydration
- Blood Glucose levels
- Hypothermia
- All Organs affected

# MEDICAL PARAMETERS

- CARDIAC IMPLICATIONS
  - Bradycardia
  - Elongated QTc
  - Potassium depletion
  - Extended pulse differential
  - Postural drop in blood pressure

- Skin/Hair
  - Lanugo
  - Hair loss
  - Dry skin/dehydration
  - Cyanosis
  - Hypothermia
  - Hypercarotenemia

- Teeth
  - Dental caries
  - Loss of enamel
  - Swollen parotid glands

# BLOOD RESULTS

- NEUTROPENIA
- LOW WHITE CELL COUNT
- HYPOKALEMIA
- LOW BLOOD GLUCOSE
- DILUTE UREA
- LOW ZINC
- REDUCED IRON/FERRITIN
- LOWERED SODIUM

# PSYCHOLOGICAL

- LOW MOOD
- LOW SELF ESTEEM
- SELF CRITICISM
- ANXIETY OR FLATNESS OF AFFECT
- OBSESSIONAL - DRIVEN

# SOCIAL

- ISOLATION
- ACADEMIC PROBLEMS – NEGLECT OR OVER FOCUSED
- FRIENDS NOTICE UNUSUAL EATING OR EXERCISE HABITS

# Screening

- “Many people have concerns about food and weight. Do you have any concerns or worries about these things?”
- Yes – Follow up with the SCOFF questionnaire
  - S –Do you make yourself **S**ick because you feel uncomfortably full?
  - C- Do you worry you have lost **C**ontrol over how much you eat?
  - O- Have you recently lost more than **O**ne stone (6.35kg)
  - F- Do you believe yourself to be **F**at when others say you are too thin?
  - F – Would you say **F**ood dominates your life?
  - * One point for every “yes”; a score of 2 or more indicates further questioning is warranted

# EARLY RECOGNITION

- It is widely researched and recognised that early intervention and treatment of ED leads to much improved outcomes.
- Treatment initiated with the first 3 years of an ED has 60% chance of recovery

# Diagnosis in males

- ***Overlooked*** due to perception that ED are a "woman's illness"
- ***Under-reported*** : AN to be ratio of 8:1 females to male. BN and other ED's considerably higher ratio. Difficult to ascertain statistics due to under reporting
- ***Unrecognised*** men do not recognise their own symptoms and behaviours as being an ED
- ***Focus*** is around developing a  more muscular body rather than a smaller one

# Warning signs in males

- Preoccupation with body building, weight lifting or muscle toning
- Weight lifting when injured
- Anxiety/stress over missed workouts
- Muscular weakness
- Decreased interest in sex, or fears around sex
- Lowered testosterone
- Use of sports drinks/powders and/or anabolic steroids

# SEEDS – SEVERE AND ENDURING EATING DISORDERS

- Entrenched restriction
- Anorexic cognitions
- Identity intertwined with anorexia
- Body mass > 17.5 but < 16
- Duration 6+ years (estimated to be less now)
- Lack of motivation to change
- 20% of ED's have an enduring illness

# SEEDS PACKAGE

Aims:  Better Illness Management:

- Recovery Model – rather than being cured  of symptoms, the person learns to create an optimum health lifestyle that supports them to live positively and adaptively with their illness or impairment, in order to promote life satisfaction through experiencing a sense of well being

# Useful websites

- CDHB Healthpathways
- NEDC.COM.AU
- CCI.health.wa.gov.au
- CEDD.org.au