

1

Introduction

'I am nobody, therefore I should have no body' (a female patient with Anorexia Nervosa).

Stigma and Eating Disorders

Patient A

A man of 34 with a 15-year history of Anorexia Nervosa had spent only a few months during that time out of hospital. He was attempting to maintain his weight in the community and required some social work assistance not available via the eating disorders service. A referral to the Community Mental Health Team (CMHT) manager was met with rejection on the grounds that the patient did not have a 'severe and enduring mental illness'.

This experience led to the author introducing the term severe and enduring eating disorder (SEED) (Robinson, 2006a). Having worked for many years with patients as well as their families, struggling with the effects of prolonged eating disorders, it was very clear to me that they could be severe, often life threatening and requiring hospital care, and as the case above exemplifies, they could go on for a very long time, so the 'severe and enduring' label, which, in the United Kingdom, is a ticket to community mental health services, was apposite. In that case, an explanation led to the patient being taken on and helped, and the case is not meant to show that such patients are frequently neglected by services. However, sometimes they are, and the

reaction reflects a number of feelings about people with eating disorders shared by both the public and helping professions. Crisp (2000) in a survey of public views found that about one-third of people believed that individuals with eating disorders could pull themselves together, have only themselves to blame and would be hard to talk to. However, this group of citizens were quite optimistic (overly so) about prognosis (90% thought that the outcome would be favourable). Amongst health care professionals, it is not uncommon to find a curious mixture of views. Some appear to believe that eating disorders are trivial, that they are suffered only by silly rich girls trying to diet and emulate glossy magazine icons. On other occasions, the same people may view eating disorders as so serious and complex that all must be treated by a specialist service. As in all extreme views, they both contain an element of truth. Some girls with anorexia or bulimia nervosa do, indeed, come from well-off families, and live in an atmosphere in which the culture of thinness predominates, although that does not mean that their illnesses are trivial. Secondly, some people with eating disorders do suffer from very severe and dangerous illness and require specialist help. Health workers sometimes, in addition, hold an admixture of other views which reduce the chances that they will agree to engage with someone with an eating disorder. The first is that the patient is to blame for the illness. There appears to be a spectrum of belief about responsibility, with accompanying attitudes, well illustrated in Crisp's study, so that in some disorders, such as dementia, the patient is largely exonerated from blame for the illness and is treated as having developed a brain disease completely beyond his control. Such a patient (in this world view) merits the greatest degree of sympathy. In the middle of the spectrum are people whose behaviour or personality may have contributed to the illness. Patients with severe depression are in this category, with half the population believing that they can 'pull themselves together' (Crisp, 2000).

In the world of physical medicine, someone with lung cancer due to lifelong heavy smoking, someone with pneumonia who is HIV positive due to sexual transmission of the virus and someone very overweight with diabetes mellitus may be victims of prejudice. Some surgeons have suggested that people who continue to drink should not be given liver transplants, and those who continue to smoke should not be offered some forms of arterial surgery unless they agree to quit (Powell and Greenhalgh, 1994), and many would concur that this is justifiable.

At the far end of the spectrum lie patients who are deemed to be 'doing it to themselves'. In this sorry group are people with eating disorders, personality disorders and addictions. Interestingly, the Mental Health Act, which suggests that perhaps individuals are not completely responsible for

Introduction

3

Minimal blame	Moderate blame	Major blame
I-----I		
Alzheimer's	Depression	Addictions
Epilepsy	Schizophrenia	Personality disorder
Learning difficulties / brain damage	Phobias	Eating disorders

Figure 1.1 The blame spectrum of mental disorders

their behaviour, can apply to the first two, but not the last set of conditions. Patients with severe eating disorders have been targets of such comments as 'she's running me round in circles while I have a ward of real patients to treat' (consultant psychiatrist). Personality disorder elicits such negative attitudes from psychiatrists that it has been proposed that the term be abandoned (Lewis and Appleby, 1988). When patients on psychiatric wards cause problems it is sometimes concluded that the problem is either 'caused by illness' or 'behavioural'. The former descriptor implies that a behaviour, such as violence, is a symptom of illness, such as schizophrenia, and probably not completely under the patient's control. The latter term 'behavioural' implies that the problem is not due to mental illness and is under at least some voluntary control. The distinction may have some validity with the former types of behaviour responding better to medication and attention, and the latter types to withdrawal of attention. The problem with the distinction is the stigma that it implies, with some patients being more worthy than others. Descriptors such as 'manipulative' and 'hysterical' have become less prevalent probably because of their negative connotations, to be replaced by successor terms associated with personality disorder. The stigmatization of people at the 'only themselves to blame' end of the blame spectrum (see Figure 1.1) may well be a reflection of health workers' anxiety that they themselves will be blamed by the institution if the patient does do something extreme. The blame culture in the NHS has, unfortunately, outlived its obituarists (Wise, 2001; National Audit Office, 2005).

Severe and Enduring?

Psychological problems are very common, while resources for treatment of mental disorders are limited. Providers of services have therefore, rightly, been encouraged to concentrate on mental disorders that can be described as

severe and enduring, at the expense of the far more numerous psychological difficulties that are, by contrast, relatively less severe and sometimes self-limiting. There has been a concern that services might be directed towards these latter groups for a number of reasons. Firstly, they are more common, secondly, they are probably more able to present themselves for help (and even demand it), and thirdly, because they are more like 'us' they are likely to be easier and more rewarding to treat. If we accept that the first call on our scarce resources should be by individuals in the severe and enduring category (SEMI: severe and enduring mental illness) there remains substantial confusion, evident in the CMHT response which opened this chapter. GPs have also indicated that they are unsure as to the boundaries of the term (Barr, 2001). One common interpretation is to equate SEMI with chronic schizophrenic or depressive psychosis. This would clearly be over-restrictive and risks depriving people with equally debilitating obsessive compulsive disorder or Anorexia Nervosa of necessary help from mental health professionals. Holloway (2005) regards schizophrenia as the paradigm of severe mental illness, while he adds 'other mental disorders whose social functioning is significantly affected by their illness or disorder (which will include some people with a diagnosis of depressive illness, obsessive-compulsive disorder and personality disorder)'. Anorexia Nervosa, which has a standardized mortality rate of around 10.5 times the norm (Birmingham *et al.*, 2005), is not included, although the implication is that it could have a place.

The 'severe and enduring' descriptor seems to have originated in the National Service Framework (NSF) for mental health, published in 1999. Introducing the term, the NSF gives us some help in its interpretation:

p46

People with recurrent or severe and enduring mental illness, for example schizophrenia, bipolar affective disorder or organic mental disorder, severe anxiety disorders or severe eating disorders, have complex needs which may require the continuing care of specialist mental health services working effectively with other agencies. Most people manage well with this care and benefit from living in the community, posing no risk to themselves or others (Department of Health, 1999a).

The intention appears to have been to include all people with mental disorder whose disorder is disabling and long lasting, whatever it is. Many patients with chronic anorexia and bulimia nervosa have problems which accord with this definition.

How Severe, How Enduring?

This book is about serious illness in people who have problems in mental, physical, occupational, social and family domains. The concept of severity is certainly relevant. It is a complex one, however. BMI on its own is not a particularly reliable marker of illness. A 16-year-old whose weight falls from a BMI of 20 to 15 in 6 months may be mortally ill. In contrast, a 40-year-old who has been at a BMI of 13 for 15 years may be working. For the 16-year-old, the clinical priorities may be as follows:

1. Saving her life.
2. Helping her improve her nutrition.
3. Engaging her and her family in therapy to help her get back to a healthy weight as soon as possible.
4. Continuing therapeutic work to help her avoid relapses.

The 40-year-old may have completely different priorities:

1. Maintaining the maximum possible level of nutritional health.
2. Managing crises, medical or psychological.
3. Keeping at work.
4. Maintaining social contacts.
5. Providing care for an elderly, ailing parent.
6. Addressing complications of her eating disorder such as osteoporosis.
7. Dealing with depression.

We have two groups of patients therefore, the acutely ill young patient with a short history of Anorexia Nervosa and not much else and the chronically ill patient with a long history of Anorexia Nervosa with physical, psychological and social complications. The acronym SEED applies only to the latter.

Consider this case:

Patient B

A 20-year-old woman presents with a 4-year history of severe weight loss and depression. During inpatient treatment for her malnutrition, her depression becomes worse and she reports hearing derogatory voices. By this time, she has been in hospital for 4 months. She is given ECT and improves, but during treatment for a leg spasm by epidural analgesia, she develops bilateral

paralysis of her legs. She is in a medical and a neurological ward for a year, and gradually improves enough to return to the eating disorders ward. She recovers memories of sexual abuse, and over the following 3 years makes a good recovery.

This illness was certainly severe (it nearly killed her) and it did endure for about 8 years. One could argue that her case should be included in the SEED category, even though she eventually recovered. One of the most remarkable aspects of treating eating disorders is that patients do, against all predictions, sometimes recover after 8, 10 and even 20 years of illness. The above case also raises the question of the boundaries of eating disorders. Did she have several illnesses or only one? Consider the case of tuberculosis (TB), before the causative bacterium was discovered. A patient might consult the doctor with a cough, with weight loss and fever, with red swellings on his legs, and even with epilepsy and personality change. Until the discovery of the bacillus, these diverse manifestations of TB could well have been thought to be caused by different processes. When the bug was discovered, and found to be lurking in the tissues of all people with these problems, they were all seen as manifestations of the same disease, TB.

In psychiatry, we largely occupy a world in which the bug has yet to be discovered. In Anorexia Nervosa it could be so many things, and most likely be a combination of several. Even in TB the bug is not the whole story. Someone infected would only actually get the disease if one or more other processes, including poverty, malnutrition (including Anorexia Nervosa) and weakness of the immune system, such as that caused by AIDS, are present. The bug is necessary but not sufficient. In Anorexia Nervosa predisposing factors such as an eating disorder in the family have been identified, but none might be essential. It is possible that, if there are 10 contributors to the disorder, 4 of them might be contributory in one patient and another 4 might together lead to the disorder in a second patient. In the patient described above (she reappears in more detail in Chapter 2), the course of the illness suggested strongly that the abuse she suffered in her adolescence was key to the development of her illness. If that is true (it is very difficult to be absolutely sure), then all problems of this patient were probably caused by it. This includes Anorexia Nervosa, psychotic depression and conversion disorder (hysterical paralysis). By analogy with infectious disease, if we have the putative causative agent (sexual abuse) then all manifestations of illness caused by it are part of the same disease.

Introduction

7

SEED, therefore, may contain diverse clinical spectra. It can be stable, with continuing ill health for many years, but there is little change in the disorder, except that produced by chronic complications. Patients with long-standing stable eating disorders in whom the illness has been continuously present for a minimum time are the group who merit the descriptor SEED. The length of time chosen is to some extent arbitrary. Steinhausen (2002) found that recovery continued to occur after 10 years of illness, although the rate appeared to be slowing when compared to 4–10 years. Ten years is by any definition a long illness, and problems associated with chronicity are likely to occur at that stage. While research which gives better guidance is awaited, I suggest that 10 years be adopted as the minimum duration of continuous disorder for SEED. The majority of patients with SEED will be underweight, and therefore fulfil criteria for Anorexia Nervosa. There will, however, be variation, and any eating disorder can be severe and long lasting enough to merit inclusion in the SEED category. SEED can therefore, if necessary, be suffixed according to the eating disorder from which the patient is suffering, i.e. SEED-AN, SEED-BN, SEED-BED, etc.

Another group of patients with a very unstable disorder, such as Patient B described above, but with a duration that may not extend to 10 years, should perhaps be identified as they require such extensive and expensive treatment. These patients could be labelled as having severe and unstable eating disorder. The group would include patients requiring prolonged and/or frequent hospital admissions for life-threatening clinical problems including undernutrition, electrolyte disturbance, depression, psychosis, suicidal and other self-harming behaviours and substance misuse.

Yager (2007) draws our attention to the distinction between treatment non-response, when the patient accepts treatments offered, and treatment reluctance, when compliance and engagement are lacking. He rightly points to motivation and its enhancement as key to management of chronic eating disorders.

Severity

How severe should a patient's illness be to merit the SEED attribution? A strict definition is one that comes from the NSF: the patient has 'complex needs which (may) require the continuing care of specialist mental health services working effectively with other agencies'. A definition focused on symptoms would be:

A patient with symptoms of an eating disorder which interfere substantially with quality of life.

The eventual definition of SEED will require a large study of patients with long-term eating disorders in which measure of physical and psychological symptoms, as well as quality of life, adaptation to illness, social consequences and use of services among others, would be made.

Assessment of a Patient with Chronic Stable SEED

How should the assessment of such a patient be approached? Her problems originate with nutritional disturbance, but certainly do not end there. It is worth giving a little thought to a system within which to assess an individual's difficulties and needs.

The Care Programme Approach (Department of Health, 1990, 1999b) gives detailed guidance on provision of care to people with SEMI, citing the following domains (see Table 1.1) as examples of those that might require attention:

1. Physical health
2. Mental health
3. Social and Family
4. Housing
5. Finance
6. Occupation (employment, education).

These domains will be used to inform the content of this book, and a proposed format for CPA documentation will be provided.

In addition to the domains, the following areas need to be addressed:

1. A list of names and contact details of professionals responsible for the delivery of the Care Programme.
2. The name and contact details of a key worker/care coordinator.
3. The name and contact details of a carer, if possible.
4. The formulation of a care plan and regular review.
5. The identification of signs of relapse or increasing risk.

Introduction

Table 1.1 Domains and handicaps in SEED

Domains	Primary handicaps	Secondary handicaps
Physical	Inability to climb stairs Poor sleep Risk of death Fractures Exercise abuse	Chronically poor health Social isolation
Psychological	Poor motivation (depression) Time management problems (OCD) Hoarding	Social isolation Home care poor
Social	Inability to eat in public Difficulty maintaining relationships Stigma	Self-neglect Social isolation
Family	Family conflict Family exhaustion	Alienation from or overdependence on family
Housing	Relapse when living alone	Frequent readmissions Confirmed in sick role
Finance	Difficulty spending	Poor home environment Social isolation
Occupation	Difficulty working	Reduced social contact

Handicap and Adaptation (See Figure 1.2)

The concept of handicap has long been used to help characterize the difficulties faced by people with physical illness such as polio, mental illness such as schizophrenia and learning difficulties. It is useful because it can be applied to any of the domains listed above. Moreover, a symptom such as difficulty eating in public, which might cause a major handicap to one person, may not cause much problem to another. The difference may reside, not in the symptom itself, but in other areas such as social support, personality and occupation. It is perhaps more helpful to talk about adaptation, because the word has positive connotations, handicap representing the half-empty glass and adaptation its more optimistic half-full complement. Adaptation

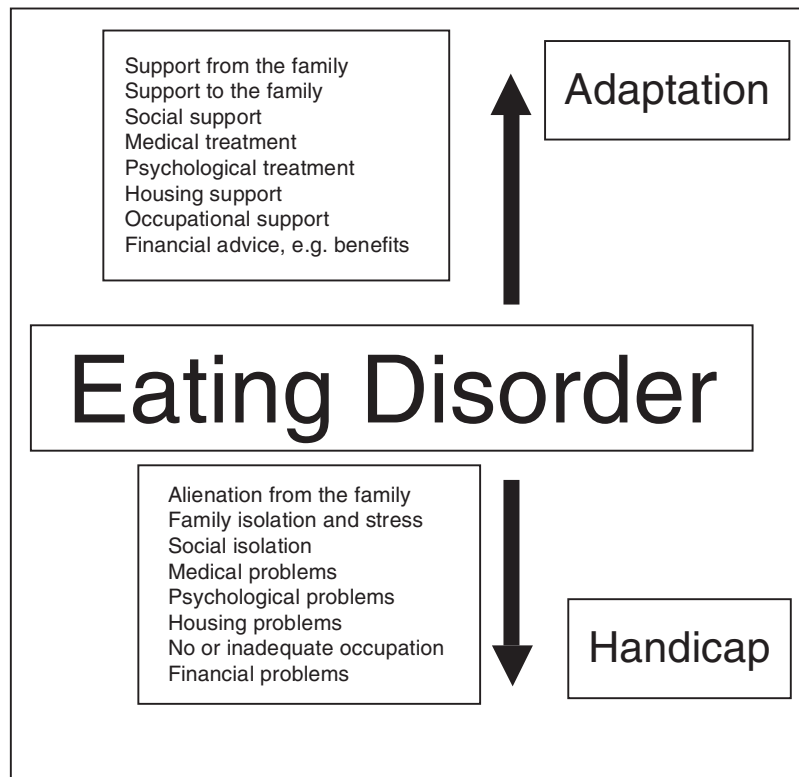


Figure 1.2 Adaptation and handicap in mental disorder.

is the end result of the specific symptom, the individual's reaction to it and the influences of society to both. Services provided to the patient need to minimize handicap and maximize adaptation.

Let us consider a person with SEED:

Patient C is aged 32 and began to lose weight in her late teens. Repeated attempts at treatment were inevitably followed by rapid relapse, but after the age of 25 she maintained a low but stable BMI of 14.2, thereby avoiding further hospitalizations. However, she continued to have problems in many areas: she had difficulty getting to her flat on the fourth floor of a house with no lift; she spent several hours each morning cleaning her flat in a ritualistic way; she had virtually no social life; and she was on long-term sick leave from her job as a bank clerk.

Introduction

11

Patient C has difficulties in a number of domains. She has problems in physical health (muscle weakness), mental health (obsessive compulsive cleaning), social function (isolation), housing (too many stairs), finance (especially if she is unable to keep her job) and occupation (her own confidence at work, attitudes of employers). Many of these problems could be addressed if she improved her nutritional state. However, she has shown that she is not able to adapt to a higher weight, and while we may wish to encourage weight gain, we should not anticipate it, and our interventions in the different domains need to be designed with the expectation that her weight will stay around the same. These interventions could extend into a wide variety of psychological, psychiatric, social and other fields. From the nutritional point of view, while weight gain might be a no-no, it would be worth checking her blood count, which could reveal anaemia, treatable with iron or vitamin B12. Her obsessive compulsive disorder (OCD) is most likely integral to her eating disorder, related to both starvation (which tends to produce OCD symptoms (Keys *et al.*, 1950)) and a drive to over-exercise. If we accept that her eating disorder is stable, these are unlikely to change. However, cognitive behaviour therapy including exposure and response prevention, established as effective treatment for OCD without an eating disorder (National Collaborating Centre for Mental Health, 2005), could be tried, especially if Patient C is desperate to reduce her cleaning rituals. Moreover, an SSRI (selective serotonin re-uptake inhibition) antidepressant could also be offered as an effective intervention in OCD. Moving onto psychosocial interventions, social isolation could be addressed in a number of ways, including activities such as classes or voluntary work and therapy or self-help groups which may or may not be eating disorder focused. Rehousing with fewer stairs might be considered, while at work she might be encouraged to question her employer's handling of her case, especially if she can be shown to perform her role adequately in spite of her long-standing eating disorder.

The overall aims would be to reduce symptoms, both physical and psychological, as far as possible, given presently available interventions and to maximize adaptation to the residual problems, and so minimize handicap.

The Sick Role: Institutionalization

Hirsch (1976) suggested that people with schizophrenia had three types of handicap with which to contend:

Primary handicap. The effects of the illness itself.

Secondary handicap. The effects of being in the role of a psychiatric patient over many years; relevant factors being the patient's ability to deal with the outside world, his attitude to himself and others and the attitudes of family, employer and the public.

Premorbid handicap. Factors that contribute to the onset of illness, such as the personality structure, poverty, poor education, and poor employment opportunities.

Can this approach be adapted for people with eating disorders? The primary handicap would encompass the effects of all the psychological, physical and social problems that comprise eating disorders and the commonly associated disorders such as depression and OCD. In the context of schizophrenia, secondary handicap was often seen as being caused due to long periods spent in hospital, with the associated infantilization of the patient and increasing dependence on the institution, resulting in patients having great difficulty leaving the hospital at the time of discharge. Since the closure of the large mental hospitals, secondary handicap has been recognized as accompanying any long-term mental illness, as a result of the combination of the symptoms (e.g. hearing voices, depression) and the resulting problems of chronicity. Schizophrenia often results in impaired relationships and social engagement. A constellation of difficulties frequently observed is as follows.

The patient feels persecuted, may behave in an odd manner, the public avoid him resulting in progressive isolation, and increasing alienation, including loss of employment and exclusion/withdrawal from social settings.

The stigma associated with eating disorders is different from that accompanying schizophrenia, in that patients are less likely to be perceived as dangerous (Crisp, 2000). People with eating disorders, especially Anorexia Nervosa, often do suffer from social isolation, however. In them, the constellation is more likely to be as follows.

The patient feels uncomfortable eating out and therefore misses many social engagements. Other people are dismayed by the patient's appearance and do not know how to help or even bring up the subject of her emaciation. The patient's opportunities for social interaction progressively diminish. Her appearance and her hormonal deficiency state make romantic encounters less

Introduction

13

likely. Her physical appearance may lead employers to judge her too ill to work, and to regard her as unsuitable because of the possible impact on customers and colleagues. Moreover, colleagues' suspicions that she may be bingeing or purging at work can lead to alienation in the workplace.

The secondary handicaps of eating disorders can, like the domains, be divided into physical, psychological, social, family, housing and occupational. Taking Hirsch's definition, the key characteristic of a secondary handicap is that it is an effect of having been in the sick role for a number of years. It should be distinguished from a late symptom. For example, a patient who develops Anorexia Nervosa at the age of 20, then has a fracture of the spine due to osteoporosis at 40, has a symptom of the Anorexia Nervosa which has appeared late in the disorder. However, that same patient may have become socially isolated over the 20 years of illness and have lost her job as a result of new management who regarded her as physically too weak to continue.

Models of Illness: Many Hats on One Head

There is an unfortunate tendency in mental health to adopt one model of illness to the exclusion of others. It is sometimes argued that to allow more than one model into one's thinking encourages sloppiness and that an individual should stick to one way of approaching clinical problems. Hence, there are battles between so-called organic, psychodynamic and cognitive behavioural schools all convinced, like religious fundamentalists, that they have the right view. However, they are more like the blind men of Indostan grasping different parts of the elephant and concluding that the animal was like the part they had touched:

*Each in his own opinion
Exceeding stiff and strong,
Though each was partly in the right,
And all were in the wrong!*

There are numerous ways to look at human behaviour, each way characterized by a different context. Different clinical situations demand different approaches; a few of which follow.

Psychodynamic or Psychoanalytic Approach

Many of the concepts elaborated by Freud and his successors are extremely valuable thinking aids in approaching eating disorders. The patient with Anorexia Nervosa is engaged in a non-verbal communication which, deciphered, says, 'I cannot feed myself or be responsible for looking after my own health.' This suggests regression to a very early stage, before the infant can feed herself. Ideas derived from a variety of psychoanalytic strands are in regular usage in attempts to make sense of eating disorders. Some of the most compelling are those of object relations and attachment theories. These theories posit the importance of primary relationships in the development of the infant and young person. The range of developmental considerations that have impacted on psychotherapeutic models have been well reviewed by Fonagy and Target (2003). Consider the following case history:

Patient D was the child of a mother who was chronically depressed. At 13 she passed through puberty and by 14 she had developed Anorexia Nervosa. In both individual and family therapy, there was evidence that she had not made a strong emotional connection with her mother and she began to relate to other adults, her father, doctors, nurses, entirely through the medium of her eating disorder. After many hospital admissions, she married a man with an obsession with fitness, and continued her eating disordered behaviour, with food restriction and over-exercise. Her relationship with her husband was dominated by her eating disorder. He attended her every meal, and made sure she ate a full diet. She managed to continue weight loss by means of over-exercising, and this led to frequent tension between them. She was referred to a day hospital in which she was given the choice to either lose weight and be admitted once again to hospital or maintain it and work on her issues. She found this approach very challenging and indicated that she felt more comfortable with a more authoritarian approach that she could resist. She communicated in therapy that she had never been close to any individual and that only through her eating disorder, which resulted in conflict with other individuals who usually tried to force her to eat, had she had any form of emotional relationship, albeit a negative one.

The object relations approach was, for her, helpful and relevant. She had never developed an emotional bond with any individual in her life, for reasons that can be conjectured, but not fully understood. She thus lacked

Introduction

15

substantial internal objects (i.e. an internal mother, father, lover, etc.) which, had they developed, might have supported her and allowed her to deal with the demands of loneliness, criticism, others' need for care, etc. In their absence, however, she substituted anorexic behaviour for internal objects resulting in relationships with others in which she was the dependent, demanding child and others always placed in the carer role, absolved of the need to care for others. She addressed (but did not satisfy) her dependency needs and became stuck at an infantile level of social development.

This formulation also suggests an approach to treatment which can be adopted by all staff. Therapeutic relationships should be supportive, but behaviour which perpetuates the regressed role should be challenged. Her therapy need not be psychoanalytic, although it could be. The insights provided by the analytic approach can inform all meetings with staff and help edge Patient D towards a more adult way of relating.

Cognitive and Behavioural Approaches

CBT is often placed as the more evidence-based alternative to analytic therapy and there is no doubt about its helpfulness in many clinical situations. The insights of CBT can also be extremely useful in other therapeutic activities, not generally thought of as CBT, for example supportive individual therapy and family therapy. Patient D's dilemma could well be presented by looking at her attitudes to herself including her body image, her deeply held beliefs (schemas) about herself as someone who could never be independent and who would always be a failure, her behaviour such as her food restriction, her repeated and obsessive exercising and her constant examination of her body parts in the mirror. The interactions between her beliefs and her behaviours reinforce each other and perpetuate the anorexic lifestyle. Fundamental beliefs about the self are, of course, commonly encountered in psychoanalytic formulations, as are many other 'CBT' concepts such as generalization and personalization.

Many of the differences between schools of therapy are to do with packaging and marketing. Like Scottish kilts, in which there is a wide variety of patterns from the different clans (some of whom will not talk to each other) all at least cover the essentials. So many of the concepts are either labelled differently in each approach, or used without being attributed by therapists. It often seems that the packaging of a therapy serves the

individuals who are building their careers by promoting a particular named therapy, more than the patients who are the presumed beneficiaries. This may, however, be too harsh, and the packages, whether psychodynamic, CBT or newer ones such as dialectical behaviour therapy (DBT) (Linehan, 1993) or mentalization-based therapy (MBT) (Bateman and Fonagy, 2004) may well provide a therapy with practical and theoretical coherence, better than eclectic approaches that try to take from all.

Biological Approaches

Psychiatrists sometimes characterize themselves or are described by others as 'biological' or 'psychosocial' in orientation. Indeed, psychiatry departments in US medical schools accrue similar labels. In the 1970s, most US departments were psychoanalytic in orientation and in the 1980s many changed to biological schools. What does the term imply? At its most extreme, it can be a deterministic set of beliefs that holds that all behaviour, including mental symptoms, is predetermined by the molecular configuration of the individual, and that psychosocial interventions merely act as additional molecular influences that make changes in the patient's chemistry and hence modify behaviour.

More usually, the term implies a belief that the most important influences which lead to psychiatric presentation are biological. The range of such influences is wide. Genetic factors are extremely important, so that the possession of a set of genes that predispose to Anorexia Nervosa is said to explain most of the patient's anorexic symptoms. In addition, chemical changes in the brain which might be partly genetically determined, but which might also arise as a result of environmental influences, are held to be of great importance. In psychiatric disorder few such changes have been conclusively identified, and many of them are inferred because certain drugs with common actions (e.g. raising serotonin levels or blocking the action of dopamine) have therapeutic effects on certain conditions (respectively depression and psychosis). This partly explains why 'biological' psychiatrists often turn to medication to help the patient. Thirdly, physical changes, for example in brain structure, are held to account for behavioural change. This is evident in a patient with advanced Alzheimer's disease but may also be posited in someone with schizophrenia who has been found to have a slight reduction in brain tissue, possibly deriving from birth trauma. In

Introduction

17

the eating disorders field, a physiological change which has been suggested as perpetuating undereating in Anorexia Nervosa by increasing fullness after meals is delayed gastric emptying. This change, which probably occurs secondary to undereating, is thought to cause prolonged gastric discomfort after meals which inhibits further eating (Robinson, 1989).

The sad thing about the tendency to be attached to one model is that most models are useful and complementary. Just as physics and chemistry, each has something different and relevant to say about the same natural phenomenon; psychodynamic, cognitive behavioural, biological and other models of behaviour all have useful ideas to contribute to the understanding of human behaviour. A holistic approach in which each level of the system is examined using the most appropriate tools could lead to a formulation with developmental, psychodynamic, cognitive, behavioural and systemic dimensions, each contributing to a comprehensive view of the problem.

Systemic Approaches

Because systemic approaches purport to include all elements in a system, they have the potential to address the above complaint. In practice, systemic views tend to look at the way elements relate to each other, rather like a satellite picture of an archipelago. The elements in question can be individuals in a family, or in a therapeutic system (e.g. patient, eating disorders team, community mental health team, family), or even ways of viewing the problem (such as a biological and a social model). These ideas are very useful for understanding tensions within the different systems, and discerning why things might be going wrong:

Patient E

A patient who was physically abused by her father before he left the family home becomes very close to her mother. In treatment for severe depression and an eating disorder, she forms a close relationship with a female therapist. The male psychiatrist's opinion that the patient requires electro-convulsive therapy for her psychotic depression is strongly resisted by the therapist. Aside from the complex clinical and ethical issues about treatment, the mirroring of the patient's relationship with her parents by the relationship with team members is important to identify, especially as it could lead to a serious rift within the team.

Complexity theory is another useful tool in the difficult task of bringing together the numerous influences that bear on clinical, and especially psychiatric, problems. Strange attractors are high-level mathematical functions that can say something about the behaviour of complex systems. They have been used to study weather patterns, and economic systems, and have been applied to human behaviour, including therapeutic systems (Robertson and Combs, 1995). The idea that there could be a formula which could reflect what is going on in a family or other system is, in itself, quite helpful. The theoretical attractor 'restricting Anorexia Nervosa' would have quite powerful organizing influences on a family system and these would be very different from those of another theoretical attractor 'bulimic Anorexia Nervosa' which would be rather more chaotic. The attractor 'borderline PD with eating disorder' could be a particularly chaotic function.

Another interesting and useful concept within complexity theory is fractal theory, in which complex systems are found to repeat similar patterns at many levels of magnification. Thus, regular fluctuations in serotonin levels could be associated with mood fluctuations, and, at a behavioural level, oscillating bingeing or self-harming behaviour. In a couple, closeness and distance in the relationship could well oscillate to the same wave and, in the therapeutic system, the frequency and intensity of interventions might be similarly oscillating to the same equation. A rather odd example of a possible fractal structure is represented by the effects of anticonvulsants in stabilizing membranes, reducing abnormal electrical discharges and suppressing epileptic attacks (all presumably causally linked). The same drugs, in an action which appears to leap neuro-organizational levels, also stabilize mood and behaviour in patients with bipolar or borderline personality disorder. The actions of the drugs at four different levels of the system have in common the smoothing of chaotic patterns.