Working with a relapse prevention plan to prevent or early detect relapse in patients with anorexia nervosa
This Guideline is a collaboration between Rintveld Center for Eating Disorders and Research Group Mental Health Nursing Inholland. It is developed in the context of the Master Advanced Nursing Practice (2010).

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1 Introduction

1.1 Introduction

Anorexia nervosa is a severe psychiatric disorder which can be defined as refusal to maintain bodyweight at or above a minimally normal weight for one’s age and height. Patients with anorexia nervosa are usually extremely underweight which seriously threatens their physical and mental functioning. This disease is a major hindrance to patients’ psychosocial development and functioning. Anorexia nervosa is a disorder that predominantly affects girls and young women. The lifetime prevalence among women is 2% (Smink, Van Hoek & Hoek, 2012). The highest annual incidence is 109 per 100,000 women aged between fifteen and nineteen (Van Son et al., 2006). The patients in this age category are the largest risk group for anorexia nervosa. Based on his systematic review, Steinhausen (2009) concluded that adults with anorexia nervosa have a 5% mortality rate compared with the 1.8% mortality rate in adolescents with anorexia nervosa. The chance for recovery from this disease is estimated at 47% for adults and 57% for adolescents. Twenty per cent of the adult patients remain chronically ill compared with 17% of the adolescent patients. The other 33% of the adults and 26% of the adolescents show improvement, but do not recover completely. In the leading guidelines in the field of eating disorders the state-of-the-art treatment for anorexia nervosa is documented (NICE clinical guideline, 2004; American Psychiatric Association, 2006; Dutch Committee for the Development of Multidisciplinary Guidelines in Mental Health Care, 2006). As with all eating-disorder treatments, it is essential that attention be given to the different aspects of the disorder and the patient’s functioning. That means that the treatment should focus on:

- eating behaviour, body weight and body image;
- psychological problems, such as lack of self-esteem, perfectionism, traumas; and
- problems with fitting into the system or functioning in society.

An unhealthy eating pattern and a low body weight are important symptoms of anorexia nervosa and receive the primary focus during treatment. A good estimate of the patient’s energy intake is important for providing valuable nutritional advice and a normal eating pattern. The treatment goals for patients with anorexia nervosa include:

- restoring healthy body weight;
- normalising the eating pattern;
- developing a normal perception of hunger and satiety; and
- correcting biological and psychological complications of malnutrition.

Psychotherapeutic interventions may be part of each phase of the treatment. These interventions can focus on motivation for behavioural change, reduction of abnormal binge and purge behaviour, weight restoration, healthy exercise, increase of self-esteem and reduction of dysfunctional cognitions. Therapeutic interventions providing more insight may be indicated after weight has been restored. Even for patients who have undergone successful treatment for anorexia nervosa, the frequency of relapse is alarming. Research has shown that the percentage of relapse varies between 30% and 57% (Eckert et al., 1995; Strober et al., 1997; Herzog et al., 1999; Carter et al., 2004; Richard et al., 2005; Keel et al., 2005; Walsh et al., 2006; McFarlane, 2008; Carter et al., 2012). Only a very minimal amount
of attention is given to relapse prevention in the leading guidelines in the field of eating disorders, although they do generally agree that relapse prevention is crucial for patients with AN. One of the guideline states:

‘An important aim in the treatment of an eating disorder is to prevent relapse, which occurs often and can have serious consequences. It is important that the patient learns how to recognize and intervene during the early signs of relapse, for example through support from others in identifying risk moments, and by learning and implementing the coping strategies that focus on tackling them’.

Despite the importance given to relapse prevention, up until now no guideline providing a goal-oriented approach has been available. This guideline aims to fulfil that need.

<table>
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<tr>
<th>Anorexia nervosa</th>
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<tr>
<td>The following are the diagnostic criteria for anorexia nervosa according to DSM-5 (American Psychiatric Association, 2014):</td>
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<tr>
<td><strong>A</strong> Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. <em>Significantly low weight</em> is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.</td>
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<td><strong>B</strong> Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though the person has a significantly low weight.</td>
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<tr>
<td><strong>C</strong> Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.</td>
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<td>There are two subtypes:</td>
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<td>Restricting type: in the past three months the person has not engaged in binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) during relapse episodes. This subtype is limited to clinical features with which the weight loss mainly comes from dieting, fasting and/or excessive exercising.</td>
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<tr>
<td>Binge eating/purging type: in the past three months the person has engaged in binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) during relapse episodes.</td>
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1.2 **Aim and target group**

The aim of this guideline is to help health professionals draw up a relapse prevention plan for adolescent and adult patients who have anorexia nervosa. The relapse prevention plan can be used by the patient, their network members (parents, partner, friends and family) and the health professionals to recognise early relapse and to take specific action to prevent any further relapse. The guideline focuses on patients with anorexia nervosa aged 12 and older. The network members are also involved in drawing up and carrying out the relapse prevention plan. The guideline can also be adapted by health professionals who are responsible for the direct treatment and counselling of patients with anorexia nervosa.

Anorexia nervosa is most common in females, it is for that reason that the authors of this guideline have chosen to use female pronouns (she and her) throughout the text.

1.3 **Structure of the guideline**

The guideline compromises three parts. Part 1 covers a theoretic framework for relapse and relapse prevention, developed on the basis of both the literature and practical experience of experts and patients, leading to conclusions and recommendations for clinical practice. Part 2 translates the recommendations into a practical manual for professionals. Part 3 is a workbook for patients and the network members.

1.4 **Methodology**

A systematic literature review was carried out and consultations took place with experts who provided advice on content and form for drawing up this guideline. A first draft of the guideline was then submitted for review by a multidisciplinary expert panel and a panel of those with experiential expertise. The comments of these panels were incorporated into the final version of the guideline. The literature consulted is listed at the end of this document.
2 Evaluation of recovery and relapse

2.1 Introduction

This chapter covers the literature on recovery from and relapse of anorexia nervosa. It addresses exactly what we now understand about recovery and relapse; it also describes when the greatest risk of relapse occurs and which factors affect it. Furthermore, it explores comorbid disorders that accompany eating disorders which should be taken into account in the context of relapse prevention.

2.2 Recovery

The focus of the treatment of patients with anorexia nervosa lies primarily on the normalisation of their eating patterns along with recovery of their body weight. In addition, there is an emphasis on psychosocial aspects such as body image, cognitions, feelings and social functioning. It is essential to place the patient’s psychosocial developmental stage central and to have specific treatment interventions tailored to that. None of the available research provides an unequivocal description of recovery from an eating disorder (Noordenbos, 2007). This absence of an unequivocal definition and the widely varying operationalisations of the concept of ‘recovery’ means that researchers also find very different recovery percentages with anorexia nervosa.

The Morgan Russell Outcome Assessment Schedule was used to determine recovery in many studies (Morgan & Hayward, 1988). This scale contains a number of recovery criteria based on five central variables, namely nutritional intake and weight, menstruation, mental state, psychosexual functioning, and socioeconomic functioning. Most studies limit themselves, however, to two or three variables, specifically: eating behaviour, body weight and menstruation (Eckert et al., 1995). Most of the effect studies use the Morgan and Russell Criteria of ‘good’, ‘moderate’ and ‘poor’ to indicated the degree of recovery (Morgan & Russell, 1975). A ‘good recovery’ is defined as weight gain within a margin of 15% of the recommended normal weight with regular menstruation is established. A ‘moderate recovery’ means the weight is lower than 85% of the recommended normal weight with irregular menstruation. The criterion of 85% of the recommended normal weight also applies to ‘poor recovery’, however, it is in combination with amenorrhea, or when the patient develops bulimia nervosa (Noordenbos, 2007). Strober et al. (1997) have stricter criteria on what ‘good recovery’ means by proposing that – in addition to weight recovery – a number of psychological, emotional and social criteria must also be met to qualify as ‘complete recovery’. In addition to ‘complete recovery’ they also have ‘partial recovery’ and define both as follows:

- ‘Partial recovery’ is when, for at least eight weeks, the eating behaviour and the weight improve and a normal menstruation cycle has returned.
- ‘Complete recovery’ means the absence of all the symptoms of anorexia nervosa for a minimum of eight consecutive weeks. This includes normalised weight, the absence of compensating behaviour (vomiting, use of laxation or diuretics, or excessive exercise), the absence of an abnormal attitude toward weight, and the absence of weight phobia. The latter includes the absence of constant worry about one’s weight or weight gain, the absence of constant hypervigilance about the amount of food to eat, and the absence of frequent weight checking.
Steinhausen (2002) and Noordenbos (2005) add other aspects to this definition of ‘complete recovery’. Steinhausen adds: reduction of comorbidity (such as addiction to alcohol, mood disorders, anxiety disorders, et cetera) and Noordenbos adds: positive self-worth, expression of emotions and feelings, and restoration of social contacts.

### 2.3 Duration to recovery

Recovery from an eating disorder generally takes a long time. The mean length of treatment found across different studies is 4.7 years before stable physical recovery can be declared. It takes from 6.5 to 9 years for psychosocial recovery (Eckert et al., 1995; Strober et al., 1997; Fenning et al., 2002; Zerwas et al., 2013). The risk of relapse decreases further as the recovery process proceeds, and it is reduced to nearly zero when complete recovery is achieved (Strober et al., 1997). Family interactions have an important part in the recovery process. The more dysfunctional the family relationships are, the longer the road to recovery is (Strober et al., 1997).

### Conclusion 1

The various definitions of recovery from anorexia nervosa found in published studies complicates any comparison of their recovery results. Currently there is no consensus on the recovery criteria for anorexia nervosa. The definition Strober et al. (1997) use – along with some additions submitted by Steinhausen (2002) and Noordenbos (2005) – are very effective in clinical practice.

The duration it takes to achieve complete recovery from an eating disorder lies between 6.5 and 9 years.

### Recommendation 1

It is recommended to define the distinct degrees of recovery. This guideline uses the definition posed by Strober et al. (1997) along with additions from Steinhausen (2002) and Noordenbos (2005):

‘Partial recovery’ is when the following criteria are met: for a minimum of eight weeks, eating behaviour and weight have improved and menstruation is regular.

‘Complete recovery’ is when the following criteria are met: for a minimum of eight consecutive weeks the symptoms of anorexia nervosa are absent and weight has normalised. No compensating behaviour (vomiting, use of laxatives or diuretics, excessive exercise) has been exhibited. There is no abnormal attitude regarding weight and no weight phobia, which includes the absence of constant worry about one’s weight or weight gain. There is an absence of constant hypervigilance about the amount of food to eat, and the absence of frequently checking one’s weight. Comorbidity is also reduced, the patient has a considerably positive self-worth and she is sufficiently able to express emotions and feelings. Restoration of social contacts have also taken place.
2.4 Relapse

Patients with anorexia nervosa might relapse into their eating disorder while on the way to recovery. The Multidisciplinary Eating Disorders Guideline (2006) defines relapse as the recurrence of the eating-disorder symptoms that require help or intervention. Pike (1998) made an attempt at a more operational definition of relapse, stating that it occurs when the following diagnostic core symptoms return after the patient had responded well to some treatment:

- weight loss under a BMI of 18.5 or below 85% of the normal weight;
- increase of restrictive eating such that it results in weight loss;
- increase of behavioural symptoms such as over-evaluation of weight and body image in comparison with the previous response;
- amenorrhea, in the event menstruation had returned during an earlier phase of recovery; and
- occurrence of medical problems related to the eating disorder.

The different studies showed much variation in reported relapse percentages, which is caused by differences in the definition of relapse, variations in the duration of follow-up, and diversity in methodologies used (Carter et al., 2012). Three comparable studies on relapse prevention of anorexia nervosa, with a follow-up period of 18 months, showed relapse percentages of 35%, 41%, and 41%, respectively (Carter et al., 2004; Carter et al., 2012; McFarlane, Olmsted & Trottier, 2008). Survival analysis in the studies also show that the highest risk of relapse lies between 4 and 17 months after completion of treatment. The risk of relapse drops to practically zero after 18 months. Studies with a longer follow-up have relapse percentages varying between 30% and 57% (Eckert et al., 1995; Strober et al., 1997; Herzog et al., 1999; Carter et al., 2004; Richard et al., 2005; Throat et al., 2005; Walsh et al., 2006; McFarlane, 2008; Carter et al., 2012). A cohort study (Berends, T., Van Meijel, B. & Van Elburg, A., 2016) with a follow-up of 18 months with 83 patients who worked with this Relapse Prevention Guideline showed a considerably lower relapse percentage. The percentage of recovery was 11% in this study. Nineteen percent of the patients had a partial relapse, but they recovered again within three months. Seventy percent had no relapse.

Conclusion 2

A large percentage of patients (30%-57%) relapse after a successful treatment in a clinic. The risk is notably higher during the first 18 months after discharge. Relapse can be defined as the occurrence or recurrence of a number of core symptoms of anorexia nervosa after the patient had responded well to some treatment (Pike, 1998):

- weight loss under a BMI of 18.5 or below 85% of the normal weight;
- increase of restrictive eating such that it results in weight loss;
- increase of behavioural symptoms such as over-evaluation of weight and body image in comparison with the previous response;
- amenorrhea, in the event menstruation had returned during an earlier phase of recovery; and
- occurrence of medical problems related to the eating disorder.
Recommendation 2

It is advisable, particularly within the first 18 months after discharge, to work on relapse prevention with the patient and auxiliaries. It is recommended to use Pike’s (1998) definition of relapse of anorexia nervosa. The expert panel also recommends to include compensating behaviour in the definition of relapse. That inclusion results in the following adjusted definition of relapse.

Relapse after the patient had responded well to treatment can be defined as the occurrence or recurrence of a number of core symptoms, which are:

- weight loss under a BMI of 18.5 or below 85% of the normal weight;
- increase of restrictive eating such that it results in weight loss;
- increase of behavioural symptoms such as over-evaluation of weight and body image in comparison with the previous response;
- increase of compensating behaviour (self-induced vomiting, misuse of laxatives, diuretics or enemas, binge eating);
- amenorrhea, in the event menstruation had returned during an earlier phase of recovery; and occurrence of medical problems related to the eating disorder.

2.5 Comorbidity

Some patients have another mental disorder along with their eating disorder. The Multidisciplinary Eating Disorders Guideline (2006) does not explicitly address the diagnostics and treatment of these comorbidities. The guideline does, however, state that an integrated treatment is needed in cases with comorbidity. The most prominent comorbid disorders are: personality disorders, anxiety disorders, affective disorders, substance addictions (Dutch Committee for the Development of Multidisciplinary Guidelines in Mental Health Care, 2006; Steinhausen, 2002; Steinhausen, 2009; Keski-Rahkonen & Mustelin, 2016). The estimate is that 40% of the patients with anorexia nervosa have a comorbid affective disorder. Fifty per cent have an anxiety disorder. The percentage of patients with obsessive-compulsive disorder is estimated to be approximately forty per cent. Further it is hypothesised that the majority of patients with anorexia nervosa have a comorbid personality disorder which is usually an avoidant personality disorder or a compulsive personality disorder (Grilo, 2002; Serpell, 2002).

Conclusion 3

Comorbidity occurs often in patients with eating disorders. The most prevalent diagnoses are: personality disorders, anxiety disorders, affective disorders, and substance addictions.

Recommendation 3

In the context of relapse prevention it is recommended to examine for comorbidity in patients who have anorexia nervosa. The comorbid disorder can be a risk factor for the occurrence of relapse.
3. Risk factors and stages of relapse

3.1 Introduction

This chapter describes the risk factors for relapse into anorexia nervosa taken from scientific literature. The different stages of relapse are also described.

3.2 Risk factors for relapse

A small number of studies have been carried out on the risk factors for relapse. Carter et al. (2004) say that the limited progress in the development of relapse prevention programmes for anorexia nervosa patients can partially be explained by the scarcity of knowledge on specific risk factors that accompany relapse. Therefore, the development of more scientific research on this topic is urgently needed. The available literature refers to a set of four risk factors that are predictive of relapse, they are:

- anorexic thoughts regarding weight and body at the time of discharge (Pike, 1998; Carter et al., 2004; Keel et al., 2005; Federici & Kaplan, 2007);
- obsessive tendencies toward exercise at the time of discharge (Strober et al., 1997; Carter et al., 2004; Federici & Kaplan, 2007);
- longer duration of the illness and earlier treatment (Carter et al., 2004); and
- low level of psychosocial functioning (Keel et al., 2005) leading to the patient having insufficient skills in dealing with psychosocial stress factors that arise in daily life, which then triggers anorectic behaviour.

It should be noted that this inventory of risk factors comes from research on adolescents and adults. Research distinguishing the risk factors specific to adolescents or adults separately is lacking.

3.3 Different stages of relapse

When describing the process of relapse we distinguish between ‘triggers’ and ‘early signs’ of relapse. Specific triggering factors could induce the onset of the relapse process. Examples of which could be the experience of certain distressing events, comments made by others about the patient’s body posture, or the loss of structure when on holiday. More and/or stronger early signs of relapse become gradually visible during the relapse process. These early signs include feelings, thoughts, behaviours and physical signals that precede an eating-disorder relapse. Examples of these signs could be missing meals, an increase in anorectic cognitions, or an increasing amount of withdrawal from one’s social surroundings. An increase in the number and/or the severity of these early signs indicate an increased risk for relapse. At first the early signs of relapse are mild, but their intensity gradually increases if effective actions are not taken to reverse the relapse process and restore balance for the patient. This relapse process is represented schematically in Figure 1.
The following phases of anorexia nervosa relapse come from clinical experience.

**Stage 1:** Stable situation: The patient has a healthy weight appropriate for age and height. The patient functions well in her living environment. Eating-disorder thoughts might be present, but the patient does not act upon them.

**Stage 2:** Mild relapse: Eating-disorder thoughts increase and the first behaviours related to the eating disorder occur sporadically, for example, occasionally choosing ‘safe’ products or sometimes omitting a snack.

**Stage 3:** Moderate relapse: Eating-disorder thoughts predominate and, to an increasing degree, the patient regularly acts on these thoughts by expressing behaviours such as eating less, exercising more or by compensating through vomiting or using laxatives. These behaviours are visible, at least partially, to those in their social surroundings. There is observable weight loss.

**Stage 4:** Complete relapse: The patient has a weight loss below 85% of the normal weight and menstruation fails to occur. Eating-disorder thoughts predominate intensely and are continuously present. The patient withdraws contact from her social surroundings and exhibits compensating behaviour.
## Conclusion 4

Evidence from research supports the following four risk factors for relapse with anorexia nervosa:

- anorexic thoughts regarding weight and body at the time of discharge;
- compulsive drive to exercise at the time of discharge;
- longer duration of the illness/earlier treatment; and
- low psychosocial functioning.

Relapse progresses in different phases whereby early signs increase in number and severity as the relapse process advances and when no effective actions have been taken to reverse the relapse process, which is often preceded by inducing factors called triggers.

## Recommendation 4

It is advisable that the health professional, in consultation with the patient, makes an estimate of the four risk factors that intensify the chance of relapse into the eating disorder.

In the interest of preventing relapse, it is recommended to explore the individual's process of relapse by identifying specific triggers and early signs of relapse.
4 Triggers and early signs

4.1 Introduction

This chapter more thoroughly explores specific factors that could induce relapse (triggers) and the signals leading up to relapse (early signs) that the patient or the patient’s network members could recognize. Triggers and early signs are very person-specific. No scientific research is available on the specific characteristics of the relapse process in patients with anorexia nervosa. Knowledge on specific triggers and early signs by anorexia nervosa is consequently limited. The findings in this chapter are to a large extent based on clinical experience.

4.2 Triggers

Triggers are factors, usually in the patient’s surroundings, that trigger the eating-disorder behaviour and hence contribute to the risk of relapse. Bloks et al. (1999) provide a list of potential triggers that are formulated from the patient’s perspective. The list contains a number of examples and is by no means exhaustive. Triggers vary greatly and any list of them should be drawn up from the individual patient’s perspective.

POSSIBLE TRIGGERS (Bloks et al., 1999):

- Negative emotions
- Failures
- Positive emotions and achieved successes
- Interpersonal conflict and relationship problems
- Encouragement from others to diet/fast
- Stressful working conditions/school situations
- Holidays
- Major life events: death, relocation, change of study or profession, etc.
- Shocking events
- Weight gain
- Imbalanced eating or daily structure
- Meetings with people who the patient knew when underweight
- Comments about weight or appearance
- Financial problems

4.3 Early signs

Early signs are feelings, behaviours and physical signals that precede a relapse into the eating disorder and therefore could serve as warning signs for relapse. There is a clear relation between early signs of relapse and the DSM-5 (APA, 2014) criteria for anorexia nervosa. Early signs and the DSM criteria are placed on a continuum with, in many cases, the early signs serving as precursors to the DSM criteria. Early signs are less expressed with regard to severity than the core symptoms of anorexia nervosa. An example can clarify this.

One of the DSM-5 criteria of anorexia nervosa is the intense anxiety for gaining weight or getting fat, while the person is actually underweight. All kinds of milder forms of
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anxiety arise as early signs during the early stage preceding relapse. An example of this would be not daring to eat a piece of cake because of anxiety that it would cause a fat stomach. This mild anxiety is an early sign of relapse, but it does not meet the DSM-5 criterion regarding severity. In addition, anxiety as an early sign does not necessarily have to be accompanied by being underweight.

Clinical experience has shown that the early signs of relapse are determined on an individual basis, which means a personalised profile of early signs needs to be drawn up for each patient. The profile’s predictive value for the occurrence of relapse increases as the profile is more precise. A precisely drawn up profile of the patient’s early signs and its translation into a relapse prevention plan increases the clinical relevance of these early sign. Early signs of anorexia nervosa have different facets. One patient would sooner tend to eat less, while another would step on the scale more often. The early signs can be placed in five categories, specifically:

- eating pattern;
- exercise pattern;
- physical functioning;
- cognitive functioning; and
- social functioning.

With regard to the eating pattern an early sign could be consciously not snacking. The exercise pattern could include an increase of activities by biking fast and taking a longer route. Physical functioning would involve physical restlessness and a decrease in weight. An example of an early sign with regard to cognitive functioning is when the patient thinks that eating a moderate portion would lead to a large weight gain. An increase of conflicts with the social surroundings regarding eating is an early sign in the area of social functioning.

**Conclusion 5**

Triggers and early signs are observable in the time leading up to a relapse. These can be used for an early-stage identification of a relapse so that preventative interventions can be implemented.

**Recommendation 5**

It is recommended that the health professional, the patient and network members collectively assess which triggers and early signs could precede a relapse into the eating disorder. These could be translated to a personalised profile of triggers and early signs. The personalised profile can be used to draw up a relapse prevention plan which can be used to identify relapse at an early stage such that preventative intervention strategies could be carried out to prevent any further relapse.
5 Actions

5.1 Introduction

This chapter covers the actions that can be carried out when relapse threatens to appear. A theoretical model is used (Van Ommen et al., 2009) along with descriptions of actions that can be taken which are divided into different categories.

5.2 Theoretical model

The patient does not always act consistently with the relapse or threatening relapse. It could be that the patient is not aware of her relapse, or that she is in denial about the relapse. The patient often tends to solve it alone without asking for help. People in the patient's social surrounding could be helpful with regard to signalling a potential relapse. They could help identify the early signs and offer support during the threatening relapse. Auxiliaries can play an important role in this process. Van Ommen et al. (2009) conducted a study on effective nursing care in adolescents with anorexia nervosa, evaluated from the patients' perspective. The study led to a theoretical model in which three central themes were rendered. These themes are:

- taking responsibility;
- offering structure; and
- normalising the eating and exercise patterns.

The authors report that a shift in care within these three themes takes place during the clinical treatment in three phases. No studies have been conducted on this in the young adult or adult health care sector, but what follows below are reports based on clinical experience and perceptions by experts in the field of eating disorders using the three above-mentioned themes.

The first phase of clinical treatment involves the therapist assuming responsibility for a healthy eating and exercise pattern. This takes place with mutual agreement between the patient and the therapists. Treatment is conducted under directive structure and intensive counselling regarding the normalisation of the eating and exercise patterns. In the second phase of the treatment the patients practice taking responsibility for their own healthy eating and exercise patterns. The structure offered is more challenging than it is directive. Normalising daily life is paramount, initially within the clinical setting, and gradually more externally. In the third phase of treatment the responsibility for healthy eating and exercise patterns lies completely in the patient's own hands. The structure is supportive and the treatment and counselling focus on normalisation of life at home. This phased progression toward recovery is also accessible for ambulant patients too, however, they proceed with a less intensive form of counselling compared with the clinical counselling. Accordingly, they focus relatively more on self-management skills and on the support and structure provided by their social system.

The model above is applicable in the reverse order in the event of a threatening relapse. Someone regresses from being a healthy or recovering person to the role of a patient. Actions should be adapted depending on the severity of the relapse. The more severe the
relapse is, the more support, challenge and direction the patient will need from her social surroundings. As an example of how to realise that, one can consider having the patient make agreements to eat together with the auxiliaries. Interventions are – depending on the nature and severity of the relapse – focused on normalising and structuring the eating and exercise patterns, or normalising psychological and social functioning. Patients have to take their own responsibility for this, but the social surroundings can also offer its support. The extent to which the patients themselves are able to carry out these actions is dependent on the severity of the relapse or threatening relapse. When patients find themselves at the start of the relapse process (Stage 2), they will be better able to carry out these actions successfully themselves. As the relapse risk increases (Stages 3 and 4) the patients will be more dependent on the support of the people in their social surroundings (partner, family, friends and health professionals).

5.2 Actions by triggers
First and foremost, it is important to formulate actions aimed at effectively dealing with the inventoried triggers. These actions might focus on avoiding these triggers. An example is consciously not watching television programmes about dieting and achieving the ideal body. Another example is consciously avoiding social events which involve extreme sport and where physical posturing is excessively valued. The actions can also focus on actively coping with the trigger. An example would be when the structure around eating falls off while the patient is on holiday. The patient can think about how to give structure to this by making a schedule about the times when eating should take place, for example. This gives the patient control instead of passively being overwhelmed by events. Effective actions regarding these potential triggers are expected to contribute to a reduced risk of relapse.

5.3 Actions by early signs
The stage of relapse the patients find themselves in must be taken into consideration when choosing preventative actions for the early signs. Actions can be planned and carried out in varying domains (Note: Here we follow the earlier categorisation given in the description of the early signs). The actions taken regard:

- the eating pattern;
- the exercise pattern;
- the physical functioning;
- the cognitive functioning; and
- the social functioning.
Conclusion 6

The actions to prevent relapse can be rendered from three central themes, which are:

- the degree to which the patient is able to take responsibility herself;
- the degree to which structuring is necessary to reverse the threatening relapse and recover equilibrium for the patient; and
- the way in which normalisation of eating, exercise and psychosocial functioning can take place effectively.

The formulation of actions focused on effectively dealing with the triggers is necessary to reduce the chance of a new relapse from occurring in the future. Actions to prevent relapse can be reproduced during different stages of relapse. They can be formulated in the following domains:

- the eating pattern;
- the exercise pattern;
- the physical functioning;
- the cognitive functioning; and
- the social functioning.

Recommendation 6

It is recommended to formulate actions in the relapse prevention plan that aim to effectively deal with the triggers that contribute to relapse.

The following guidelines apply when formulating preventative actions that are carried out when early signs occur:

A. There is a link between the different stages of relapse.

B. They are formulated in the following five domains:

- the eating pattern;
- the exercise pattern;
- the physical functioning;
- the cognitive functioning; and
- the social functioning.

C. They correspond to the following three principles:

- the degree to which the patient is able to take responsibility herself;
- the degree to which structuring is necessary to reverse the threatening relapse and recover equilibrium for the patient; and
- the way in which normalisation of eating, exercise and psychosocial functioning can take place effectively.
References:


