

SPECIALIZED TREATMENTS FOR PEOPLE WITH LONG-STANDING EATING DISORDERS: PERSONALIZATION OR DISCRIMINATION?

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Patients with long-standing illness: What to do ?

- About 20% of people with EDs have long-standing illness characterized by minimal improvement and significant impairment (e.g. Dobrescu et al, 2020; Eddy et al, 2017; Wonderlich et al, 2020)
- Is there reason to believe that such people represent a distinct category?
 - Defining clinical criteria?
 - Duration, number of unsuccessful treatments or relapses, comorbidity
 - Unique etiology?
 - Biology, Traits, Developmental factors
- How might the classification effort be useful?
 - Developing specific active treatments suited to this hypothetical subgroup
 - Principled basis for withdrawal of active treatment, transition to palliative care, etc.

Implications of different viewpoints

- “A palliative, holding management that offers support and comfort to partially alleviate the effects of the disease” (Strober, 2004)
- “When managing patients with decades-long disease and multiple comorbidities, clinicians must be realistic about the low odds of effecting cure and adjust treatment expectations accordingly. For patients with SE-AN, a variety of low-intensity treatment approaches, at times extending to palliative and hospice care, may be useful (Yager, 2019).
- « ...treatments may devolve into relatively unfocused, intermittent, supportive interventions, where goals become unclear and monitoring of clinical status
• becomes impressionistic and imprecise » (Wonderlich et al, 2012)
- “Care pathways for longstanding eating disorders must offer paths to recovery, not managed decline” (Downs, 2024)
- « Accommodate incremental response. People cannot recover on demand, and it is normal not to recover during an initial time-limited episode of treatment, or even after several such episodes.” (Steiger, 2017)
- **Call for a principled, progress-oriented treatment approach**

Conceptualizations of long-standing AN

- “frequently relapsing” (Herzog et al, 1999; Pike, 1998)
- “treatment resistant” (Strober, 2004)
- “severe and enduring” (Robinson, 2009; Touyz & Hay, 2015)
- “long-standing” (Broomfield et al, 2021; Reay et al, 2022; Calvert, 2024)
- “incrementally responding” (Steiger, 2017)

A decorative border on the left side of the slide, featuring a teal background with several colorful speech bubbles (pink, orange, yellow, and light grey) containing dark blue question marks. The border has a torn paper effect.

QUESTION NO. 1

Is there a « deadline » after which recovery is unlikely ?

RECOVERY RATES INCREASE WITH TIME

	ANOREXIA NERVOSA	BOULIMIA NERVOSA
1st 10 years	31%	68%
2 nd 10 years	63%	68%

► [J Clin Psychiatry](#). Author manuscript; available in PMC: 2021 Feb 15.

Published in final edited form as: [J Clin Psychiatry](#). 2017 Feb;78(2):184–189. doi: [10.4088/JCP.15m10393](#)

Recovery From Anorexia Nervosa and Bulimia Nervosa at 22-Year Follow-Up

[Kamryn T Eddy](#)^{a,b,*}, [Nassim Tabri](#)^{a,b}, [Jennifer J Thomas](#)^{a,b}, [Helen B Murray](#)^a, [Aparna Keshaviah](#)^a, [Elizabeth Hastings](#)^a, [Katherine Edkins](#)^a, [Meera Krishna](#)^a, [David B Herzog](#)^b, [Pamela K Keel](#)^c, [Debra L Franko](#)^{a,d}

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PMCID: PMC7883487 NIHMSID: NIHMS1668194 PMID: [28002660](#)

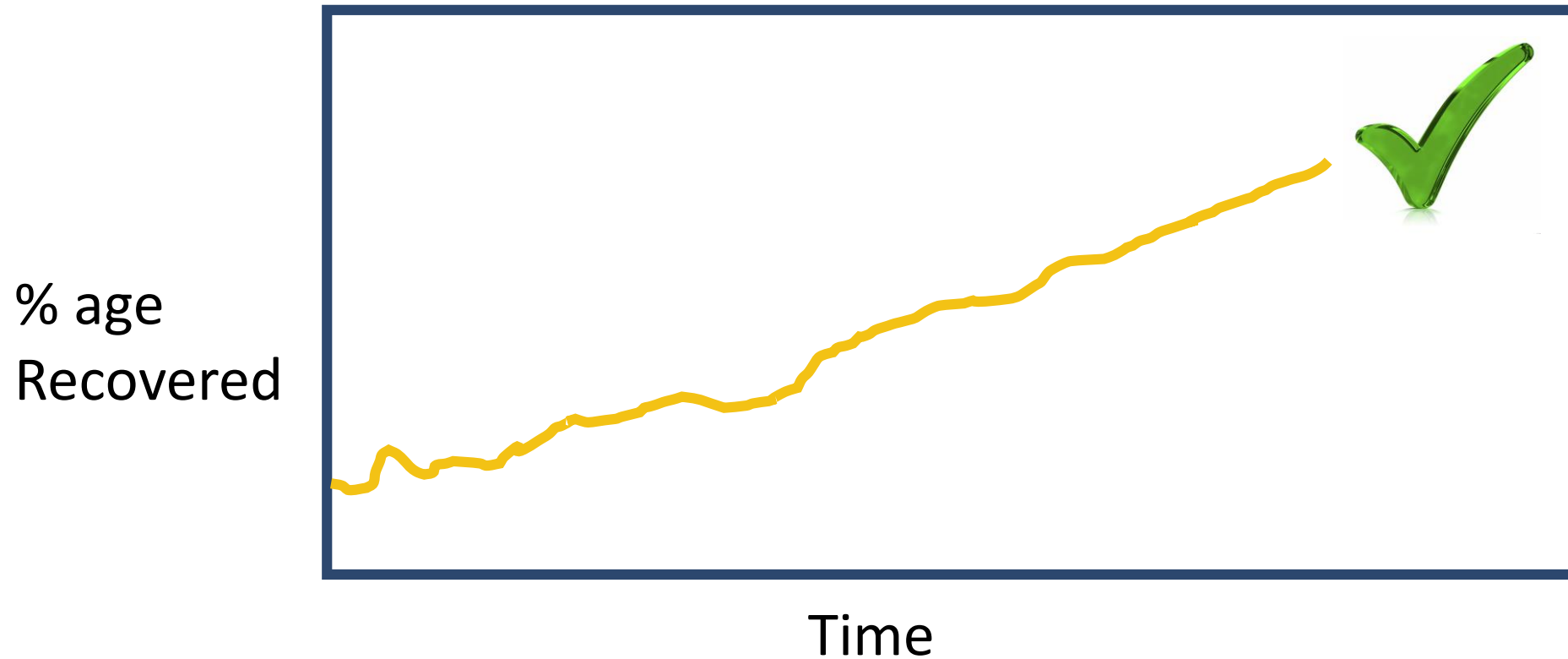
EVIDENCE OF INCREMENTAL RESPONSE

415 studies, including 88,372 people with heterogenous EDs

Global recovery: 46% (average follow-up: 45 months)

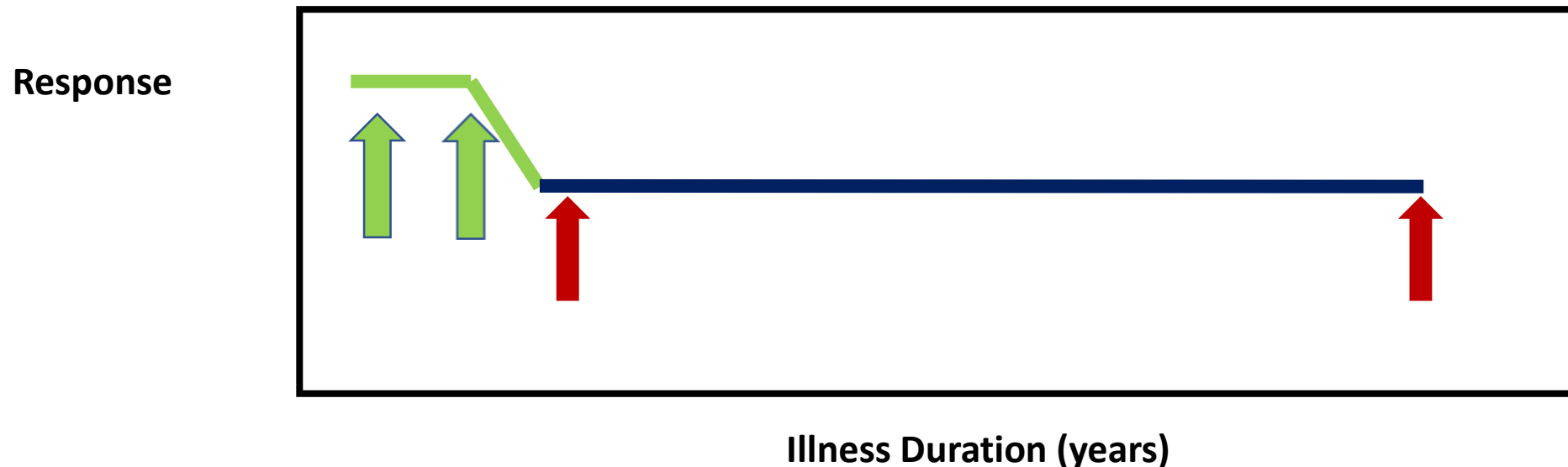
Time	% recovered
< 2 years	42%
2 to <4 years	43%
4 – <6 years	54%
6 – < 8 years	59%
8 to < 10 years	64%
≥ 10 years	67%

...the longer the follow-up, the larger the proportion of people who recover.



EXCEPT:

- Very recent onset illnesses are associated with better outcome (Gorrell et al., 2022)
- This argues in favour of the importance of early intervention





QUESTION NO. 2:

Does duration of illness have prognostic value?

DOES DURATION OF ILLNESS PREDICT TREATMENT RESPONSE ?

YES

DOI: 10.1002/erv.2822

RESEARCH ARTICLE WILEY

The impact of duration of illness on treatment nonresponse and drop-out: Exploring the relevance of enduring eating disorder concept

Fernando Fernández-Aranda^{1,2,3,4} | Janet Treasure⁵ | Georgios Paslakis⁶ | Zaida Agüera^{1,2,3,7} | Mónica Giménez¹ | Roser Granero^{3,8} | Isabel Sánchez^{1,3} | Eduardo Serrano-Troncoso⁹ | Philip Gorwood¹⁰ | Beate Herpertz-Dahlmann¹¹ | Eva-Maria Bonin¹² | Palmiero Monteleone¹³ | Susana Jiménez-Murcia^{1,2,3,4}

- 1199 patients with EDs (outpatient and dayprogram)
- Outcome of AN, BN or OSFED (but not BED) associated with illness duration and number of previous treatments

- Patients with AN (illness duration ≥ 7 years) reported greater use of intensive services, ED symptoms, and poorer work/social adjustment at baseline
- Lower rates of improvement in work/social adjustment at 12 months compared to “early stage” respondents.

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DOI: 10.1002/eat.23246

ORIGINAL ARTICLE International Journal of
EATING DISORDERS WILEY

A multicenter audit of outpatient care for adult anorexia nervosa: Symptom trajectory, service use, and evidence in support of “early stage” versus “severe and enduring” classification

Suman Ambwani PhD¹ | Valentina Cardi PhD² | Gaia Albano MSc^{2,3} | Li Cao MS^{4,5} | Ross D. Crosby PhD, FAED^{4,5} | Pamela Macdonald PhD² | Ulrike Schmidt MD, PhD, FRCPsych, FAED² | Janet Treasure PhD, FRCP, FRCPsych, FAED, OBE²

Contents lists available at ScienceDirect

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Predictors of outcomes in outpatients with anorexia nervosa – Results from the ANTOP study CrossMark

Beate Wild^{a,*}, Hans-Christoph Friederich^a, Stephan Zipfel^b, Gaby Resmark^b, Katrin Giel^b, Martin Teufel^b, Dieter Schellberg^a, Bernd Löwe^c, Martina de Zwaan^d, Almut Zeeck^e, Stephan Herpertz^f, Markus Burgmer^g, Jörn von Wietersheim^h, Sefik Tagayⁱ, Andreas Dinkel^j, Wolfgang Herzog^a

- 169 AN, outpatient treatment
- Illness duration > 6 years predicted poorer recovery and BMI at 1 year

DOES DURATION OF ILLNESS PREDICT TREATMENT RESPONSE ?

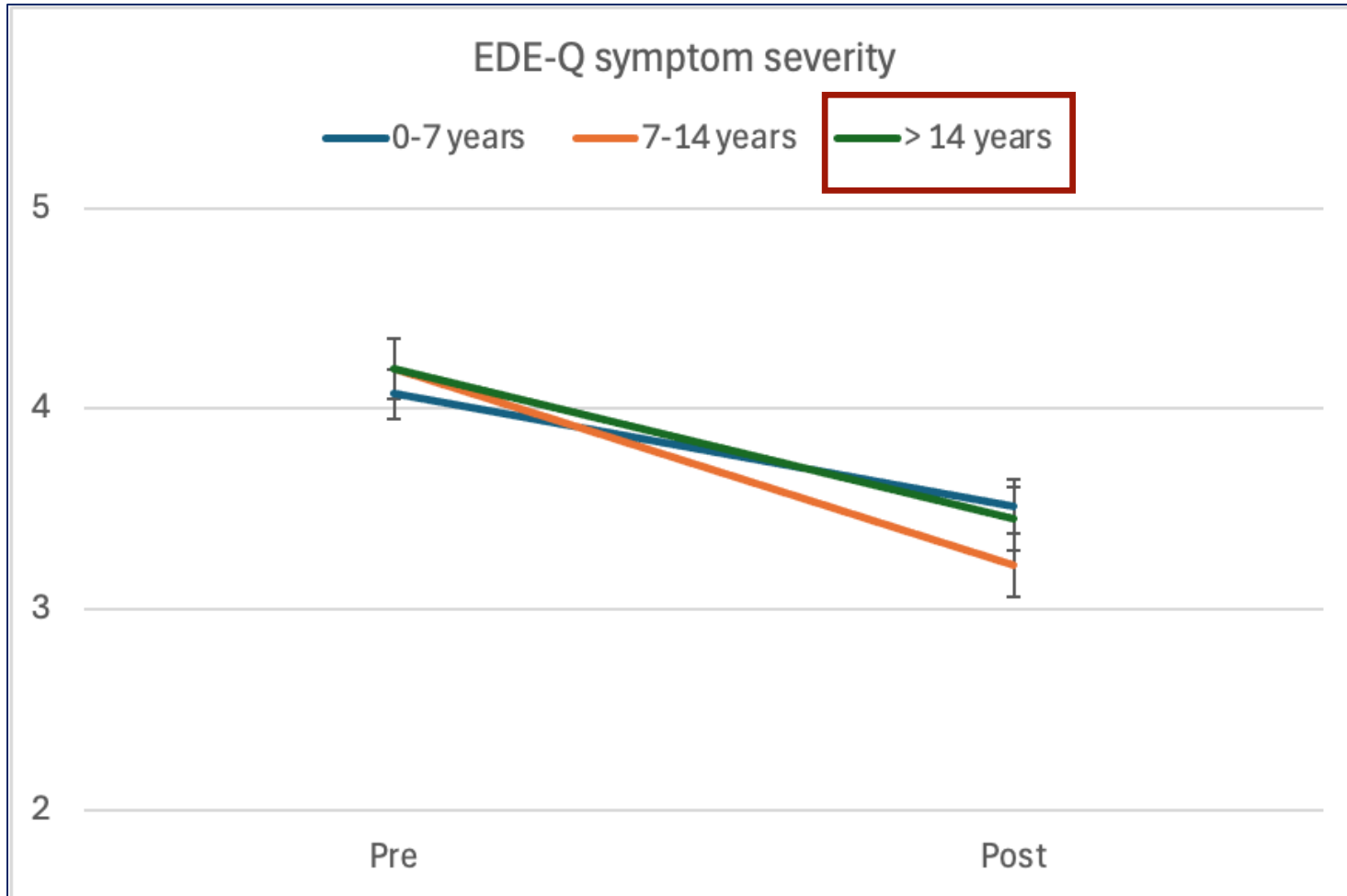
NO



Meta-analysis & individual studies:

- CBT, FBT, MANTRA: Illness duration did not predict outcome in AN or BN (e.g., Duggan et al., 2026; Gregertsen et al., 2019; Datta et al., 2023; Kopp et al., 2026)
 - Various ED treatments: Illness duration did not predict clinical outcome for adults with AN (e.g. Venables et al., 2025)
-
- Studied illness duration: mostly <10 years; or inpatients
 - Limited sample sizes (often n < 100)
 - Studies rarely include outpatients with an ED > 1 decade

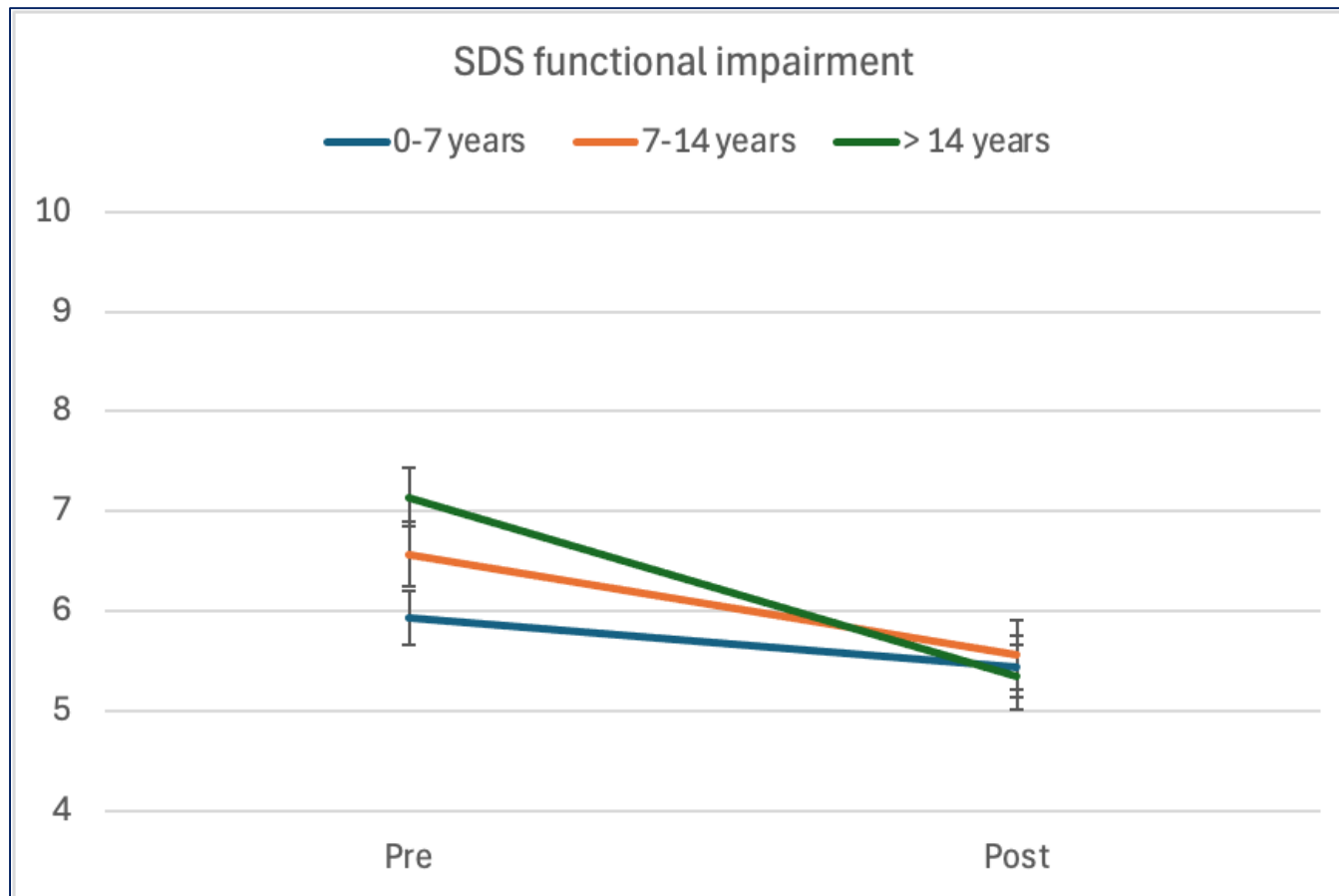
ILLNESS DURATION & TREATMENT OUTCOME



Outpatient treatment:

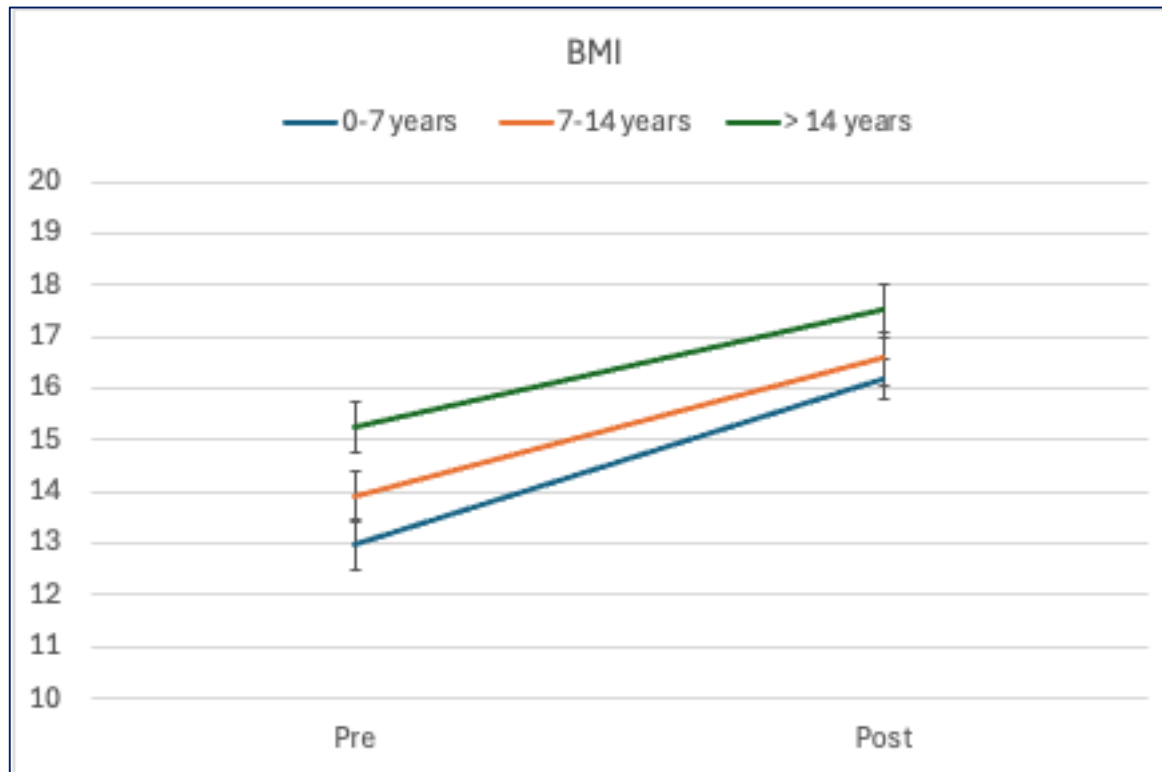
- Treatment effect (all)
- **No influence of illness duration** on response to the next episode of treatment

ILLNESS DURATION AND FUNCTIONAL IMPAIRMENT



- Outpatient treatment:
- Treatment effect (all)
 - People with longstanding ED (> 14 y) have **greater** functional impairment
 - Time-limited outpatient treatment **lowers** their functional impairment

ILLNESS DURATION AND BMI (INPATIENT)



Inpatient treatment:

- Treatment effect (all)
- People with longstanding ED (> 14 y) have **higher BMI** upon admission
- No influence of illness duration on BMI change following hospitalization

COMORBIDITY & TREATMENT RESPONSE

STUDY	DESIGN	MEASURES	RESULT
Linardon et al (2016)	Systematic review, 65 articles on CBT outcome	<ul style="list-style-type: none"> Depression, Personality Disorder, Self Esteem Depression General Psychopathology 	BN X Mixed EDs X BED X
Vall & Wade (2015)	Systematic review, 126 studies, diverse EDs	<ul style="list-style-type: none"> Depression Comorbid psychopathology Interpersonal functioning 	 ✓ ✓ ✓
Gorrel et al (2023)	Narrative summary, studies since Vall & Wade (2015)	<ul style="list-style-type: none"> Personality factors Comorbid psychopathology Trauma; PTSD 	 +/- +/- Perhaps for BED; not for mixed
Reilly et al (2024)	Outcomes in n= 1971 adolescents	<ul style="list-style-type: none"> Depression Anxiety Comorbidity (present/absent) 	 X X ✓
Datta et al (2024)	Outcomes in adolescents with AN or BN (6 trials, n=724)	<ul style="list-style-type: none"> Comorbid psychopathology Any prior hospitalization 	 X ✓

KEY MESSAGES

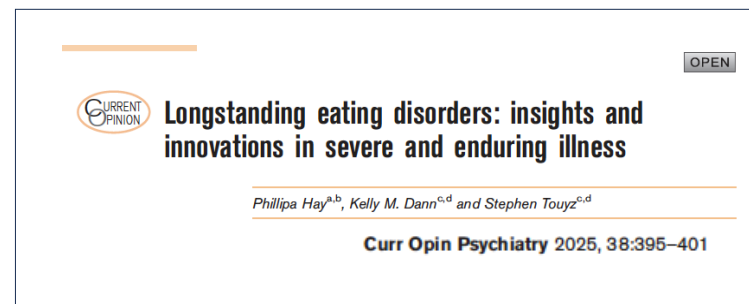
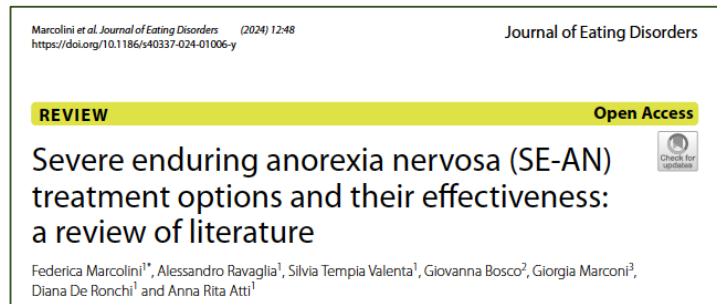
- Meta-analysis of 25 studies: Early response to treatment (at 4 to 6 weeks) is the most robust predictor of outcome (Chang & Waller, 2021)
- Illness duration is not a consistent predictor of treatment response
- Let people's own response dictate treatment steps required
- No reliable basis for prognostication based on comorbidity



QUESTION NO. 3

Are conventional (best-practice) treatments helpful for people with long-standing illnesses ?

CONVENTIONAL TREATMENTS HELP PEOPLE WITH LONG-STANDING ILLNESSES



Examples of Reviews & Individual studies, comparing long-standing EDs vs. more recent onset:

- Raykos et al 2018 : People with long-standing AN respond just as well to **CBT-E** as do those with more recent onset AN
- Calugi et al 2017: 66 adults with AN, classified according to > 7 years or not. Similar improvements after CBT-E (BMI, ED symptoms, psychopathology)
- Hay et al 2013: 63 adults with AN \geq 7 years, randomized to modified CBT-AN or **SSCM**; significant improvements in BMI and QoL with both therapies
- Kotilahti et al 2020; Hay et al., 2025: **Varlous treatments** produce benefits in people with long-standing AN and BN



Tested Approaches to treating long-Standing EDs

Treating severe and enduring anorexia nervosa: a randomized controlled trial

S. Touyz^{1*}, D. Le Grange², H. Lacey³, P. Hay^{4,5}, R. Smith¹, S. Maguire¹, B. Bamford³, K. M. P. and R. D. Crosby⁷

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Background. There are no evidence-based treatments for severe and enduring anorexia nervosa (SE-AN). We evaluated the relative efficacy of cognitive behavioral therapy (CBT-AN) and specialist supportive clinical management (SSCM) for adults with SE-AN.

Eating Disorder Symptoms and Quality of Life: Where Should Clinicians Place their Focus in Severe and Enduring Anorexia Nervosa?

models. Changes in both BMI and EDE were found to significantly affect current and future QoL ratings.

Discussion: Findings suggest that improvements in QoL may be dependent on symptom change and weight gain. Treatments seeking solely to improve QoL may be unlikely to produce lasting change and clinicians should maintain a focus on weight and behavioral symptoms as much as on improvements in QoL. © 2014 Wiley Periodicals, Inc.

Keywords: anorexia nervosa; severe and enduring; quality of life; treatment outcome

(Int J Eat Disord 2015; 48:133–138)

- Both modified to prioritize quality of life and harm reduction.
- Weight gain a secondary aim in both

63 participants with SE-AN
≥ 7-year illness history

Randomized to modified **CBT-AN** or **SSCM**
30 OPD visits over 8 months

Results:

- Meaningful improvements in BMI and QoL with both therapies.
- 76% completed therapy
- Benefits sustained to 1-year follow-up

BRIEF REPORT

Severe and Enduring Anorexia Nervosa? Illness Severity and Duration Are Unrelated to Outcomes From Cognitive Behaviour Therapy

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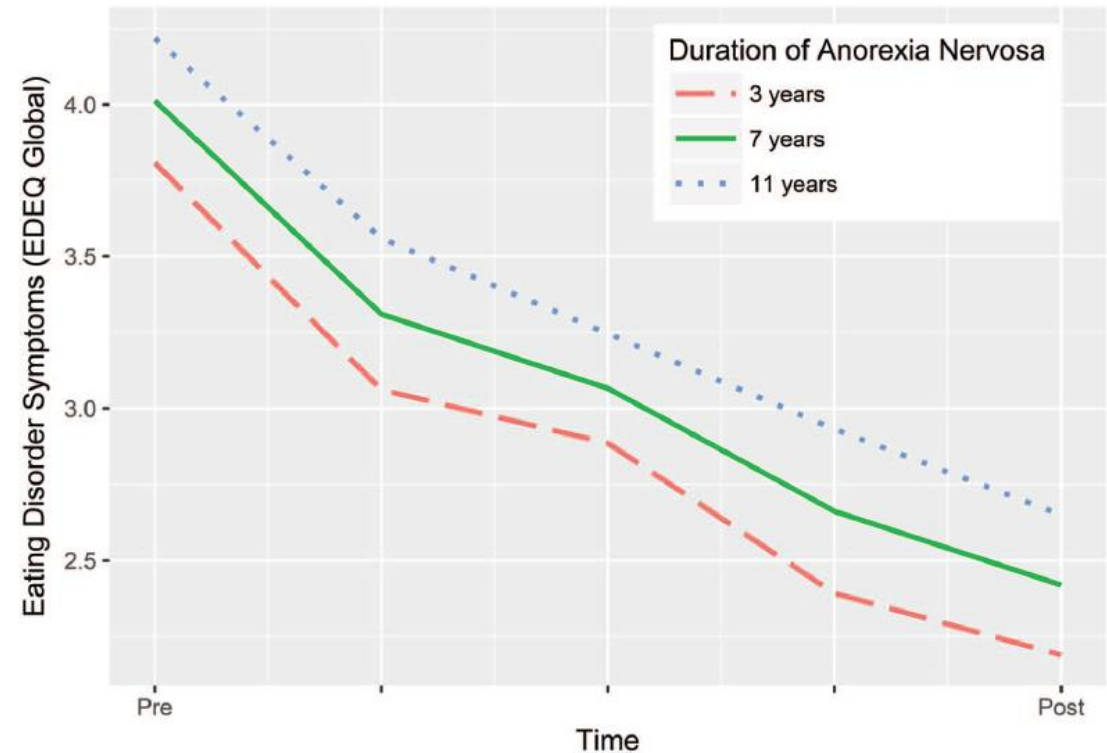
David M. Erceg-Hurn and Peter M. McEvoy
Centre for Clinical Interventions, Perth, Australia
and Curtin University

Anthea Fursland
Centre for Clinical Interventions, Perth, Australia and Western
Australia Eating Disorders Outreach & Consultation Service,
Perth, Australia

Glenn Waller
University of Sheffield

Objective: The present study aimed to examine whether Anorexia Nervosa (AN) illness severity or duration is associated with retention or treatment response in outpatient, enhanced cognitive-behavioral therapy (CBT-E). **Method:** Patients with a confirmed AN diagnosis ($N = 134$) completed measures of eating disorder symptoms and quality of life, and had their BMI objectively measured before, during, and after treatment. We evaluated whether illness severity or duration predicted treatment outcomes, using longitudinal regression models. **Results:** Greater levels of illness severity and duration were not associated with poorer treatment outcomes. **Conclusions:** Patients with more severe or long-standing AN illness did just as well in CBT-E as any other patient starting treatment. Therefore, classifying individuals as “severe and enduring” appears to lack clinical utility in CBT-E. Clinicians should continue to administer evidence-supported treatments such as CBT-E for patients with AN, regardless of duration or severity of AN illness.

b) Association Between Duration and Change in Eating Disorder Symptoms



- People with AN ($n = 134$) in CBT-E
- Evaluated whether illness severity (EDEQ, BMI) or duration predicted treatment outcomes
- **Outcomes:** EDE-Q, BMI, completion of all stages of Rx

Results: Greater levels of illness severity and duration NOT associated with poorer treatment outcomes (EDEQ, BMI, QoL, completion)

Out-patient psychological therapies for adults with anorexia nervosa: randomised controlled trial

Ulrike Schmidt, Anna Oldershaw, Fatima Jichi, Lot Sternheim, Helen Startup, Virginia McIntosh, Jennifer Jordan, Kate Tchanturia, Geoffrey Wolff, Michael Rooney, Sabine Landau* and Janet Treasure*

Background

Very limited evidence is available on how to treat adults with anorexia nervosa and treatment outcomes are poor. Novel treatment approaches are urgently needed.

Aims

To evaluate the efficacy and acceptability of a novel psychological therapy for anorexia nervosa (Maudsley Model of Anorexia Nervosa Treatment for Adults, MANTRA) compared with specialist supportive clinical management (SSCM) in a randomised controlled trial.

Method

Seventy-two adult out-patients with anorexia nervosa or eating disorder not otherwise specified were recruited from a specialist eating disorder service in the UK. Participants were randomly allocated to 20 once weekly sessions of MANTRA or SSCM and optional additional sessions depending on severity and clinical need (trial registration: ISRCTN62920529). The primary outcomes were body mass index, weight and global score on the Eating Disorders Examination at end of treatment (6 months) and follow-up (12 months). Secondary outcomes included: depression, anxiety and clinical impairment; neuropsychological outcomes; recovery rates; and additional service utilisation.

Results

At baseline, patients randomised to MANTRA were significantly less likely to be in a partner relationship than those receiving SSCM (3/34 v. 10/36; $P < 0.05$). Patients in both treatments improved significantly in terms of eating disorder and other outcomes, with no differences between groups. Strictly defined recovery rates were low. However, MANTRA patients were significantly more likely to require additional in-patient or day-care treatment than those receiving SSCM (7/34 v. 0/37; $P = 0.004$).

Conclusions

Adults with anorexia nervosa are a difficult to treat group. The imbalance between groups in partner relationships may explain differences in service utilisation favouring SSCM. This study confirms SSCM as a useful treatment for out-patients with anorexia nervosa. The novel treatment, MANTRA, designed for this patient group may need adaptations to fully exploit its potential.

Declaration of interest

U.S. receives salary support from the NIHR (Mental Health Biomedical Research Centre) at South London and Maudsley NHS Foundation Trust and King's College London.

Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA)

- Employs a motivational interviewing style
- Includes work on “non-anorexic” identity

MANTRA vs. SSCM

- 142 outpatients with AN; mean 8 and 7 years illness durations
- 20–30 weekly sessions

The MOSAIC study - comparison of the Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA) with Specialist Supportive Clinical Management (SSCM) in outpatients with anorexia nervosa or eating disorder not otherwise specified, anorexia nervosa type: study protocol for a randomized controlled trial

Ulrike Schmidt^{1*}, Beth Renwick¹, Anna Lose¹, Martha Kenyon¹, Hannah DeJong¹, Hannah Broadbent¹, Rachel Loomes², Charlotte Watson³, Shreena Ghelani³, Lucy Serpell^{4,9}, Lorna Richards⁵, Eric Johnson-Sabine⁵, Nicky Boughton², Linette Whitehead², Jennifer Beecham^{6,7}, Janet Treasure¹ and Sabine Landau⁸

Results:

- Both resulted in significant improvements in BMI, ED symptoms, other psychopathology, and clinical impairment
- MANTRA rated as being more acceptable and credible
- MANTRA had higher treatment completion rates

Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial

Stephan Zipfel, Beate Wild, Gaby Groß, Hans-Christoph Friederich, Martin Teufel, Dieter Schellberg, Katrin E Giel, Martina de Zwaan, Andreas Dinkel, Stephan Herpertz, Markus Burgmer, Bernd Löwe, Sefik Tagay, Jörn von Wietersheim, Almut Zeeck, Carmen Schade-Brittinger, Henning Schauenburg, Wolfgang Herzog on behalf of the ANTOP study group*

Summary

Background Psychotherapy is the treatment of choice for patients with anorexia nervosa, although evidence of efficacy is weak. The Anorexia Nervosa Treatment of OutPatients (ANTOP) study aimed to assess the efficacy and safety of two manual-based outpatient treatments for anorexia nervosa—focal psychodynamic therapy and enhanced cognitive behaviour therapy—versus optimised treatment as usual.

Methods The ANTOP study is a multicentre, randomised controlled efficacy trial in adults with anorexia nervosa. We recruited patients from ten university hospitals in Germany. Participants were randomly allocated to 10 months of treatment with either focal psychodynamic therapy, enhanced cognitive behaviour therapy, or optimised treatment as usual (including outpatient psychotherapy and structured care from a family doctor). The primary outcome was weight gain, measured as increased body-mass index (BMI) at the end of treatment. A key secondary outcome was rate of recovery (based on a combination of weight gain and eating disorder-specific psychopathology). Analysis was by intention to treat. This trial is registered at <http://isrctn.org>, number ISRCTN72809357.

Findings Of 727 adults screened for inclusion, 242 underwent randomisation: 80 to focal psychodynamic therapy, 80 to enhanced cognitive behaviour therapy, and 82 to optimised treatment as usual. At the end of treatment, 54 patients (22%) were lost to follow-up, and at 12-month follow-up a total of 73 (30%) had dropped out. At the end of treatment, BMI had increased in all study groups (focal psychodynamic therapy 0.73 kg/m², enhanced cognitive behaviour therapy 0.93 kg/m², optimised treatment as usual 0.69 kg/m²); no differences were noted between groups (mean difference between focal psychodynamic therapy and enhanced cognitive behaviour therapy -0.45, 95% CI -0.96 to 0.07; focal psychodynamic therapy vs optimised treatment as usual -0.14, -0.68 to 0.39; enhanced

Anorexia Nervosa Treatment of Outpatients (ANTOP) Trial

Compared Focal Psychodynamic Therapy (FPT)
vs. CBT-E vs. TAU
N = 242
39% > 6 years

Zipfel et al, 2014;
Herzog et al, 2022

Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in female outpatients with anorexia nervosa (ANTOP study): 5-year follow-up of a randomised controlled trial in Germany

Wolfgang Herzog*, Beate Wild*, Katrin E Giel, Florian Junne, Hans-Christoph Friederich, Gaby Resmark, Martin Teufel, Dieter Schellberg, Martina de Zwaan, Andreas Dinkel, Stephan Herpertz, Markus Burgmer, Bernd Löwe, Almut Zeeck, Jörn von Wietersheim, Sefik Tagay, Carmen Schade-Brittinger, Henning Schauenburg, Ulrike Schmidt, Stephan Zipfel

Summary

Background Anorexia nervosa is a serious illness leading to substantial morbidity and mortality. The Anorexia Nervosa Treatment of Outpatients (ANTOP) study is the largest randomised controlled trial (RCT) globally that uses psychotherapy in outpatients with anorexia nervosa. In this Article, we report the results of the 5-year follow-up.

Methods The ANTOP study is an open-label, multicentre RCT involving 242 adult female outpatients with anorexia nervosa. Participants were recruited from ten university hospitals in Germany, had to be aged at least 18 years and female, and have a diagnosis of anorexia nervosa with a body-mass index (BMI) of 15.0–18.5 kg/m². Participants were randomly allocated (1:1:1) to 10 months of treatment with focal psychodynamic therapy, enhanced cognitive behaviour therapy, or optimised treatment as usual; complete masking of the participants was not possible. The mean duration of the follow-up was 5.96 years (SD 0.2) after randomisation. The primary outcome was change in BMI from baseline at the end of treatment; here, we present the change in BMI from baseline to the 5-year follow-up, using an intention-to-treat approach with a mixed model for repeated measurements. Groups were also compared according to global outcome (based on the combination of BMI and measures of anorexia severity), eating pathology (based on the Eating Disorder Inventory 2), and other secondary mental health outcomes. We did a linear regression analysis to identify the predictors of BMI at follow-up.

Results:

- All groups gained weight, decreased general and ED-specific psychopathology
- At 12-month follow-up, no difference between CBT-E and FPT groups
- CBT-E produced more rapid weight gain and ED symptom improvements



Community and Rehab Oriented Approaches

Community Outreach Partnership Program (COPP)

Jointly operated by a hospital-based ED programme and a community-based mental health rehab team

Emphasis on QoL; harm reduction

Goals and pace set by client

Develops use of community supports vs. reliance upon hospital care

Outreach counsellor coordinates

RESEARCH ARTICLE

Setting the Eating Disorder Aside: An Alternative Model of Care

Kim D. Williams^{1*}, Tracey Dobney² & Josie Geller^{1,3}

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²Vancouver Coastal Health, Vancouver, British Columbia, Canada

³University of British Columbia, Vancouver, British Columbia, Canada

Sample goals:

- reducing dependency upon hospitalizations
- slowing weight loss or stabilizing a low weight
- bingeing on foods that are less harmful
- containing time spent on ED behaviours

Results:

Reduced psychiatric symptoms

Reduced ED symptoms

Improved QoL

RESEARCH

Open Access



A novel outpatient treatment model for patients with severe and enduring anorexia nervosa: an observational study of patient characteristics, treatment goals, and treatment course

Monica Algars^{1,2*}, Svetlana Oshukova¹ and Jaana Suokas¹

- Aims: Enhance quality of life, maintain medical stability, and minimize harm for patients with SE-AN
- Inclusion: Illness of ≥ 10 years, ≥ 3 previous ED treatments, stable medical status, BMI > 12
- Requirements: Patients' weight not to decrease during treatment; adherence to mutually agreed upon plans.
- Duration of treatment flexible; no set duration or end date.

Participants (n= 22)

60% benefited from the treatment

66.6% met or partially met treatment goals

69.2% remained weight stable or showed an increase in BMI



Role of inpatient
treatment ?

Inpatient treatment for a long-standing ED

- **Banford et al (2015)**
 - harm reduction
 - improved quality of life
 - reducing medical risk
 - decreasing crisis hospital dependency
- **Woodside et al (2016)**
 - collaborative and realistic goal setting tailored to each individual
 - no goal is too small
- **Wonderlich J et al (2024)**
 - aim for improved quality of life
 - patients set goals in 3 domains: QoL, medical stability, and meal plan (tailored to their tolerances).
 - step down planning (e.g., partial hospitalization, intensive outpatient, outpatient)

Main themes: Clinical flexibility, collaborative care, adaptability

RESEARCH ARTICLE

Open Access

Self-admission in the treatment of eating disorders: an analysis of healthcare resource reallocation



Mattias Strand^{1,2*}, Cynthia M. Bulik^{3,4,5}, Sanna A. Gustafsson⁶ and Elisabeth Welch^{1,7}

- Rationale: On inpatient units, turnover is LOW and wait lists are LONG
- Stockholm Centre for EDs: 2 of 11 adult beds are earmarked for **SELF-ADMISSION**
- Participants can **ADMIT THEMSELVES** at will as often as they want for a maximum of 7 days
- Patients **CONTACT THE WARD DIRECTLY**
- Waiting list if both designated beds are already occupied
- Program participants must:
 - Maintain outpatient or day treatment contact
 - Follow the basic treatment framework at the ward

Results.

- 67% reduction in regular inpatient admission
- Hospital beds were made more available for non-participants due to the removal of a yearly average of 13.2 high-utilizers from the regular waiting list

Potential Biological Treatments/Adjuncts

Non-invasive brain stimulation

- high freq rTMS DLPFC (Dalton et al, 2018, 2020)
shows promise...but outcomes are heterogeneous; “by no means a panacea”
- transcranial Direct-Current Stimulation (tDCS) DLPFC
reduced eating psychopathology and depression, no changes in BMI (Strumila et al, 2019)
- transcutaneous auricular (taVNS) allows for noninvasive (i.e. without surgery) stimulation of the vagus nerve

Deep brain stimulation

improved mood and BMI; habituation; hardware-related infections (De Vloo et al, 2021; Fernandes Arroiteia et al, 2020; Abode-Iyamah et al, 2019)

Novel medications (Himmerich et al, 2025)

- Metreleptin
- Dronabinol, a synthetic cannabinoid
- Ketamine
- Psilocybin
- Anti-inflammatory medications (e.g. cyclooxygenase inhibitors, cytokine inhibitors)

Microbiome-based interventions

- Lactobacillus salivarius and Lactobacillus gasseri supplementation
- Prebiotics and probiotics



Common concepts
Overall approach

Progress-oriented therapy: Assumptions

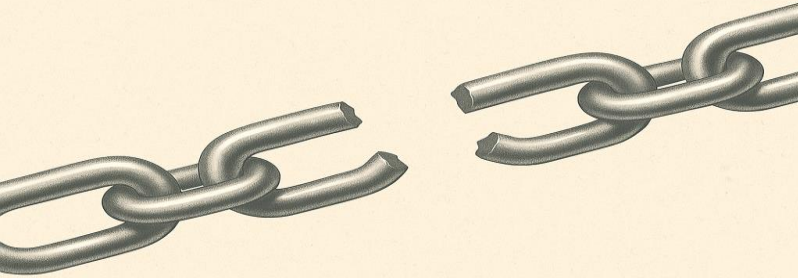
- People cannot recover from an ED on demand
- Chronicity of illness or non-response to past treatments are not good outcome predictors
- Long-term hospitalization is not indicated
- Need a care trajectory involving episodes of varying intensity, adapted to the needs of the moment
- This may require repeated trials, informed outpatient support, admissions, therapy leave, etc.

Progress-oriented therapy: Practice points (2)

- Place the person (and their carers) at the center of treatment
- Involve the person's network (parents, siblings, carers)

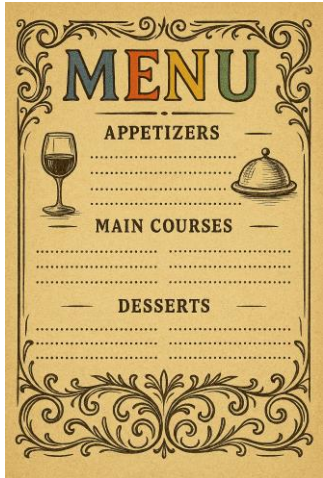
Adopt an approach that is:

- Collaborative
- Flexible
- Informative
- Supportive of voluntary engagement
- Respectful of preferences
- Tolerable
 - i.e., Avoid aggressive change-oriented techniques
- Supportive of self-acceptance



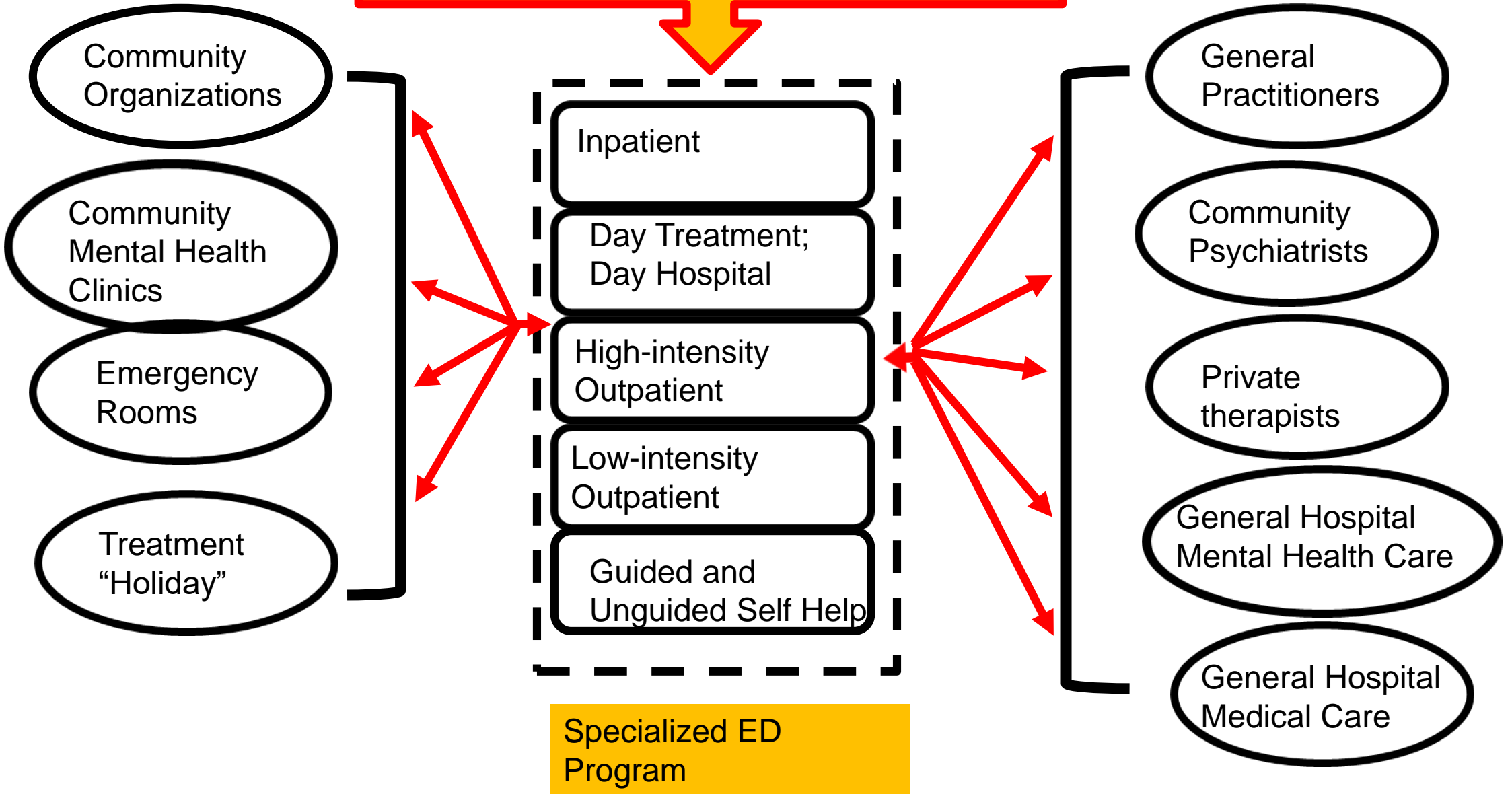
What's missing?

- Seamless care pathway
- Menu of options
- Flexibility
- Access when needed
- “Dedicated” team and case coordinator



NOTE: Long et al (2012). 34 consecutive adults with AN. Data for pre-admission (inpatient), post-discharge and 4 years after admission. Better results for those who had **continuity of care on an outpatient basis with the same therapists.**

Specialized program provides care, knowledge exchange, consultation, and coordination



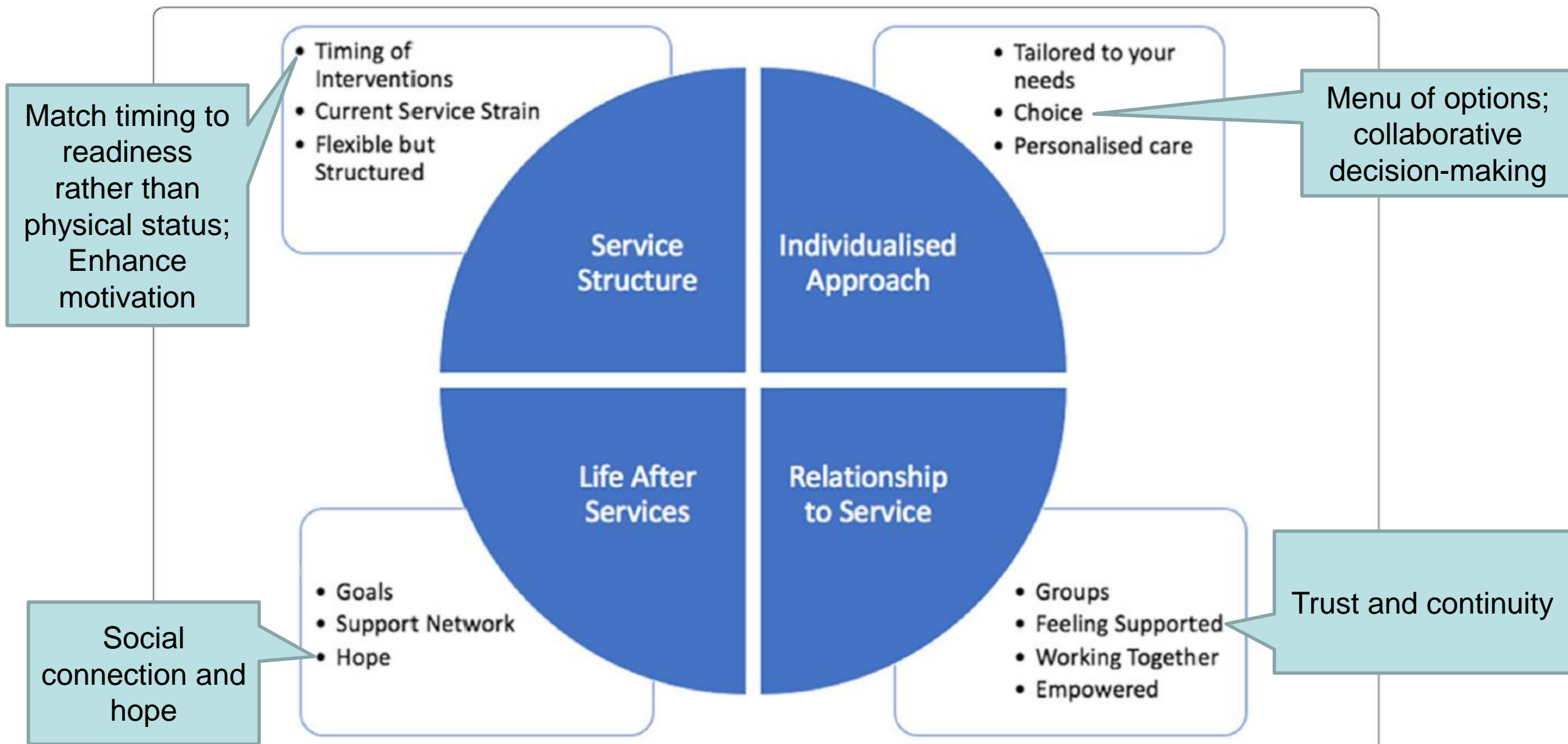


Fig. 3 Map of themes and subthemes in response to research question three: how can the NHS eating disorder service develop a care pathway which better meets the needs of service-users with L-ED?

Distinct Long- Standing ED Program or ED Program with Flexibility Throughout ?

Considerations:

- **Resources**
- **Volume**
- **Capacity for Flexibility**
- **Does the special group of patients exist?**
- **Are different interventions necessary?**

Case-based discussion

Before we
begin...

Think of a patient in your practice right now who evokes feelings of hopelessness or uncertainty.

Now think of a patient you—or your team—had once felt discouraged about, who ultimately surprised you and made a meaningful recovery.

Too often...

Woman in her 50s, separated, administrative assistant.

- Estranged from adult daughter and grandson.
- Restrictive anorexia since age 15.

Pattern:

- Multiple ICU/emergency admissions with BMI < 11
- Discharges after stabilization; lost to follow-up, returns in ~2 years with severe compromise
- Comorbid anxiety disorder; consistently refuses medication

Last admission:

- Accepted low-dose SSRI
- Discharged at BMI 13.5
- Refused day program, agreed to outpatient follow-up

Discussion

- What emotions does these type of cases evoke in you or your team?
- How do these reactions shape care decisions?
- What approach would you recommend?



What happened?

Treatment Course

- Job loss after attempted RTW → enabled group + individual therapy
- Weight low but stable (BMI <14)
- Completed group; obtained new job → no longer available for in-person care
- Transitioned to online psychiatric follow-up (low weight/med monitoring)

Long-Term Outcome

- Low-intensity follow-up (q8–12 weeks)
- Marked anxiety reduction with medication (despite discontinuation attempts)
- Gradual weight gain to BMI 14.8, sustained ×6 years
- No further sick leave
- Improved family relationships (reconnected with daughter & grandson)

Not ready...

27-year-old woman, employed full-time as a psychiatric nurse.

- Longstanding restrictive anorexia nervosa (followed since age 12) with multiple hospitalizations. Comorbid generalized anxiety disorder and coeliac disease.
- Continuous psychological follow-up from age 18; therapist retired 4 years ago. No full remission; period of partial stability with higher weight
- Ongoing weight loss over the past 3 years. Current BMI 13.5 with medical complications
- Strong resistance to hospitalization. Remains engaged and motivated for outpatient treatment

What happened?

- No improvement with outpatient treatment; refused hospitalization
- Discharged from the program after 10 months, with follow-up by family physician and referral to community therapist
- Treatment team experienced challenges due to a strong therapeutic alliance and the patient's feelings of abandonment
- 1-year post-discharge, re-contacted team to explore hospitalization; family physician also requested support
- Hospitalization was offered, but the patient ultimately declined

Discussion

- Managing refusal of higher care despite medical risk
- Supporting staff with chronic, high-risk, low-engagement patients
- Balancing program limits with fluctuating motivation
- Determining when to discontinue outpatient care
- Maintaining team coherence amid strong individual alliances



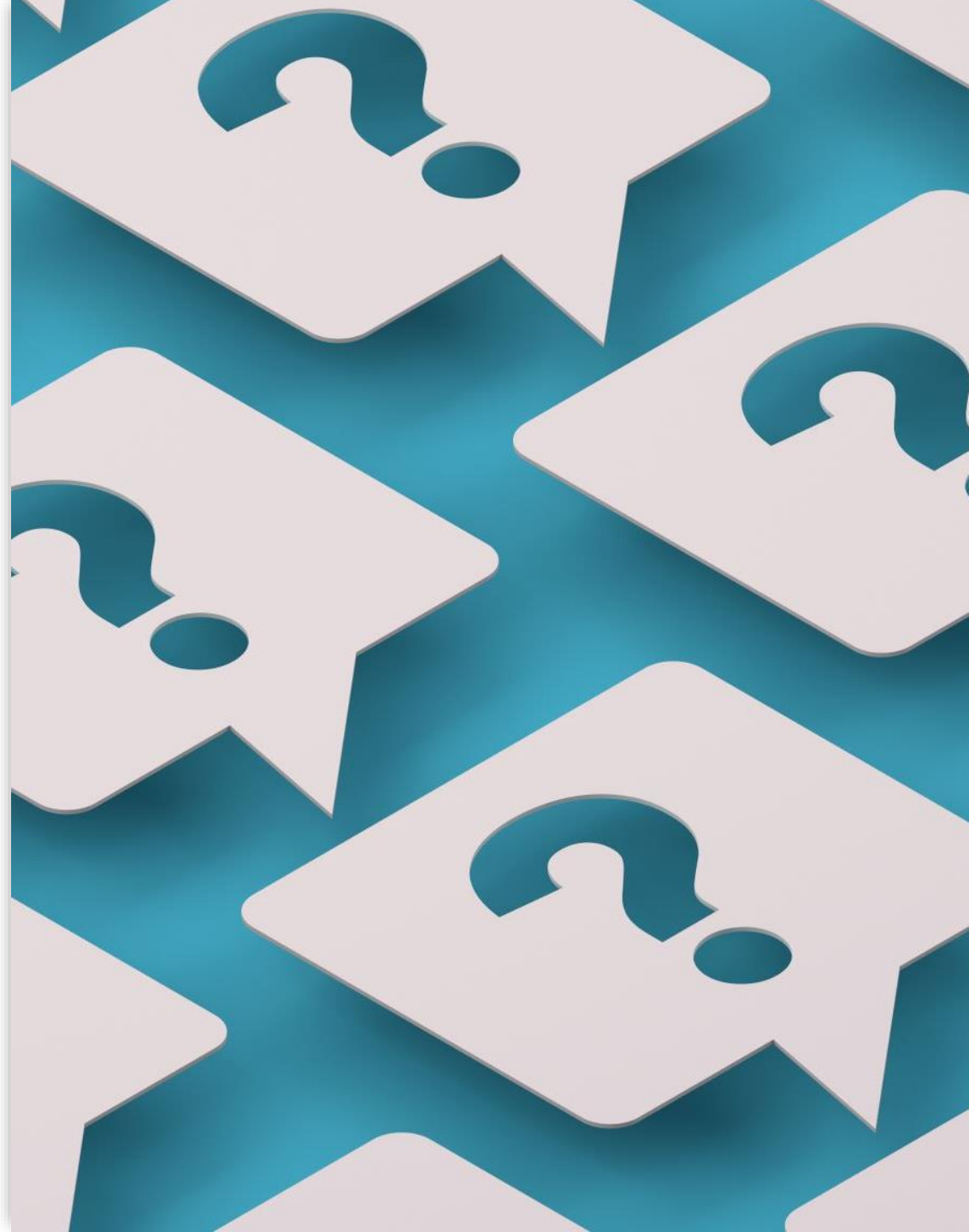
Too old...

71-year-old artist, referred from ER. Severe hyponatremia (Na 122), BMI 12.7 → stabilized and discharged

- Anorexia since childhood
 - Previously “functional” at BMI <16
 - No prior ED treatment; repeatedly refused specialized ED care
- Steady decline in recent years.
 - Strong, enduring ED cognitions and behaviours
 - Marked physical complications (incl. fecal incontinence)
- Refuses hospitalization; reluctantly open to outpatient

Discussion

- Thoughts? Feelings?
- Where do we draw the line between respecting autonomy and preventing foreseeable harm in severe, chronic AN?



What happened?

- We offered outpatient treatment (individual and group therapy, nutritional consultation, and medical follow-up).
- She committed to treatment and despite challenges achieved a BMI of 19.3 in one year.

Concluding remarks



Approach: Patient centred

- Consider giving the patient what they are asking for!
- Accept that some people will never give up their ED but are willing to work towards a better quality of life
- Co-creating expectations and goals (with mutually agreed upon non-negotiables)
- Accept revolving door as a viable and therapeutic option for some. Be welcoming rather than rejecting
- Creating a safe place (team/therapist).
 - Providing continuity even virtuality
 - Being the right place at the right time (when the patient is ready to engage with treatment differently)



Approach: Therapist centred

- Team approach/therapeutic community
 - To process anger, frustration, resentment, feeling of betrayal (I gave too much)
- Humane compassionate stance
 - Authenticity: Believe--not just pretend that there is **HOPE**
- Humility
- Experience (seeing people get better for a million reasons and reminding ourselves that recovery is possible)

Thanks !