A Storm in a teacup?

...a cornucopia of diagnoses

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Miss Lauren Clegget (Occupational Therapist)
Mr Bruce Walmsley (Clinical Psychologist) – in absentia
Presentation to Emergency

- Lily - an 81 year old lady presented with worsening confusion over a period of 24 hours.
- Worsening anxiety over a period of three months.
- Long history of Bronchiectasis, GORD and Glaucoma.
- Delirium screening done and admitted under medical team.
Admission to the Mater

- Diagnosed with Urinary tract Infection.
- Treated with Intravenous Tazocin and later oral Nitrofurantoin.
- Regularly assessed by CL psychiatric team.
- Transferred to the Mental Health Unit for Older Persons for clarification of diagnosis and treatment.
Evaluation in Older Persons Unit.

- Worsening anxiety since storms in April 2015.
- Deterioration in mood.
- Worsening pre-occupation with cleanliness.
- Complaining of persistent diarrhoea. Makes her feel dirty.
- Poor sleep and appetite.
- Poor concentration.
- Passive suicidal ideation.
Mental State Examination:

- Thin elderly lady with very short hair (shaven look).
- Curled in foetal position in her bed.
- No eye contact (mostly closed)
- Under covers & speaking in a high pitched childlike voice.
- Crying & admitting depressed mood.
- Pre-occupied with bowel function & fear of being dirty.
- Continually asking to end interview so she could go to the toilet.
- Repetitive requests to have medication to suppress bowel function.
- No clear hallucinations.
- No FTD.
Diagnosis?

- Delirium
- Agitated Depression
- Melancholia
- Psychosis
- Anxiety disorder
Initial Management

- Tab Venlafaxine 37.5mg daily. Dose gradually increased to 225mg daily.
- Tab Risperidone 0.5mg daily. Dose increased to 1mg daily.
- Considered ECT if trial of medication unsuccessful.
- Suspiciously rapid response to medication.
- Delirium? Cause?
Past Mental Health History

Long standing anxiety. Multiple perceived stressors. Anxiety difficult to control.

Pre-occupation with cleanliness. Frequent showers and brushing teeth; cutting hair very short to aid in cleanliness. Important to stay in control.

Episode of depression following death of her husband in 1980?

Rapid weight gain following death of her husband. Large weight loss nine years ago.
Past Mental Health History

- No previous admission to mental health units
- No previous suicide attempts.
- Self harm? “I hurt myself.”
Personal history

- Avoidant during interview
- If pressed reports she is tired. Can become angry and terminate interview.
- When in extreme distress curls into foetal position on her bed. “Regression.”
- Limited information available from her partner and adopted daughter.
Personal History

Born in Botany.
Lived on a farm during childhood.
Father: Gambler and heavy drinker. History of depression. May have received ECT
Sister: Depression. Received ECT.
Brother: Depression.
Parents critical of her.
Childhood trauma????
Personal history

- Completed year 12 and then completed a course in nursing.
- Worked at the ANU in a research capacity for several years.
- Married for 21 years.
- Migrated to Canada with husband.
- One biological son, one adopted son and one adopted daughter.
Personal history

- Returned to Australia in the late 1970’s with three children.
- Did not return to Canada when husband was ill.
- Met current partner in 1980.
- Husband passed away in the early 1980’s.
Eating and exercise

- Pre-occupation with her body weight extending back to childhood.
- Restriction of food intake. Sometimes avoids meals for up to 48 hours.
- Tends to fill up on large quantities of dilute coffee and milk.
- No evidence of use of diuretics or laxatives or purging in the past?
Eating and exercise

- In the past was an avid runner and bush walker.
- Currently walks constantly using her walker.
- Faye reports that her eating is one way that she is able to remain in “control.”
- Disturbed body image
  - Fear of becoming fat
- BMI at time of admission: 19.5 kg/m²
Corroborative history from partner

- The client restricts dietary intake:
  - Shifting decisions about what to eat/avoid;
  - Last-minute decisions at the restaurant door not to have dinner;
  - Purposely avoids wearing bottom set of dentures to avoid eating;
  - Skips meals for 48 hours subsequent to reporting “I’m getting fat”

- Client has a limited social network beyond family (described as disinterested in other people);

- Perceives the client to be controlling (medications, dietary intake, extent of partner’s social contact with friends). He believes that when the client senses that her control is being challenged, she regresses to a “12 year old girl” who presents as “angry and withdrawn” and often reports “If you don’t like it go!” He perceives the client to “snap-out of” these regressions;

- Client reports family history of depression and alcohol misuse in the client’s father, and depression in two of the client’s siblings.

- Client’s partner describes his relationship with the client as one of a ‘guilty carer’. He reports a discordant relationship with the client’s adult-children whom he views as “odd”, “suspicious” and “paranoid.”
Updated management:

- **Further investigations**
  - Bone density Scan – osteoporosis
  - Dental appointment – awaiting outcome
  - Planning bisphosphonate infusion
  - Regular Calcium / magnesium / phosphate
  - Vitamin D level – regular supplementation

- **Eating Management Plan…**
Aims of management plan

- To increase BMI to a safer level and stabilise body weight
- Reduce eating disorder behaviours sufficient to restore medical and behavioural stability
- Assist in the development of appropriate eating behaviour to allow for continued medical stability in the community
- Avoid re-feeding syndrome caused by too rapid re-feeding
- Manage, with the help of psychiatric staff, the behavioural problems common in patients with eating disorder behaviour, such as resisting nutrition, staff splitting, and anxiety.
Lily’s meal time management plan

- Lily must **NOT** consume milk and water or coffee prior to or during meals.
- Lily is required to **consume 50% of a normal meal** in the dining room at the allocated meal times under the supervision of staff.
- After each meal, she is required to **remain in the common area for 1 hour** under the supervision of staff.
If Lily is able to comply with all aspects of the plan, she can then:

- Attend the group walk with her co-patients after breakfast
- After lunch, she can have 1 hour escorted leave with her family to the coffee shop.

If Lily does not consume her meal or supplements then she will not be allowed to take her leave from the unit after that meal time.
Challenges to management plan

- Inconsistent implementation by staff
- Gap in knowledge/skills of staff in managing eating disorders
- Lily’s well engrained eating disorder behaviours
- Impact of physical activity on effectiveness of plan
- Inconsistent recording of meal consumption, fluids, and weights.
- Partner enabling disordered eating behaviour
Opioid use disorder

- Difficult to quantify the exact quantity of opioid use. This included:
  - Liquid codeine (for cough).
  - Endone (for neck pain).
  - Panadine forte (for neck pain).
  - Likely to have gone into withdrawal when admitted to hospital.
  - May have contributed to delirium.
Prior to April Storm:

- Was living with partner in a two story house.
- She lived on first floor, partner lived on ground floor.
- Partner is a hoarder.
- Significant stress in relationship.
- Moved to ground floor after April Storms.
Current situation

- Partner has called it quits. Would like pay out.
- No friends in local area.
- Biological son: Lives in Queensland.
- Adopted daughter: Supportive but lives in Wollongong.
- Adopted son: No contact for many years.
- Condition of house?
Clinical impression

- Major depressive episode. Resolving.
- Generalized anxiety disorder.
- Eating disorder - ? Anorexia nervosa/? Not otherwise specified.
- Opioid used disorder.
- Obsessional traits.
- Coping mechanism: control/avoidance/regression.
- Unresolved childhood trauma.
- Personality disorder?
Psychological assessment

- Overvaluation of shape and weight, although not to the exclusion of other life domains such as hobbies (gardening, painting, playing the piano and ukulele);
- Intense fear of weight gain and fatness (reported that feeling fat equated with being fat);
- Pursuit of weight gain seen as appropriate (reported no reason for treatment or change in eating);
Psychological assessment

- Past over-exercise (jogging, walking, aerobics);
- Selectiveness with food (driven by personal sense of control);
- Co-morbidities (anxiety, low mood, irritability, mood lability – angry outbursts and self-withdrawal).
- Thinking biases (‘all-or-nothing’, ‘discounting the positive’)
Psychological support

- Suitable for Cognitive Behavioural Therapy (CBT):
  - Able to – access negative automatic thoughts; recognise and differentiate emotions; identify personal contribution to psychological difficulties; conceptualise the CBT model; form a therapeutic relationship; remain focused during sessions;
  - Past positive experiences of receiving group-based CBT for regulating mood (in particular, physical interventions such as muscle relaxation exercises and breathing exercises);
  - BUT past negative experiences of receiving CBT for eating disorders.

- Client’s goal for therapy – CBT cognitive interventions for regulating anxiety;
Psychological support

- At MHUOP receiving individual CBT with a primary focus on regulating anxiety and a secondary focus on weight. In particular, cognitive interventions including:
  - Thought recording;
  - Thought challenging;
  - Education – negative spirals, automatic thoughts, unhelpful rules for living, unhelpful thinking styles and behavioural responses, gentle exploration of the effects of being underweight;
  - Socratic questioning – to explore what is causing her to feel less in control; non-food ways of staying in control;

- Expert advice sought from the Centre for Psychotherapy.
Outcomes

- Client reports benefit from psychology support;
- Client has moved beyond superficial therapeutic engagement to active engagement (especially when the client perceives choice, control, and collaboration);
- Noted during therapy: less agitation, fewer instances of self-withdrawal and regression, clearer voice, increased ease of conversation, greater insight on anxiety; more direct but appropriate eye contact.
Current Plan

- Continue current medication.
- Neurocognitive testing to investigate global cognition including executive function.
- Supportive psychotherapy to cope with breakup.
- Development of new techniques to manage anxiety.
- Education around the importance of maintaining a good body weight.
- Optimize body weight prior to discharge from hospital through eating plan.
- Housing?
Eating Disorders in Older People History:

- **Ryle (1936)**
  - Case series n=51 of which 13 cases between ages 30 and 59 years (little detail re diagnostic criteria)

- **Feighner’s criteria (1972)**
  - Exclude diagnosis of anorexia nervosa if age of onset is > 25 years.

- **Dally and Gomez (1979)**
  - Age of onset < 36 years.
Eating Disorders in Older People

History:

- DSM III-R (1987)
  - Begin in adolescence – rare cases up to early thirties.

- DSM-IV (1994)
  - Introduced Binge Eating Disorder.

- Multiple case reports (1970s – 1980s)
  - First onset over age 50.
  - Earlier onset persisting over age 50.
Epidemiology:

- Incidence - insufficient data
- Prevalence
  - 3.8% females (60 – 70 yrs) met criteria for an eating disorder (Mangweth-Matzek 2006)
- Graduates
  - Young onset natural history tends to chronicity
  - With recovery of normal weight 50% still have abnormal attitudes to eating - Hsu (1980)
  - Even those with a single episode with good recovery can remain vulnerable to relapse 50 years later – Cosford and Arnold (1991)
  - Anorexia more likely to graduate than Bulimia (case reports and Review of midlife and beyond by Elran-Barak 2015)
Epidemiology:

- New cases >65 years
  - case reports only
  - Greater association with depression (possibly a causal relationship)

- Young old vs. Old old – no information

- Morbidity – (>40yrs) 60.5% vs (<29yrs) 9.9% report medical symptoms – Elran-Barak (2015). Few > 65 yrs in this study.

- Mortality – no reliable data
Clinical Features:

- Clinical features are similar to younger sufferers – Cosford and Arnold (1992)

- A.N. eating related symptoms
  - Fasting; skipping meals; exercise; purging; laxatives; binge eating
  - No difference between >40 yrs and <25 yrs (Elran-Barak, R et al. 2015)
Relationship with other diagnoses:

- Anxiety disorders?
- OCD
  - Holden (1990)
    - “Is anorexia nervosa an obsessive compulsive disorder?”
    - Pre-morbid obsessional personality traits in anorexia n.
    - In normal individuals starvation intensifies obsessional thoughts about food.
- Mood disorders
  - Depression frequently co-exists
    - Primary vs. Secondary Eating Disorder
Relationship with other diagnoses:

- Grief and Loss
  - Cosford and Arnold (1992) noted several cases were precipitated by death of a spouse or an adult child leaving home.
- Personality disorder ?
- Anorexia of Ageing – a biological perfect storm (contributes to under-diagnosis of Anorexia nervosa)
  - Physiological changes of aging
  - Polypharmacy
  - Medical comorbidities
Aetiology:

- **Early life trauma**
  - Failure of emotional maturation.

- **External losses**
  - An attempt to achieve control in a predisposed person during a time of uncertainty
  - Losses noted in case reports include
    - Death of spouse
    - Retirement
    - Daughter’s marriage

- **Ageing as a stressor**
  - Rediscovery of previous coping strategies
Aetiology:

- Social pressure to be slim
- Genetic predisposition
- Perpetuating factors
  - Social withdrawal
  - Reduced outside interests
  - Power gained over family
Treatment Approaches:

- Review by Cosford and Arnold (1992)
  - No published trials regarding treatment of eating disorders in the elderly

  - Lowest mortality in females 60 – 69 yrs - BMI 27.3 kg/m2
  - Lowest mortality in females 20 – 29 yrs - BMI 19.5 kg/m2

- What works best for this age group? No reliable data…

- Biological
  - Antidepressants
  - ?appetite stimulants – no data
  - Prevention / Treatment of medical comorbidity
    - Sarcopaenia; osteoporosis; anaemia; delayed wound healing
Treatment Approaches:

- Psychological
  - CBT
- Significant others – spouse / carer stress
  - Family therapy
- RANZCP Guidelines remind us of using the least restrictive care
  - Preference for community vs. inpatient care
  - Barriers to community care for older people – frailty, social isolation, medical comorbidity
Post Script:

- Since partner informed her of the need to separate
  - Lily has shown significant improvement in eating behaviour.
  - Continuing contact with partner.
  - Partner’s behaviour -
    - Seems overly affectionate toward Lily
    - Sent a threatening letter to Lily’s daughter about money
    - He told social worker that he wants “$50,000 or half the value of the house”
    - Attempted to get Lily to sign over the car registration to himself
  - Daughter informs that he has arranged for Lily to sign $20,000- to him whilst she was admitted under the Mental Health Act.