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ORIGINAL ARTICLE

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Evidence of effectiveness of specialist supportive clinical management for anorexia nervosa in routine clinical practice: Outcomes from a clinical case series

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Abstract

Objective: This study provides a preliminary report on the effectiveness of Specialist Supportive Clinical Management (SSCM) in a clinical case series of adults with anorexia nervosa, to supplement evidence of efficacy from controlled trials.

Method: Body mass index (BMI), eating disorder symptoms, mood and anxiety were measured at the start and end of treatment for 42 adults who received SSCM in a community eating disorders service.

Results: Significant improvements were observed on all outcome measures, with larger effect sizes for symptom change than BMI. Recovery rates appear similar to those in clinical trials.

Discussion: The study offers preliminary support for the effectiveness of SSCM in routine settings and identifies several areas for further research.

KEYWORDS
anorexia nervosa, eating disorders, psychological therapy, SSCM

1 | INTRODUCTION

The treatment of anorexia nervosa (AN) poses a challenge to eating disorders (ED) services. The standardized mortality rate is elevated (Arcelus et al., 2011), recovery rates are low (13%–50%; Wonderlich et al., 2020), and although psychological therapies are the recommended treatment, dropout rates are consistently high (DeJong et al., 2012). A recent comprehensive review which looked at outcomes for adults with AN noted modest positive effects on body mass index (BMI), ED symptoms and quality of life, with no significant differences between therapies, indicating the lack of a superior treatment (Jansingh et al., 2020). Therefore, it is necessary to identify more effective treatments and the factors associated with greater effectiveness.

One approach requiring further evaluation is Specialist Supportive Clinical Management (SSCM; McIntosh et al., 2006). This is a supportive therapy that combines two central tenets. The first being the need for clinical management, which focusses on improving weight and normalizing eating behaviors using psychoeducation, nutritional advice, and the monitoring of weight and target symptoms. Time can also be given to considering the potential for relapse, with the therapist working alongside the client to encourage them to build upon their progress in between sessions and following the completion of treatment. Second, it is important that while clinical management tasks are attended to with the primary aim of weight restoration, clients are encouraged to lead the sessions and may use the time to initiate exploration of broader emotional issues if they wish. The therapist

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should demonstrate warmth, empathy, and reflective encouragement without attempting to "fix" difficulties through use of other psychological models or tools. The overarching aim is to develop a strong therapeutic alliance to foster motivation and enable change through collaborative working (McIntosh et al., 2006).

SSCM appears to be equally effective to other leading ED therapies (Kiely et al., 2022; NICE, 2017). SSCM was initially developed as an active control intervention in an RCT comparing Cognitive Behavioral Therapy (CBT) and IPT; however, SSCM emerged as superior to IPT in the intent-to-treat analysis, and superior to both IPT and CBT among completers (McIntosh et al., 2005). Subsequently, SSCM has featured in a further five treatment trials for adults with AN, as a comparison to CBT (Touyz et al., 2013), CBT-Enhanced (CBT-E; Byrne et al., 2017), the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA; Byrne et al., 2017; Schmidt et al., 2012; Schmidt et al., 2015) and Mentalization-based therapy (MBT-ED; Robinson et al., 2016). In all trials, SSCM performed equally to the comparison treatments. It has been suggested that the lack of detectable differences between treatments could be attributed to non-specific factors common to all AN therapies (Byrne et al., 2017; McIntosh et al., 2006). Nonetheless, the inclusion of these common elements in SSCM suggests intrinsic value as a treatment (Byrne et al., 2017; Jordan et al., 2020).

Nonetheless, the effectiveness of SSCM requires further evaluation. To date, SSCM has only been evaluated in RCTs, which provide moderate indications of efficacy (which is comparable to the other treatments discussed above), but does not demonstrate effectiveness when delivered in routine practice. These trials employ well-controlled designs, observations of therapist adherence, and typically apply tight inclusion criteria targeting mild to moderate illness, although one trial involving SSCM included participants with severe and enduring presentations (Touyz et al., 2013). Therefore, there is a need to conduct effectiveness studies to investigate whether similar outcomes can be achieved in routine clinical settings, where the diversity of cases is greater (including severity or chronicity of illness and presence of comorbidities). This approach has recently been adopted to explore whether evidence-based treatments can be delivered in routine clinical settings with similar patient outcomes (Turner et al., 2015).

The present study reports outcomes from a case series of adults with AN who received SSCM in a routine clinical setting, to provide a preliminary estimate of the effectiveness of this treatment outside controlled trials. The primary outcomes were the change in BMI and ED pathology between the start and end of treatment, while secondary outcomes were changes in mood and anxiety symptoms.

2 | METHOD

2.1 | Ethics

The study involved the analysis of data routinely collected by the service, so National Research Ethics Service approval was not required. Approval was granted at a local level for the analysis of secondary data (ERGO ID: 64209).

Individuals accessing the service are routinely given an information sheet explaining that their anonymized data may be used for service evaluation purposes, and encouraged to discuss any concerns. Completing these measures indicated implicit assent unless stated otherwise.

2.2 | Participants

Participants were 45 individuals referred to an NHS Community Eating Disorders Service in the UK and offered treatment with SSCM. All had an initial assessment based on the Eating Disorders Examination (EDE version 16, Fairburn, 2008) or a semi-structured interview (Waller et al., 2007) and had been diagnosed with AN, AN-partial remission or Atypical AN (under the category "Other Specified Feeding or Eating Disorder"; OSFED), according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013). Following assessment treatment options (as per NICE guidelines, 2017) are discussed with patients and this sample consists of those who opted for SSCM. Of the 45 offered, 42 participants agreed to start SSCM, resulting in a sample of 42.

2.3 | Outcome measures

Several measures are routinely administered by the service to monitor ED symptoms, mood and anxiety, and participants completed all measures at the start and end of treatment.

The Eating Disorder Examination Questionnaire (EDE-Q 6.0; Fairburn & Beglin, 2008) is a self-report version of the Eating Disorder Examination Interview (Fairburn, 2008). The EDE-Q assesses core ED-related attitudes and behaviors over the previous 28 days, and has been found to have similar validity to the EDE Interview (Fairburn & Beglin, 1994). Community normative scores are available for both women (Mond et al., 2006) and men (Lavender et al., 2010).

The ED-15 (Tatham et al., 2015) is a validated brief symptom measure of weekly changes in symptoms during treatment. The first 10 items capture ED-related attitudes, separated into weight/shape concerns and eating concerns, while the remaining items assess the frequency of behavioral symptoms.

Two widely used measures of anxiety and mood, the Generalized Anxiety Disorder Assessment (GAD-7, Spitzer et al., 2006) and the Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001) were used to assess features of anxiety and depression, respectively.

2.4 | Treatment

Treatment was delivered by an experienced Eating Disorders Nurse Specialist, who received regular clinical supervision and had attended

a 2 day training course on SSCM run by the British Psychological Society. This was delivered by one of the authors of the SSCM manual. Essential components of treatment included weekly weighing and monitoring of behavioral symptoms, collaborative goal-setting, psychoeducation, practical advice, and support and, in later sessions, relapse prevention (McIntosh et al., 2006). Sessions were usually weekly, but could be flexible depending on clients' needs. Most clients were treated prior to the COVID-19 pandemic, and therefore attended face-to-face sessions. Treatment was initially contracted for six sessions, then reviewed and extended up to a maximum of 20, depending on the client's progress toward their goals and active engagement in treatment. Treatment was reviewed earlier if there were concerns regarding progress, engagement, or risk.

2.5 | Data analysis

All analyses were conducted following the intention-to-treat principle, involving carrying forward the last available observation point. The number of participants included in the sample varied due to the variability of completed questionnaires and the resulting missing data (see *N* values in Table 1). After determining suitability for parametric tests, changes in BMI, eating pathology, mood and anxiety between the start and end of treatment were investigated using paired samples *t*-tests. Bonferroni corrections were applied to the EDE-Q and ED-15 subscales, to correct for multiple tests. Both measures were analyzed as the EDE-Q is reported in previous research and the ED-15 was administered weekly, therefore providing the most recent information for each participant. Due to the lack of previous research in routine clinical samples to inform expected effect sizes, achieved power was calculated post hoc using GPower 3.1 (Faul et al., 2007). Recovery was measured based on participants restoring weight to BMI > 18.5 kg/m^2, and/or achieving an EDE-Q global score less than 1*SD* above the community mean (2.77 for females and 2.09 for males). Recovery rates at last observation were calculated as percentages.

3 | RESULTS

3.1 | Participant characteristics

Of the 45 participants offered SSCM Figure 1, 3 chose not to take up treatment and are not involved in the analysis, leaving a sample of 42, of whom 38 were female and 4 were male, with an average age of 27.65 years (*SD* = 11.32, range = 18–56). The average BMI at the start of treatment was 16.78 kg/m^2 (*SD* = 1.53, range = 12.60–20.10). Participants attended an average of 9.32 sessions (*SD* = 4.86, range = 2–20).

3.2 | Treatment outcomes

Table 1 shows the changes in primary and secondary outcomes from the start to end of treatment. The average change in BMI was an increase of .52 kg/m^2, reaching statistical significance with a small effect size. Significant improvements were observed on all scales of both eating pathology measures (indicated by a reduction in scores), with medium to large effect sizes.

Significant reductions in scores were also observed on the GAD-7 and PHQ-9, with medium effect sizes, indicating improvements in anxiety and depression symptoms.

TABLE 1 Change in primary and secondary outcomes between the start and end of treatment (using intention-to-treat analysis).

				Paired *t*-test				95% CIs	
	N	Start of treatment *M* (*SD*)	End of treatment *M* (*SD*)	Mean difference	*r*	*t*	*p*	*d*	Lower–upper	Achieved power
BMI	33	16.78 (1.53)	17.30 (2.04)	−.52 (1.36)	.747	−2.215	.034	−.386	−.737 to −.029	.58
ED-15										
Weight and shape concerns	32	3.51 (1.46)	2.82 (1.68)	.68 (1.51)	.545	2.557	.016	.452	.084–.813	.69
Eating concerns	32	4.38 (1.07)	3.20 (1.55)	1.19 (1.14)	.679	5.876	<.001	1.039	.602–1.465	.99
Global score	32	3.85 (1.14)	2.98 (1.53)	.88 (1.27)	.579	3.900	<.001	.689	.299–1.071	.96
EDE-Q										
Restraint	31	3.81 (1.36)	2.00 (1.61)	1.81 (1.79)	.279	5.612	<.001	1.008	.568–1.436	.99
Eating concerns	31	3.43 (1.41)	2.07 (1.66)	1.35 (1.37)	.612	5.491	<.001	.986	.550–1.412	.99
Shape concerns	31	4.05 (1.27)	2.97 (1.80)	1.08 (1.32)	.680	4.567	<.001	.82	.407–1.223	.99
Weight concerns	31	3.73 (1.31)	2.50 (1.66)	1.22 (1.20)	.698	5.678	<.001	1.02	.578–1.450	.99
Global score	31	3.75 (1.13)	2.39 (1.56)	1.37 (1.26)	.603	6.059	<.001	1.088	.636–1.529	.99
GAD-7	31	13.45 (6.02)	9.77 (6.03)	3.68 (5.00)	.617	4.087	<.001	.734	.332–1.127	.98
PHQ-9	31	13.61 (72)	9.48 (6.62)	4.13 (6.78)	.484	3.390	.002	.609	.221–.989	.91

Abbreviations: BMI, body mass index; ED-15, Eating Disorder-15 item; EDE-Q, Eating Disorder Examination Questionnaire; GAD-7, Generalized Anxiety Disorder-7 item; PHQ-9, Patient Health Questionnaire-9 item.

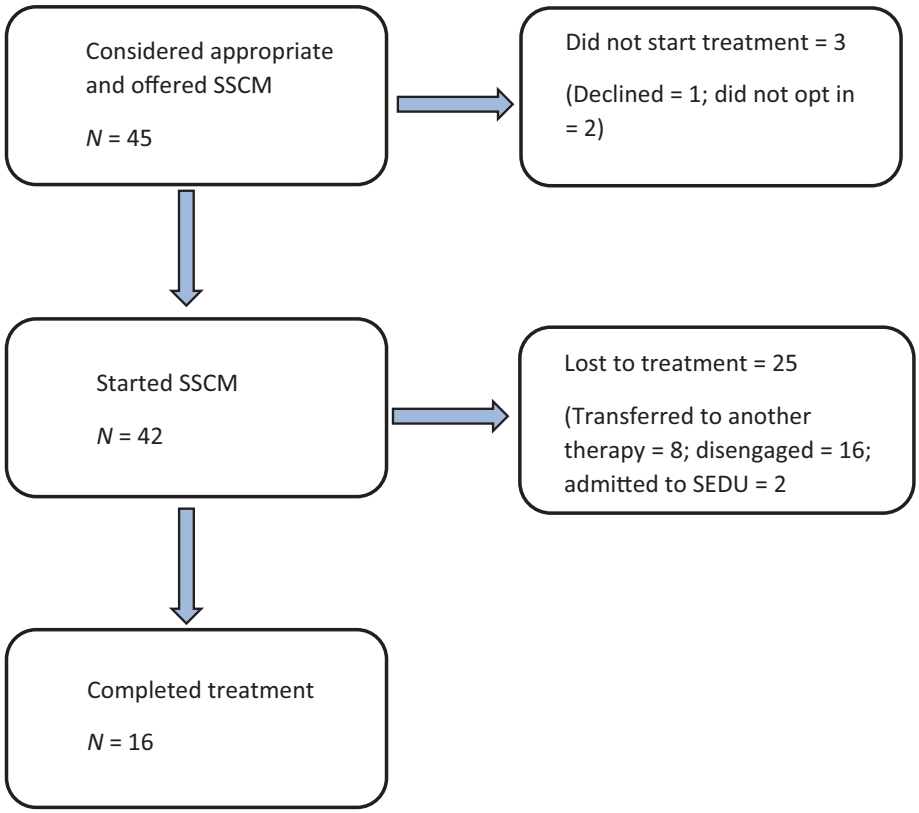

FIGURE 1 CONSORT diagram showing recruitment, retention and attrition of patients undertaking SSCM.

3.3 | Recovery rates

In this clinical case series, recovery was defined in three ways, based on achieving BMI > 18.5 kg/m^2, reporting an EDE-Q global score less than 1*SD* above the community mean (2.77 for females and 2.09 for males), or meeting both criteria. Using intent-to-treat analysis, 18.18% ($n = 3$ of the completers) of participants had achieved BMI > 18.5, 58.06% ($n = 6$ of the completers) reported a normal EDE-Q score, and 16.67% ($n = 6$ of the completers) met both criteria.

4 | DISCUSSION

This study offers a preliminary evaluation of the effectiveness of SSCM in a clinical case series of adults with AN. Significant improvements were observed for all outcomes, with a small effect size for BMI, and medium to large effect sizes for ED symptoms and mood. One possible explanation for this discrepancy is that weight gain may rely on behavioral and attitudinal change (as captured in symptom measures), and therefore requires more time, which is particularly pertinent as the mean number of sessions attended was lower than in RCTs.

Overall recovery rates in this case series (18.18% of participants achieved BMI > 18.5, 58.06% reported a normal EDE-Q score and 16.67% met both criteria) appear intermediate to those for SSCM in RCTs, where this information was available (12.73%–32.5%; Byrne et al., 2017; Schmidt et al., 2012; Schmidt et al., 2015), though this study had a lower proportion of participants achieving a BMI > 18.5. Although the treatment outcomes appear generally consistent with those reported in RCTs (while acknowledging the limitations of a significantly smaller sample size) definitive comparisons of the magnitude of change would not be reliable without standardization to account for the greater variability in this sample. Therefore, direct comparison with previous RCTs may not be possible due to the potential heterogeneity within respective data sets related to factors such as severity, duration of illness, and presence of any co-morbidities.

Nonetheless, the degree of improvement in BMI required to indicate effectiveness is unclear, as clinically significant change (Jacobson & Truax, 1991) is difficult to define with respect to BMI and is necessarily individually determined (Schlegl et al., 2014). Furthermore, it is often challenging to accurately define recovery, with definitions varying between studies and challenges evident when attempting to in reach a consensus (Dawson et al., 2015). A further reflection relates to treatment dose. Within the current study, length of treatment was determined collaboratively between patient and therapist. Ending of treatment was indicated normally through a mutual discussion and agreement that the patient had achieved their own personal therapy goals and felt a subjective improvement in their quality of life and symptoms, the timing of which varying across the sample. Therefore, treatment dose did not always replicate those of previously discussed RCTs. While arguably a limitation of this study, the nature of personalized care plans (with flexible treatment dose) within this clinical setting is likely to reflect routine clinical practice.

Another consideration is the potential limitation of using a single therapist and the implications this may have for treatment outcomes and generalizability. A future direction for research should include data obtained by a group of therapists delivering SSCM from across different services. This would ensure better generalizability of clinical effectiveness both across clinicians and services.

This was the first study to evaluate SSCM in a routine clinical setting, and several areas for improvement and further study are noted. The study was underpowered with respect to BMI, and analysis of follow-up data was not feasible. Replication with a larger sample would allow a more reliable indication of BMI change, ensure that the substantial changes in ED symptom scores were not spurious, and ascertain possible predictors of attrition. Analyzing follow-up data would indicate whether BMI continues to improve, and whether treatment effects are sustained. Additionally, comparing SSCM outcomes with another recommended therapy in the same setting would provide an additional means of investigating effectiveness.

Overall, there is preliminary support for SSCM as an effective treatment in routine clinical practice. Future research should consider possible predictors of treatment outcome, and whether treatment effects are sustained over time.

AUTHOR CONTRIBUTIONS

Francesca Purvis: Conceptualization; data curation; investigation; writing – review and editing. **Alexandra Thorpe:** Data curation; formal analysis; methodology; writing – original draft; writing – review and editing. **Hannah Turner:** Conceptualization; methodology; supervision; validation. **Peter Lawrence:** Supervision.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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