

COMMENTARY

Balancing risk requires a balanced approach

COMMENTARY ON... SEVERE AND ENDURING EATING DISORDERS: RECOGNITION AND MANAGEMENT[†]

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SUMMARY

Paul Robinson's article provides an excellent summary of some of the challenges faced by clinicians working with patients with severe and enduring eating disorders (SEED) and outlines a robust approach to the recognition and management of this complex group of patients. This commentary expands on some of the points raised, adds some further views and suggests a tailored approach to establishing a therapeutic alliance with patients and carers.

DECLARATION OF INTEREST

None.

Robinson (2014, this issue) importantly highlights the ego-syntonic nature of the core psychopathology characteristic of severe and enduring eating disorders (SEED), which in chronic cases can become deeply entwined with the sufferer's sense of identity, further perpetuating many of the underlying causative factors and increasing resistance to change. As the length of illness increases, the hopes of recovery dwindle and the core anorexic features and disordered eating behaviours become increasingly self-sustaining. The long-term psychological effects of starvation, such as depression, anxiety, social phobia and cognitive impairment, further perpetuate the illness, leading to increased social isolation, disability and disengagement.

Patients will often have received extensive evidence-based out-patient and community treatments, in addition to numerous lengthy in-patient admissions to specialist eating disorder units, all of which fail to achieve recovery in terms of nutritional rehabilitation and sustained psychological change. Moreover, these admissions are usually punctuated by numerous admissions to local medical units for stabilisation of physical risk and nasogastric feeding. These experiences can be highly traumatic for the patient and their

family and often intensify established feelings of failure, isolation and hopelessness.

Although many patients wish to be free from suffering, they are unable to accept weight gain and interventions aimed at doing so can be perceived as a direct attack on their very being. This creates a dichotomous paradigm whereby the clinician is invariably drawn into making a clinical decision to either enforce treatment, and thereby run the risk of disengagement, increased resistance and suicidality, or actively withdraw from treatment, thereby increasing the likelihood of further physical decline and long-term disability. This paradigm mirrors the cognitive dissonance experienced by the patient, whereby their wish to live is offset by an inability to maintain a weight compatible with life. Invariably, the clinician will at some point encounter feelings of frustration, ambivalence, confusion and ineffectiveness, all the while having to manage the 'quicksand of transference and countertransference in which patient and therapist are frequently and easily snared' (Strober 2004). It is not surprising, therefore, that psychiatrists report a lack of confidence when caring for such patients, particularly in terms of risk management (Jones 2013).

Tailoring treatment

Robinson highlights the physical risk associated with anorexia nervosa, which carries a mortality rate of 6% and standard mortality ratios significantly higher than those seen in other chronic mental health conditions (Arcelus 2011). Much of this heightened risk can be attributed to the array of acute and long-term physical complications associated with the chronic disordered eating behaviours. However, one in five deaths are thought to be due to suicide (Arcelus 2011), highlighting the delicate balance required when managing physical and psychological risk simultaneously. In patients with SEED, where fear of change, lack of insight and limited motivation

[†]See pp. 392–401, this issue.

are common, an overemphasis on weight gain or adopting an autocratic, paternalistic approach to risk management will often lead to an increase in anorexic symptomatology and resistance, with potentially disastrous outcomes. This said, regular physical health monitoring and crisis management must remain a cornerstone of long-term management, and any changes in the nature of this monitoring process (e.g. increasing the frequency of weight and blood monitoring, changes to crisis weight) should be negotiated carefully with the patient and communicated to all parties involved in their care.

In cases where a traditional recovery model approach, i.e. weight gain alongside psychological intervention, has failed, it is often more helpful to shift the goals of treatment towards weight maintenance, with the primary aims of maximising quality of life, reducing hospital admissions and promoting independence. Essential to such an approach is the establishment of a long-term therapeutic alliance between the clinician and the patient: recent research suggests that it is a strong predictor of therapeutic response in terms of both eating disorder psychopathology and depressive symptoms in patients with SEED (Stiles-Shields 2013).

Establishing a therapeutic alliance

We would suggest that clinicians adopt the following tailored approach, similar to that outlined by Strober (2004).

- Give assurances that weight gain will not be the principle objective of treatment and that any steps taken in this area will be negotiated carefully and collaboratively, to avoid panic and regression. Continue to explore the possibility of nutritional change (e.g. challenge narrow diet choices) without the risk of weight gain, so that energy levels may improve. Input from a dietitian experienced in the treatment of SEED is invaluable.
- Offer affirmation of their understanding that the patient's illness is as protective as it is handicapping and that the patient's established routines cannot be radically altered at this time.
- Encourage social activity and engagement in hobbies, with input from an occupational therapist where possible. This may present alternative means of achieving a sense of pleasure and mastery and prevent further social isolation.
- Meet and support families and carers, with the aim of educating them about the nature of SEED and discouraging disparagement of the patient.
- Reassure the patient that the effectiveness of any changes or interventions will be measured

against their tolerance of the anxieties that may be triggered, so that risk of terminating treatment will be minimised.

Given the sometimes exhaustive transference and countertransference experienced during treatment, we would recommend that clinicians should not care for more than three patients with SEED at any one time and that they should have some outlet in terms of supervision to confer about the range of conflicting emotions that they are likely to experience.

Adopting a tailored approach requires an element of positive risk-taking and has implications in terms of service development and risk management at a trust level. The Yorkshire Centre for Eating Disorders in Leeds recently developed a new community-based service specifically designed to meet the needs of patients with SEED that has been shown to improve quality of life, reduce hospital admissions, minimise healthcare costs and improve patient satisfaction (Saeidi 2013).

MARSIPAN and coordinated care

Establishing coordinated care between psychiatric and general medical services for patients with SEED can be extremely challenging and can often result in treatment delays, patient dissatisfaction and an unravelling of interface working at a time when patients need it most. With this in mind, clinicians should be aware of the MARSIPAN report (Robinson 2012; Royal College of Psychiatrists 2014), which offers guidance on the management of patients with severe anorexia nervosa admitted to medical units. It outlines standards in relation to physical risk assessment, location and timing of medical treatment, transfer between services, specialist support for medical teams, medical re-feeding, use of the Mental Health Act and collaborative working between medical and mental health services. In response to the first edition of this report (Royal College of Psychiatrists 2010) a number of MARSIPAN expert working groups have been set up across the UK, consisting of representatives from local medical and specialist eating disorder services who meet regularly to discuss clinical issues, training, care pathways and probity in relation to very sick patients with anorexia nervosa, thus promoting coordinated care.

Conclusions

Working with patients with SEED can be challenging and clinicians are advised to adopt a tailored approach in the long-term management

of this high-risk patient group. This will require an understanding of the psychopathology and developmental theories of chronic anorexia nervosa, knowledge of physical risk and local care pathways, the ability to establish a long-term therapeutic alliance, a willingness to negotiate goals of treatment and the interpersonal skills needed to navigate the transference and countertransference experienced during treatment.

References

- Arcelus J, Mitchell AJ, Wales J (2011) Mortality rates in patients with anorexia nervosa and other eating disorders. *Archives of General Psychiatry*, **68**: 724–31.
- Jones WR, Saeidi S, Morgan JF (2013) Knowledge and attitudes of psychiatrists towards eating disorders. *European Eating Disorders Review*, **21**: 84–8.
- Robinson P (2012) Avoiding deaths in hospital from anorexia nervosa: the MARSIPAN project. *Psychiatrist*, **36**: 109–13.
- Robinson (2014) Severe and enduring eating disorders: recognition and management. *Advances in Psychiatric Treatment*, **20**: 392–401.
- Royal College of Psychiatrists (2010) *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa* (College Report CR162). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2014) *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa* (2nd edn) (College Report CR189). Royal College of Psychiatrists.
- Saeidi S, Fieldsend G, Morgan JF (2013) Managing anorexia nervosa in the community. *Nursing Times*, **109**: 12–4.
- Stiles-Shields C, Touyz S, Hay P, et al (2013) Therapeutic alliance in two treatments for adults with severe and enduring anorexia nervosa. *International Journal of Eating Disorders*, **46**: 783–9.
- Strober (2004) Managing the chronic, treatment-resistant patient with anorexia nervosa. *International Journal of Eating Disorders*, **36**: 245–55.