**Psychologically informed care for patients with anorexia nervosa on a medical ward**

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Eating disorders are distressing and challenging illnesses that can affect people of all ages and backgrounds, although they are much more common in women than in men (Galmiche et al., 2019). They often have profound effects on individuals and families, disrupting their social, psychological, physical and occupational functioning. The most commonly seen eating disorders are Binge Eating Disorder, Bulimia Nervosa and Anorexia Nervosa, alongside their atypical presentations (Hay et al., 2017)

It is challenging to accurately gauge the number of people with an eating disorder due to the likelihood of underreporting. However, a meta-analysis by Galmiche et al (2019) identified that the lifetime prevalence rates for eating disorders worldwide were 8.4% for women and 2.2% for men, with anorexia nervosa around 1.4% of women and 0.2% of men, with a significant increase in prevalence over the past two decades. However, the 2019 Health Survey for England (NHS Digital 2020) identified that 16% of adults surveyed screened positive for a possible eating disorder, reporting that worries about food and eating negatively affected on their life, revealing the potential scale of the problem. The prevalence of eating disorders has also likely continued to increase as a result of the coronavirus disease 2019 (COVID-19) pandemic (Taquet et al 2022). Eating disorder symptoms are likely to have been exacerbated for a number of reasons over this time due to in part a combination of social isolation (Touyz et al., 2020); changes to routine and structure; and a temptation to focus more on restrictive eating exercise habits due to changes in accountability, with some individuals feeling that they could ‘give in’ to the eating disorder (Brown et al., 2021) .

Eating disorders often start in adolescence, and are much more common in this age group, with one study suggesting that onset began before the age of 22 years in 75% of cases (Volpe et al 2016). In terms of hospital admissions, in 2021-2022 the most affected age group was 15 years to 19 years with more than 4,000 admissions for anorexia nervosa, followed by 2,200 of those diagnosed in the age group 20 years to 24 years (NHS Digital 2022). Eating disorders are also associated with a worrying high mortality, with a 9 times greater risk when compared with their age-matched counterparts (Auger et al., 2021) emphasising the need to optimise treatment outcomes for those affected.

Symptoms and treatment of anorexia nervosa

While many eating disorders share common symptoms, anorexia nervosa is categorised by a person’s drive to restrict their energy intake relative to their body’s physical requirements, leading to a significantly low body weight in the context of their age, sex, developmental trajectory and physical health (DSM-V-TR, American Psychiatric Association 2022). The individual will also likely present with a strong preoccupation with their weight and body shape which typically represents an overvaluation of this compared with other aspects of their life (Fairburn, 2008), which is likely to cause significant distress (Mitchinson et al., 2017).

Alongside the drive for thinness, the individual may often find it challenging to recognise how unwell they have become. This is often coupled with demonstrating significant body image distortion and dissatisfaction, which perpetuates the cycle of disordered eating and weight loss through the negative mood states it generates (Mitchinson et al., 2017). Many individuals who experience menstruation will notice that this will cease (amenorrhea). Although this symptom is no longer diagnostic, it can represent significant physical health risks and impairment in functioning, and coupled with maintaining a low Body Mass Index (BMI), individuals are at a high risk of bone mineral density loss, osteopetrosis, and subsequent bone fractures (Lopes et al., 2022).

Clinical symptoms such as binge eating and compensatory behaviours such as purging and laxative use are evident in other eating disorders such as bulimia nervosa and binge eating disorder. In anorexia nervosa, these symptoms may or may not be present alongside presenting low weight, but for many who originally have a restrictive form of the illness, bingeing and purging symptoms can frequently become apparent over time, which significantly worsens the nature of the illness (Serra et al., 2022).

While multifactorial in its aetiology, the development of anorexia nervosa is likely related to a complex and interlinked series of risk factors which can be biological, psychological and social in origin. For many people, certain focuses and pressures within society have a significant role, such as the influence of social media and its effect on body image concerns, where social comparison and the ‘thin/fit’ ideal are prevalent (Dane and Bhatia 2023).

The course of anorexia nervosa can be highly variable, with recovery possible at any stage; however, risks of relapse and enduring illness often remain high for many people (National Institute for Health and Care Excellence (NICE) 2019). When diagnosed at an early stage, recovery outcomes are more favourable (Treasure et al 2015); however, anorexia nervosa still represents a significant challenge to healthcare services, since recovery rates remain modest, estimated at between 13-50% after 1-2 years (Wonderlich et al 2020). Recovery is likely to be complicated by the effects of social stigma, with many misconceptions about the presentation of eating disorders and their causes (Schaumberg et al 2017). Therefore, it is likely that stigma has also played a part in individuals delaying seeking help with their symptoms (Ali et al 2017).

Outpatient psychological therapy is the preferred first-line treatment for anorexia nervosa; however, many people are unable to access this in a timely way, as the process of both seeking help for onward referral and accessing a specialist service can be many years in duration (Austin et al., 2020). This may go some way to explain deterioration in the community, and the delay in accessing specialist care and thus starting recovery can be associated with a poorer prognosis in the context of the benefit of early change (Vall & Wade., 2016). . A lack of training for GPs in the core knowledge about eating disorders may also be a barrier for individuals in accessing treatment or the early signs of these illnesses being identified (Beat 2023). As a result, many people will need more intensive treatment for anorexia nervosa, such as day patient, specialist eating disorder admission or medical admissions in the event of significant deterioration to prevent loss of life (Treasure et al., 2021). In accordance with NICE (2020) guidelines, this should be in an age-appropriate setting and in a hospital as close to the person’s home as possible. In a specialist eating disorder unit, treatments are likely to combine weight restoration and psychological therapies and support, whilst in the acute medical ward medical stabilisation, safe refeeding and weight restoration would be prioritised.

Medical risks associated with anorexia nervosa

With the rise in admissions and physical complications associated with the effects of anorexia nervosa (NHS Digital, 2022), attention has focused on acute care and the safe management of patients presenting with urgent need for refeeding in general hospitals. In some cases, the care of people with anorexia nervosa was not adequately optimised often due to the complex nature of the condition in relation to fears around refeeding complications, which can be lethal in malnourished individuals (Staab et al., 2022). There is clear evidence of failings in specialist eating disorder services, acute medical settings and primary care, which were highlighted in the report produced by the Parliamentary and Health Service Ombudsman (2017) on the case of Averil Hart, a patient with anorexia nervosa who died in 2012 of hypoglycaemia in what was considered to be a preventable death. This report showed serious shortfalls in communication and coordination between services, and the importance of appropriate professional training.

These concerns have been addressed in the new Managing Medical Emergencies in Eating Disorders guidance (Royal College of Psychiatrists 2023), which seeks to outline safe practice guidelines through the clearer parameters indicating severity of medical risk. The guidance includes a risk assessment framework and accessible checklists to ensure that acute medical risk is easily identified and acted on, covering a range of physical parameters such as pulse, blood pressure, cardiac function, temperature, and biochemical and haematological abnormalities. This aims to aid healthcare professionals in understanding which presenting symptoms should be perceived as ‘red flags’ and how someone unwell with an eating disorder may present from a holistic viewpoint.

While the patient should always be considered an active participant in their recovery, at this stage in their treatment, it is possible that high levels of ambivalence may preclude their ability to make the autonomous change related behaviours that would be expected within most evidence-based psychological therapies (Gulliksen et al., 2015). . Although the priority must initially be safe refeeding and weight restoration in the acute medical setting (Attia and Walsh 2023), there are several approaches that nurses can take to support day-to-day ward care while patients recover enough physically to access specialist mental health interventions.

Psychological effects of anorexia nervosa

Despite clearer guidance on the care of patients with eating disorders in medical emergencies (Royal College of Psychiatrists 2023), many challenges for nurses still remain in caring for patients with anorexia nervosa on medical wards. A particular challenge is how to support the process of recovery in patients experiencing an insidious and challenging illness that often seeks to undermine the life-saving care plans put in place by members of the multidisciplinary team (Fixsen et al 2023). An intense anxiety related to weight gain is likely at the core of a patient’s presentation from a psychological perspective, but this can present in different ways. For example, in the authors’ clinical experience it is not unusual to see a high level of compliance and treatment adherence from an individual who is internally terrified at the prospect of change and weight gain, and may turn their distress and turmoil inwards, perhaps resulting in self-harming behaviours. Indeed, the evidence shows that up to 72% of people with eating disorders also engage in self-harm behaviours, with this being particularly apparent in those with a binge-purge element to their illness (Kostro et al 2014, Sagiv and Gvion 2020).

Conversely, due to the desperation they are feeling in combination with possible low motivation to recover, coupled with the benefits the individual may see in continued restriction, others may become overtly distressed and even aggressive towards those treating them, seeking to undermine treatment, for example by declining oral food and supplements or covertly tampering with or purging nasogastric feeds. Individuals may also seek to influence others to inadvertently collude with their illness to interfere with their treatment plan in an attempt to satisfy the illness which is driving for thinness and control (Kells & Kelly-Weeder, 2016.)

Therefore, it is important for nurses to be aware of the psychological symptoms that the patient may present with and to understand how these symptoms could affect their response to treatment. For example, a distorted body image, compounded by the effects of starvation on the brain, might mean that the patient feels unable to agree to life-saving treatment such as refeeding, and the anxiety associated with weight gain and potentially losing control of this. might manifest through panic attacks and episodes of high expressed emotions. The individual may also feel a sense of achievement when they lose more weight, despite already being gravely unwell. Cognitive impairment linked to low BMI could also certainly affect the individual's ability to opt for recovery orientated treatment, which in turn becomes a maintaining factor of the illness for many (Zakzanis et al., 2010).

The presentation of anorexia nervosa can be further complicated by the presence of a depressive mood state. This is often multifactorial in nature and, while complex in aetiology, it is thought that associated low mood in patients with anorexia nervosa is likely to stem from a combination of psychological and physical factors, both related to the eating disorder and, in some cases, pre-morbid (Godart et al 2007). Anorexia nervosa may give rise to self-harming behaviours and suicidal ideation, as well as cognitive deficits such as altered level of concentration and attention, and memory issues (Smith et al 2018). This can complicate orientating a patient to their treatment plan or may mean that they find it challenging to understand certain ward routines. Some patients who are undergoing refeeding may attempt to compensate for the increase in oral or nasogastric intake through potentially harmful means, for example by taking laxatives, diuretics or diet pills that they may have brought in from home. Some individuals may induce vomiting or exercise in a covert way in an attempt to lose calories. (MEED guidelines; Royal College of Psychiatrists, 2022).

Challenges in the medical ward environment

The acute ward environment is fast-paced and not always optimally designed to monitor people with an eating disorder with severely compromised physical health. Due to the nature of the ward environment, a person who engages in compensatory behaviours can often do so successfully, which could lead to significant deterioration if weight restoration is prevented. This deterioration and potential risk of death is preventable; however, in this environment it is highly challenging for healthcare staff to monitor all of these patients’ mealtimes, times off the ward and visits to the bathroom. It can also be distressing for staff to watch and to monitor these patients for long periods of time leading to feelings of stress and exasperation (MEED guidelines; Royal College of Psychiatrists, 2022).

The way in which patients are weighed frequently and assessed on this while in a busy acute ward environment means that it can be challenging for nurses to provide the psychological support that is necessary to undertake such tasks. This means that people with eating disorders, whose cognitive and physical functioning is already significantly compromised, are not provided with this adequate support during this emotive task. The resulting distress may be linked in part to the continual emphasis on the individual’s outer appearance (whilst neglecting the inner psychological turmoil), as well as the conflict that the weight on the scales may generate internally, such as the feeling ‘I'm not sick enough’ (Eiring et al., 2021).

In addition, there is a significant link between eating disorders and neurodiversity (Westwood et al 2017, Kerr-Gaffney et al 2021). Research has demonstrated that there is a higher prevalence of autism in individuals receiving treatment for anorexia nervosa, and many autistic women experience prolonged eating disorder symptoms (Saure et al 2020). Furthermore, even specialist eating disorder inpatient settings can present challenges for autistic women due to the need to adapt to new routines as part of their care (Babb et al 2021). It is therefore conceivable that a high-stimulus acute ward environment may further exacerbate things for a group of people who exhibit a combination of anorexia nervosa and autistic traits who often face a poorer prognosis in standard care within eating disorders (Tchanchuria et al., 2016). An awareness of the needs of this client group and possible clinical overlap is likely to encourage more tailored treatments within clinical teams to facilitate in more successful recovery related treatment (Tchanchuria et al., 2019).

Psychological informed guidance for adult nurses

It is important to acknowledge may challenges that caring for someone with anorexia nervosa can generate , and the associated stress this can lead to, even for experienced and specialised teams. Nurses strive to care compassionately and to collaborate with patients to achieve shared goals and outcomes. However, when the person does not agree with their care plan, or if this is being enforced on them in their best interests under the Mental Health Act 1983 (amended 2007) in the UK, then significant challenges can arise, including fractures in the therapeutic relationship and team splitting. This act can enforce life-saving treatment resulting from mental disorder under a specific framework and set of safeguards.

Stigmatising beliefs about eating disorders from some healthcare professionals, who may attribute blame to the individuals and feel that they are at least partly responsible for their illness, may be evident in healthcare settings (McNicholas et al 2016). Such beliefs may be driven by uncertainty and a lack of confidence in caring for this patient group due to limited previous exposure or training, which may subsequently lead to fear or avoidance. Stigma may compound the shame and isolation that the individual feels due to their own self-stigmatisation and may thus reinforce the negative symptoms of the illness, affecting their longer-term recovery (Foran et al 2020). Therefore, it is important for nurses to use a non-judgmental approach when supporting patients with anorexia nervosa or other eating disorders, and to recognise and reflect on any pre-existing biases or judgements they might have about these illnesses.

Communication can be a challenging area and might be intensified by a sense of mutual distrust between nurse and patient. Communication can be further complicated when the patient is subject to restrictions under the Mental Health Act 1983 (amended 2007), and nurses may be unsure about whether honesty and clarity in terms of divulging treatment plans is likely to helpful or instead perceived as inflammatory. In the context of healthcare environments, which are likely to be highly stressful with associated increased levels of emotional demands, communication is likely to become increasingly fraught (Yorke et al 2018). Among the likely effects of starvation on cognitive function, it is vital to recognise the underlying emotions in patients with anorexia nervosa and acknowledge that they may currently feel ambivalent about change.

Even if the individual requires treatment under the Mental Health Act 1983 (amended 2007), it is vital to work collaboratively with them and their family, and to be clear about treatment and recovery goals so that the patient feels they are being treated as an equal and an active participant in their care (Sly et al 2014). Weight restoration is often a highly sensitive area, but keeping the conversations out in the open can dissuade the secretive side of the illness and ensures that clear expectations and boundaries are established. The nurse may find that the individual feels relieved to have responsibility over the agonising decision to eat taken from them, and may find that a calm, clear and honest communication style helps to develop a trusting relationship (Salzmann-Erikson & Dahlen, 2017). From our clinical experience, it is preferable to sidestep conversations about calories, specifics of weight gain and body image and instead focus on the underlying emotion, or onto more neutral ground.

While the nurse may wish to provide reassurance about the patient’s weight, appearance, or components of meal given for example, the relief that the patient feels from it can be short lived, and the nurse may inadvertently collude with or reinforce eating disordered cognitions, thus strengthening the illness (Treasure et al., 2011). Talking about interests outside of their eating disorder and engaging patients in meaningful activities while on the ward is likely to have a greater therapeutic effect. (Snowden and Gelling 2022). Even having simple conversations and encouraging the use of distraction techniques can be helpful at particularly challenging or distressing times for the patient such as during and after meal times (Monaghan & Doyle, 2023). Any attempts to enhance the therapeutic relationship when the patient is in distress is likely to have a positive effect on treatment outcomes (Sly et al 2013), thus support the patient’s recovery.

When supporting a patient to engage with refeeding and associated physical monitoring, it is vital to provide as much psychological support as possible to improve adherence and optimise recovery. Nurses can find it particularly frustrating when the patient appears ambivalent about behaviour change (Tierney 2008), which may lead them to become tempted to enter a ‘battle of wills’ or attempt to convince the patient with reasoning.

In some cases, when the risk to life is severe, physical restraint needs to be used in an individual who is so unwell they are compelled to tamper with or decline nasogastric feeding, Due to the risks associated with restraint, it should be undertaken only as a last resort for the least time possible, and under the Mental Health Act 1983 (amended 2007) to ensure that all safeguards are adhered to, with other supportive techniques utilised first. It should also be planned and managed carefully with mental health liaison teams. These teams are usually based in the hospital and they comprise specialist practitioners, typically including mental health nurses, psychologists and psychiatrists. They are well placed to support and inform care planning from a psychological perspective, with the benefit of having a psychiatric overview of the nature of the eating disorder and how it may manifest, combined with understanding the nature of the physical complications of the illness (MEED guidelines, Royal College of Psychiatrists, 2022)

Other techniques to encourage the patient to feel empowered in relation to their treatment should be prioritised. This might involve educating the patient on the effects of starvation and the rationale for refeeding, undertaken in collaboration with specialist dietitians, as well as discussing the risks associated with compensatory behaviours (Attia and Walsh 2023). It may be helpful for some patients to conceptualise oral or nasogastric food intake as ‘medicine’, which nurses can encourage if appropriate. At times of feeds, nurses can provide support by validating the effort of the patient and acknowledging their difficulties to enable them to feel heard and understood. These meaningful interactions can also encourage connectedness and foster feelings of hope, which may subsequently reduce emotional distress and suicidal ideation originating from the patient feeling they are ‘a burden’ (Stavarski et al 2019).

Most nurses practising in the adult field of nursing are not trained specifically in how to support people who are experiencing an eating disorder. However, the physical health monitoring tools are typically in place to manage physical deterioration, so the psychological component is around feeling confident and not being scared to talk to people with mental illness. Arguably one of the most significant challenges of mental illness is the associated stigma, which can sometimes be compounded due to healthcare professionals’ lack of confidence or knowledge, resulting in people with mental illness being ignored in general settings or stigmatised. To address this, supervision and oversight from an adult community eating disorders service of the individual’s overall care, in collaboration with the mental health liaison team , can be beneficial.

Partnership working between the mental health liaison team, ward teams, as well as specialist eating disorder services can support with monitoring the patient’s day-to-day mental health and its effects on their physical health. This may be especially useful to support and enhance the ward team’s understanding of the complexities of the illness and how it may be manifesting on the ward. Additionally, it can support understanding and managing risks around the patient’s potential for physical deterioration, for example if they are still losing weight, which may not be immediately explainable. When a person is admitted to inpatient care for medical stabilisation, it is best practice for their family and carers to be involved, to have a clear care and management plan across all agencies (including community services) aimed at enhancing the effectiveness of medical management and to support transitions to more appropriate settings, such as to specialist eating disorder units, if indicated to support onward recovery. (NICE 2018).

Conclusion

Caring for patients with anorexia nervosa in a medical ward can be challenging for nurses, fraught with emotions and fears around ‘saying the wrong thing’. Complications arise when the patient is unable to agree to life-saving care, thus complicating the dynamic between the nurse and patient and potentially meaning that optimal care cannot be cannot be provided. Knowledge of the physical and psychological risks that are common among this group is essential when supporting patients with anorexia nervosa.

To support patients’ recovery, it is important to adopt a calm, empathetic and non-judgemental approach. In addition, maintaining direct and honest communication and attempting to nurture what is often a fragile therapeutic relationship can directly enhance the quality of care that patients receive and thus improve treatment outcomes.

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