Anorexia nervosa is the strongest predictor of adolescent mortality with a rate 15 per cent higher than depression (Gowers et al, 2000). The term anorexia nervosa was first coined by Sir William Gull in the late 19th century but knowledge of the illness remained scant until the 1950s. The seminal work by Ancel Keys into starvation, involving a group of conscientious objectors in the 1950s, along with an increase in the popularity of psychiatry, promoted an interest among clinicians in eating disorders. The first specialist eating disorder units opened in the early 1970s. Before this, eating disorders were misunderstood and largely managed within mainstream psychiatric services, often resulting in poor outcomes.

Research into eating disorders has continued and specialist facilities have been found to be the most effective, with patients treated as inpatients, day patients or outpatients depending on individual need (Palmer, 1999). Recent research has focused on the relative benefits of inpatient and outpatient treatment and the types of treatment programme that promote the best outcome.

Gowers et al (2000) studied the impact of hospitalisation on the outcome of adolescent anorexia nervosa. The findings showed that outpatients fared better, although it should be noted that the inpatient unit studied was a general psychiatric ward where the patients were more acutely ill than were the outpatients. This is the case in most comparative studies in this area so there are significant limitations in the available research.

Connan and Treasure (2000) carried out a comparative study of inpatient and outpatient treatment. Results suggested the need for both strategies and found the most important factor was the approach to treatment. An eclectic approach that incorporated psychodynamic, cognitive behavioural, cultural, family work, rather than a purely behavioural approach to food and weight as was the norm, was found to be the best strategy to combat the illness. The study stressed that the exact ratio of each aspect of the approach should be tailored to an individual’s needs.

The eating disorder service
The eating disorder service is a modern, self-contained unit based in the grounds of The Priory Hospital, Roehampton, London, and provides treatment for patients of all ages with eating disorders including anorexia nervosa, bulimia nervosa and related conditions. The service has 18 inpatient beds, 10 day-care places and an outpatient department.

Care is delivered through a multidisciplinary team of professionals. Two staff consultants and a visiting professor lead the clinical team, which consists of clinicians from a variety of backgrounds. The central philosophy of the unit is one of alliance between patients and staff.

On admission each patient is prescribed a period of room rest. This can be for up to two weeks and depends on the individual. Room rest gives the patient an opportunity to reflect upon the aims of admission, and allows them to recuperate physically and begin to tolerate food.

Initially patients are expected to eat a 1500kcal/day diet in their room, increasing to 3000kcal/day during the period of room rest. Patients then take their meals in the communal dining room at the unit, where supportive eating is provided and monitored by a nurse. As they progress through the programme they move to an unsupervised dining room at the unit followed by the main hospital dining room where they serve their own food.

The rationale of this approach is that the patient hands over the control of their food and weight to the team when they are first admitted to hospital. This allows the patient to concentrate on the underlying psychological issues that prompted the onset of their eating disorder. As the patient progresses and reaches target weight, this control is gradually handed back so that the patient learns new ways of managing his or her food and feelings.

The aims of the treatment are to restore normal healthy eating habits and a healthy weight while enabling the patient to discover underlying difficulties and the techniques that can help to manage them. A target weight is calculated according to the age, sex and height of the patient with adjustments being made for the age at which the disorder manifested.

A 1kg band is added to this target weight which acts as a safe boundary for patients and allows for the normal weight fluctuations that occur as they try to maintain their healthy body weight during recovery. Patients are weighed twice weekly after going to the toilet and before breakfast. A dietician monitors the patients’ diets in liaison with the rest of the team.

Psychological and physiological growth are stunted by the onset of the eating disorder. Patients returning to this point are then able to begin the journey towards recovery and confront the issues that precipitated and perpetuated the illness.

The treatment programme
Anorexia nervosa is a chronic disorder. Reaching the patient’s target weight is just the first stage, but it provides a platform for recovery, which may take between two and seven years.
Each patient has a key worker who coordinates the care for the individual and liaises with the multidisciplinary team, the family and outside agencies. An associate worker supports the key worker in this role. Patients also meet with another member of the multidisciplinary team who acts as their ‘logbook partner’.

The logbook is a record of their individual journey towards recovery and acts as a guided form of supportive counselling. Each week the patient chooses a page from the logbook with a different subject heading, for example, ‘my relationship with my mother’. They will then reflect on the chosen topic and explore their feelings with their logbook partner. This is very useful in the early stages of treatment as it prompts patients to start opening up emotionally.

Every patient has an individual therapist who meets with them weekly and undertakes family or couple therapy depending on individual needs. Decisions regarding progress and changes to the care plan are made through multidisciplinary discussion, in consultation with the patient, in the weekly ward rounds.

The unit runs an extensive group therapy programme. An occupational therapist coordinates 25 groups per week. These groups are psychodynamic, cognitive and psycho-educational in approach and also include a broad range of creative therapies, including:

- **Cognitive groups** – exploring and challenging the links between thoughts, feelings, physical symptoms and behaviour and how it might need to change;
- **Small psychodynamic groups** – ‘closed’ groups that help patients get in touch with their feelings in a supportive environment;
- **Assertiveness groups** – encouraging individuals to gain insight into their own behaviour and begin to understand responses from other people, focusing on personal responsibility;
- **Body image groups** – challenging cognitive distortions of body shape and enhancing awareness of the symbolic meanings that the patients have attached to their bodies;
- **Psycho-educational groups** – related to food, eating and biological aspects of health.

Other groups such as art therapy, dance and psychodrama encourage alternative forms of expression for those who struggle to verbalise their feelings. Social groups and organised trips occur regularly to promote interaction and socialisation in a supportive environment.

In addition, patients also engage in swimming, music, yoga and exercise groups depending on their individual care plans. Activity is increased in a supervised and controlled manner because of individual energy requirements and psychological safety; a feature of eating disorders is often the tendency for overactivity.

The group programme is divided into two stages. Stage one is for those patients beginning their recovery, while stage two is for those who are close to their normal body weight. This ensures that the groups are geared towards challenging the relevant issues at each stage of recovery. The occupational therapist meets with patients during the first few days of admission to formulate a specific programme and continues to review this regularly.

As weight increases the physiological and psychological needs of the individual change. Underlying issues are slowly exposed as the patients are faced with a similar physical and mental state to that at the onset of the illness. It can be very distressing for the patient to get in touch with these feelings. The key worker, individual therapist and therapy groups provide support and help patients to explore these issues in a safe environment. This helps to prevent relapses of the eating disorder.

As patients reach their target weight and move through the programme they become more independent and take increased and graduated responsibility for their eating. Patients partake in meal preparation where they shop for food and return to cook for themselves at the unit. They may also go shopping for clothes with their key worker or visit a restaurant. Patients also begin planned visits and overnight stays at home to facilitate the transition from hospitalisation to the partial hospitalisation or day-care phase.

Day care may be initially from 8am to 8pm, seven days a week, depending on the needs of the patient. This will be reduced gradually until discharge to outpatient care where support and treatment is delivered by the consultant, dietitian and individual therapist.

Training, ongoing research projects and clinical effectiveness are integral to the service’s commitment to maintaining and improving standards of care and treatment efficacy.

**Audit of treatment outcomes**

This audit was completed at the end of 2001. It looked into the outcomes of treatment for all patients with anorexia nervosa admitted to the unit in 1997.

In 1997, 31 patients were admitted to the unit. The following data was recorded:

- **Age**;
- **Height**;
- **Initial weight and body mass index (BMI)**;
- **Speed of weight gain**.

Four years later, the former patients and their relatives were given a semi-structured interview on the telephone. The researcher had not had previous contact with the former patients or their families and had not been working on the unit in 1997. The aims of the interviews were to gain information about the former patient’s current weight, eating habits, social and working lives, whether they had required further treatment and how satisfactorily they rated their experience of the unit.

**Results**

Eight of the patients were not included in the study as four did not have anorexia nervosa and four did not manage to reach their target weight. Twenty-three patients successfully reached their target weight and completed the programme.

The researcher managed to contact 20 out of 23 former patients. Four of the 20 patients required readmission; two of them were at normal weight and were progress-
and has since successfully completed her university degree. She is now working as a full-time research officer.

Ms Collinford says that the most positive aspects of the programme for her were the help and support from the intensive group programme. ‘It increased my confidence and improved my social interaction,’ she says. ‘I found it very supportive sharing difficulties with others. The help and support from the team enabled me to explore my fears. Ultimately the programme gave me my life back.

‘I was obsessed with food every waking moment, I was very isolated and couldn’t relate to others. Now my confidence has improved, I am holding down a full-time job and feel like I am really me now. I still have bad days but I now have the skills and understanding to pick myself up from these and carry on.’ Her comments reflect many of those found in the audit.

**Conclusion**

There have been a limited number of audits carried out on eating disorder services. Long-term follow-up studies are notoriously difficult to execute and evaluate. Of the studies that have been carried out, varying results have been found. Button and Marshall (1997) studied the progress and service consumption of a cohort of 100 referrals to an eating disorder service over a 2-4 year period. European Eating Disorder Review; 5: 1, 47-63.


**TABLE 1 PATIENT PROFILE**

<table>
<thead>
<tr>
<th>Average age:</th>
<th>20 years 2 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average admission BMI:</td>
<td>15.0</td>
</tr>
<tr>
<td>Average target BMI:</td>
<td>19.58</td>
</tr>
<tr>
<td>Average weight gain per week:</td>
<td>1.04kg</td>
</tr>
<tr>
<td>Average percentage below mean weight for height and age:</td>
<td>27.2%</td>
</tr>
</tbody>
</table>

For related articles on this subject and links to relevant websites see www.nursingtimes.net