Working with a relapse prevention plan to prevent or early detect relapse in patients with anorexia nervosa

Guideline Relapse Prevention Anorexia Nervosa

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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 2-4% (Smink, van Hoeken & Hoek, 2012), whereas the prevalence among men is ten times lower (Raevouri, Keski-Rahkonen & Hoek, 2014). The overall incidence rate has remained stable over the past decades (i.e. 6.0 per 100,000), and the age-specific incidence is highest in the age group 15-19 years (Smink et al, 2016). 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, 2017; American Psychiatric Association, 2006; Dutch Guideline Eating disorders, 2017). 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. Review of Berends and colleagues, 2018 in press, shows that 31% of the patients relapse after
successful treatment. This result was irrespective of the mean age of participants, implying that younger patients with anorexia nervosa are at the same risk of relapse as older patients.

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.

**Anorexia nervosa**

The following are the diagnostic criteria for anorexia nervosa according to DSM-5 (American Psychiatric Association, 2013):

A  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. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B  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.

C  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.

There are two subtypes:

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.

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.
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) nor for remission or relapse. This absence of an unequivocal definition and the widely varying operationalisations of the concept of ‘recovery’, ‘remission’ and ‘relapse’ means that researchers also find very different recovery, remission and relapse percentages with anorexia nervosa.

In a 2017 review on relapse, remission and recovery in anorexia nervosa, Khalsa et al. provided a summary of the different definitions used and concluded that there is limited consensus about these definitions (Khalsa et al, 2017). They proposed a set of standardised criteria for relapse, remission and recovery for AN, which is internally consistent and can facilitate longitudinal assessment by clinicians and researchers. The suggested criteria for recovery, remission, and relapse include objective measures (BMI; observable behaviors of restricting, binging, and purging), subjective measures (fear of gaining weight, disturbance of body image), standardized ratings (EDE), and specific durations of follow-up (1, 3, 6, and 12 months) that are conducive to utilization across both clinical and research settings. Figure 1 provides an overview of these definitions.
### Figure 1: Overview of definitions of recovery, remission and relapse by Khalsa et al. (2017).

#### 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; 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 relapse, remission and recovery from anorexia nervosa found in published studies complicates any comparison of the results. The definitions provided by Khalsa et al. (2017) are internally consistent and can facilitate longitudinal assessment by clinicians and researchers.

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 make a distinction in the definitions of recovery, remission and relapse according to the degree of recovery. This guideline uses the definitions proposed by Khalsa et al. (2017).
2.4 Relapse

Patients with anorexia nervosa might relapse into their eating disorder while on the way to recovery. 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).

In a systematic review, Berends and colleagues (2018, in press) present with a meta-analysis that the overall estimated rate of relapse in patients with AN is 31%. This result was irrespective of the mean age of participants, implying that younger patients with anorexia nervosa are at the same risk of relapse as older patients. And they found that the highest risk of relapse occurred during the first year after discharge; however, it appeared that this risk could continue for up to 2 years.

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 high percentage of patients (31%) relapses after successful treatment. The highest risk of relapse occurs in the first year after treatment, however, it appeared that this risk could continue for up to 2 years. Relapse can be defined as the recurrence of the core symptoms of anorexia nervosa, after previous initial response to treatment. Distinction is made between partial and full relapse (Khalsa, 2017).

### Recommendation 2

It is recommended to actively guide patients and their network during the first two years after treatment to prevent relapse. It is recommended to use the definitions provided by Khalsa et al (2017) when defining relapse.

2.5 Comorbidity

Some patients have another mental disorder along with their eating disorder. The Dutch Guideline Eating disorders (2017) 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 (Steinhausen, 2002; Steinhausen, 2009; Keski-Rahkonen & Mustelin, 2016; Dutch Guideline Eating disorders, 2017). 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.
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. **Factors associated with relapse 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 **Factors associated with relapse**

More and more studies are presenting factors associated with relapse. Unfortunately there is a substantial variability in these factors due to the different procedures and instruments used in the studies to identify them. An overview is presented in the review of Berends et al. (2018 in press) of all factors significantly associated with a higher risk of relapse, presented in table 1. A formation of the following four clusters was made: 1) Eating disorder variables, 2) Comorbidity symptoms, 3) Process treatment variables, and 4) Demographic variables.

<table>
<thead>
<tr>
<th>Eating disorder variables:</th>
<th>Measure moment / timing of risk</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Increase on EDE-Q Shape Concern</td>
<td>Pre-posttreatment</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Increase on EDE-Q Weight Concern</td>
<td>Pre-posttreatment</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Concern about weight or shape</td>
<td>After remission</td>
<td>Keel et al., 2005 [27]</td>
</tr>
<tr>
<td>- Fear of gaining weight or becoming fat</td>
<td>After remission</td>
<td>Keel et al., 2005 [27]</td>
</tr>
<tr>
<td>- Higher EDE fear of weight gain scores</td>
<td>At discharge</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Low desired weight</td>
<td>N.R.</td>
<td>Richard et al., 2005 [28]</td>
</tr>
<tr>
<td>- Misperception of body</td>
<td>After remission</td>
<td>Keel et al., 2005 [27]</td>
</tr>
<tr>
<td>- Higher scores on EDE-Q eating concern</td>
<td>At admission</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Weight restoration curves characterised by high NCV, i.e., by sudden drops in weight</td>
<td>During treatment</td>
<td>Avnon et al., 2017 [15]</td>
</tr>
<tr>
<td>- BP subtype of AN</td>
<td>At admission</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- High-level exercise</td>
<td>During first 3 months after discharge</td>
<td>Carter et al., 2004 [17]</td>
</tr>
<tr>
<td>- Low severity of eating disorder symptoms (EDI)</td>
<td>N.R.</td>
<td>Richard et al., 2005 [28]</td>
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<table>
<thead>
<tr>
<th>Comorbidity symptoms:</th>
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<tbody>
<tr>
<td>- Higher scores on PI Checking behavior subscale</td>
<td>At admission</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Higher discharge scores on Washing compulsions (PI scale)</td>
<td>Posttreatment</td>
<td>Carter et al., 2004 [17]</td>
</tr>
<tr>
<td>- Higher discharge scores on Ruminations (PI scale)</td>
<td>Posttreatment</td>
<td>Carter et al., 2004 [17]</td>
</tr>
<tr>
<td>- Insufficient change in problem avoidance scales (CSI)</td>
<td>Pre-posttreatment</td>
<td>Carter et al., 2004 [17]</td>
</tr>
<tr>
<td>- Decrease in level of motivation</td>
<td>Pre-treatment to 4 weeks</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Lower motivation to recover</td>
<td>At discharge</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Decrease on the Rosenberg Self- Esteem Scale</td>
<td>Pre-posttreatment</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- Worse psychosocial function</td>
<td>At admission</td>
<td>Keel et al., 2005 [27]</td>
</tr>
<tr>
<td>- History of childhood physical abuse</td>
<td>At admission</td>
<td>Carter et al., 2012 [18]</td>
</tr>
<tr>
<td>- History of suicide attempts</td>
<td>At admission</td>
<td>Carter et al., 2004 [17]</td>
</tr>
<tr>
<td>- Worse global assessment of functioning scale scores</td>
<td>After remission</td>
<td>Keel et al., 2005 [27]</td>
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<tr>
<th>Process treatment variables:</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>- Longer duration of treatment</td>
<td>At start aftercare program</td>
<td>Berends et al., 2016 [16]</td>
</tr>
<tr>
<td>- Type of treatment (in- and outpatient higher risk vs only outpatient)</td>
<td>Treatment process</td>
<td>Berends et al., 2016 [16]</td>
</tr>
<tr>
<td>- Previous specialised treatment for eating disorder</td>
<td>At admission</td>
<td>Carter et al., 2004 [17]</td>
</tr>
<tr>
<td>- Relapse twice as high after short term (less than a year) therapeutic contact as after longer contact (one year or more).</td>
<td>Treatment process</td>
<td>Isager et al., 1985 [26]</td>
</tr>
<tr>
<td>- Increased individual psychotherapy</td>
<td>After remission</td>
<td>Keel et al., 2005 [27]</td>
</tr>
<tr>
<td>- Additional psychiatric treatment</td>
<td>During follow-up</td>
<td>Richard et al., 2005 [28]</td>
</tr>
<tr>
<td>- Additional medical treatment</td>
<td>During follow-up</td>
<td>Richard et al., 2005 [28]</td>
</tr>
<tr>
<td>- Treatment in a non-specialised hospital</td>
<td>Treatment process</td>
<td>Richard et al., 2005 [28]</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Demographic variables:</th>
<th></th>
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<tbody>
<tr>
<td>- Higher age</td>
<td>After remission</td>
<td>Keel et al., 2005 [27]</td>
</tr>
<tr>
<td>- Long duration of illness</td>
<td>At start aftercare program</td>
<td>Berends, 2016 [16]</td>
</tr>
<tr>
<td>- Final outcome status (chronic course vs. partial or full recovery)</td>
<td>N.R.</td>
<td>Richard et al., 2005 [28]</td>
</tr>
<tr>
<td></td>
<td>Post-discharge</td>
<td>Strober et al., 1997 [29]</td>
</tr>
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Tabel 1: Factors associated with relapse. N.R. = Not Reported.
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.

![Figure 1: Relapse process](image)

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 occurs 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: Full 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 shows a wide variety of risk factors for relapse in anorexia nervosa. Extensive screening is required during treatment to determine the presence of relevant factors. With this knowledge, the relapse prevention plans can be personalised.

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 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, 2013) 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
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 signs. 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 (network members) could be helpful with regard to signalling a potential relapse. They could help identify the early signs and offer support during the threatening relapse.

Network members 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:


