positive CAMHS Child & Adolescent Mental Health Services

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

Eating disorders secondary to trauma:
Difficult Dilemmas in Treatment

Caz Nahman
Hopewood Pegaus ward

Outline

- Several brief case outlines
- Common Themes
- Dilemmas

AA – Young adolesent

- AN diagnosed age 11
- Admission 1- Jan 17-March 18 (GAU then SEDU) Section 3 MHA
- Copied peers GAU – ligation ++; Self-harm ++
- 5 weeks later – paeds ward – 5kg weight loss; purging +++
- June 18-January 19 – Pegasus admission
- Feeds under restraint; ++nose bleeds – ENT advised PEG
- Began eating; Came off section
- Now 8kg weight loss in 10 weeks; Awaiting bed

AB Older adolescent

Early childhood emotional abuse and witness to ++DV

- Trauma around meal times
- Severe peer bullying – overweight/tall
- Admission 1 SEDU – 4 months: DC at 85%mBMI – aggression to staff
- 16kg weight loss in 2 months
- Admission 2 – SEDU – 4 months – DC at 85%mBMI ++ violence (past – martial arts so hard to restrain)
- Admission 2 – “hands off approach” and began eating
- Admission 3 - GAU

AC – Older adolescent

- Long standing school refusal/not leaving room
- Episodes of food refusal and severe family distress around this
- 2X MHA sections (nobody able to assess)
- Minimal weight loss on admission
- +++aggression on ward with food refusal
- Hands-off approach – eats biscuits and ++milky sugary coffee

AD- mid adolescent

- Father IVI drug user/mother anxiety & agarophobia
- Witness to ++DV
- Binge-purge AN; ++admissions with dangerously low K+
- Food refusal and +++violence and self-harm on SEDU and ongoing purging
- Emotional distress rapidly escalates to violence and head-banging
- Fearful of low secure/PICU so stopped purging and healthy weight now

AE- Younger adolescent

- ASD; Early trauma and neglect, selective mutism
- Struggled – secondary school; challenging behaviour and self-harm
- Food refusal and rapid weight loss; ?body image concerns
- Prolonged admission with ++Feeds under restraint
- Any attempts to move towards discharge sabotaged
- Apparently below SS threshold for accomodation

AF – Older adolescent

- AN; self-harming; ++purging
- Academic expectations
- ++emotional dysregulation
- 4X admissions
- Feeds under restraint; significant physical complications of purging
- Ambivalent about discharge

AG – Younger teen

- Youngest of several; mum – home-maker with bg early trauma; father – controlling
- All 4 siblings competitive for maternal attention and material rewards
- Poor interpersonal skills and school attendance
- Aggressive, bullies peers, challenging behaviour

Anorexia Nervosa DSM 5

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

C. 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 persistent lack of recognition of the seriousness of the current low body weight.

Is nature of AN changing?

- Mostly different to previous AN
- Apart from 1 not classic perfectionist high achieving
- Often refusing “life”
- Often verbally arguing to be home but behaviour indicates opposite
- Fight any interventions that might be helpful
- Competitive with peers in a negative way

And…

Many SUI's

- Feeding under restraint/reliance on NG
- Assaults on staff; Damage to upper airways
- Self-harm/self-ligating/absconding
- Challenging in hospital school environment
- Very close but conflictual peer relationships
- Negative to peers who don't join in with their behaviour

In addition

- Mistrustful of staff/treating team
- Families struggle to change/adapt
- Food refusal elicits care-giver response while self-harm/emotional distress often ignored
- Poor outcomes post discharge with worsening presentation each re-admission
- Very disruptive to ward environment
- Challenging to evidence need for SS involvement

Open to floor for more discussion

Does this mirror others experiences?

Any success stories?

How to enhance motivation to change?

Some benefit from ++firm boundaries but others better with “hands-off approach”

Positive behaviour plans

"All about me" booklets

Develop a "Red; Amber; Green plan"

RED

Identify life-threatening behaviours

Possible triggers

What young person “needs”

How to support

Consequences

Amber

"treatment interfering"

Triggers?

What young person needs/how to support

Consequences

Green

Positive/target behaviours that we would like to see:

- E.g. managing meal plan and compensatory behaviour;
- staying within ward rules (e.g. polite and respectful to staff and peers; not going into peers bedrooms; attending therapy groups)
- Asking staff for help/support in an appropriate way

Identifying motivation for the unmotivated:

Idea's?

Finding that "spark" or interest?

If we could design the “ideal service” for this group

What would it look like?

What goals would we like to achieve?

Role on inpatient ED/PICU