11: Summary sheet for psychologists and therapists

Who is this for?
Psychologists and other professionals responsible for managing, supervising and providing psychological therapy for eating disorders.

a. Risk assessment

Therapists' main role is to administer an accepted form of psychological therapy. However, they also need to be clear that the patient in front of them is well enough to attend (and leave) a therapy session. They should have access to a complete risk assessment with current updates so that they know what might give rise to concern. The most likely areas are body mass index (BMI), electrolytes in patients who purge, and behaviour by the patient aimed at concealing true BMI. The therapist or a team member weighs the patient and the result is available in the session. It is useful to keep a graph of weight and use it in the session so that any deterioration is clearly visible. If the patient is at risk of low potassium recent results (at most 1–2 days old) need to be available in the session. Other monitoring tests are usually done by other team members, but could be done by the therapist. Any concerns of the therapist, including non-attendance at monitoring, should be discussed urgently with the supervisor and the team doctor. A risk assessment checklist is provided in Chapter 2.

See Chapter 2 and Appendix 3

b. Location of care

Therapy may take place in primary, outpatient or inpatient care. The therapist should ensure that a supervisor and doctor are readily available to deal with concerns.

See Chapter 3

c. Safe refeeding

In primary care and outpatients, the therapist may manage nutritional treatment with some input from dietician and doctor. The therapist should be clear what is happening to weight and other risk factors. If there is a concern about risk, the dietician or doctor should be consulted.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Therapists frequently have to help patients deal with behaviours that can impede recovery. These include drinking water to increase apparent weight, excessively exercising and taking laxatives to reduce weight. As long as they are known, the behaviours can be

addressed in therapy. However, some might only come to light later on, e.g. when the weight chart is apparently stable but muscle strength sharply declines. The therapist needs to be aware of these possibilities and discuss them with other members of the multidisciplinary or primary care team. They can then be brought up in therapy and addressed with the patient.

See Chapter 6

e. Families and carers

The therapist may be providing family therapy for an eating disorder, and the same requirements for supervision and medical consultation apply as for individual therapy. Sometimes it can be useful to see the family as part of individual therapy, especially if there are substantial anxieties about the patient's physical state.

See Chapter 7

f. Compulsory admission and treatment

Under revised mental health legislation, a psychologist can be the responsible clinician for an inpatient. Senior psychologists should consider whether they wish to take on this role. For therapists treating patients receiving compulsory treatment, the role can be paradoxically split between the patient support and advocate role and being a member of the team which is imposing compulsory treatment. This should be discussed in therapy. The patient may have mixed feelings about being compelled to have treatment.

See Chapter 8

f. Diabetes mellitus type 1

Diabetes mellitus when combined with an eating disorder can lead to severe medical problems. The therapist needs to have a good knowledge of both eating disorders and diabetes and be aware of the patient's current medical problems. Sometimes neglecting the diabetes can seem like a form of self-harm. In others, the combination can emphasise how powerful the eating disorder can be, as in a patient who said, "I'd rather be blind than fat."

See Chapter 9 and Annexe 3