Correspondence

Eating disorder in children and adolescents – risky business?

Although we agree with Dr Wrate that a context to risk is important,[1] we cannot concur with his view of the context. As healthcare professionals caring for young people with eating disorders, we do not regard seven deaths in children and adolescents as reassuring. When put into the context of more 'traditional' paediatric illnesses, 1.5 deaths per year are not far removed from 12 deaths from diabetic ketoacidosis and 14 deaths from invasive childhood meningococcal disease (sources available from the authors on request). Even within the 18 years since Dr Wrate's search, there has been a continuing reduction of vaccine-preventable diseases, improvement in neonatal outcomes and survival from childhood malignancies, resulting in a shift in childhood illnesses from communicable to non-communicable diseases, including eating disorders.

Death is a preventable outcome of eating disorders and may be secondary to lack of awareness, knowledge or timely treatment; yet it would seem that paediatric medical and mental health services are sometimes ill equipped to meet the challenges of young patients presenting with eating disorders, especially acutely. Studies show that 50% of children less than 13 years old are hospitalised early in their illness[2] and numbers of children under 14 hospitalised for eating disorders have risen over the past 10 years. A recent survey of on-call paediatric registrars in hospitals in England and Wales revealed poor knowledge of the acute management of children with eating disorders (C. Cumby, 2012, personal communication). Most were unaware of the frequent cardiovascular complications and unable to outline the complications of refeeding syndrome.

We agree with Dr Wrate that there has been too much emphasis historically on hospitalisation rather than on good-quality out-patient treatments and early intervention; however, we believe that it is important not to negate risk in order to redress this balance. The decision to admit is a complex one; unfortunately, it is our observation that admission to hospital is often more dependent on available services and experience of healthcare professionals than clinical need.

We also wish to comment on Dr Wrate's commentary on morbidity in eating disorders in childhood, which he describes as relating only to bone mineral density. Not wanting to understate the significance of potentially irreversible low bone density as a medical complication, we must highlight the multisystem effects of eating disorders and associated malnutrition in this group. Other unique medical complications found in children with eating disorders include an impact on growth and development and changes in brain structure and function.[3,4] Such complications are treatable if recognised early and treated aggressively.

To date, there are too few data on the outcomes of children with eating disorders for us to relax about risk. In preparing the Junior MARSIPAN report,[5] instances of deaths were rare. Nonetheless, the cases described in the report show this is risky business indeed and examples were not hard to come by. The risk assessment framework in the Junior MARSIPAN report acknowledges the complexity of risk assessment, and is stratified to avoid overstatement. Valuable lessons learnt from improvements in survival from preventable childhood diseases such as meningococcal disease include the importance of early recognition, awareness and training. In the absence of consistency, we argue that erring on the side of caution is prudent and the MARSIPAN guidelines are important safeguards to help clinicians understand, recognise and treat eating disorders.

Declaration of interest
L.H. and D.N. contributed as authors to Junior MARSIPAN; D.N. is president of the Academy for Eating Disorders.

1 Wrate RM. Death and risk in adolescent anorexia nervosa. *Psychiatrist* 2012; **36**: 316–7.

2 Nicholls DE, Lynn R, Viner RM. Childhood eating disorders: British national surveillance study. *Br J Psychiatry* 2011; **198**: 295–301.

3 Hudson LD, Court AJ. What paediatricians should know about eating disorders in children and young people. *J Paediatr Child Health* 2012; Mar 7. doi: 10.1111/j.1440-1754.2012.02433.x. (Epub ahead of print)

4 Chui HT, Christensen BK, Zipursky RB, Richards BA, Hanratty MK, Kabani NJ, et al. Cognitive function and brain structure in females with a history of adolescent-onset anorexia nervosa. *Pediatrics* 2008; **122**: e426–37.

5 Junior MARSIPAN Group. *Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa* (College Report CR168). RCPsych Publications, 2012.

Lee Hudson, Research Fellow and Honorary Consultant Paediatrician, Department of General and Adolescent Paediatrics, UCL Institute of Child Health, London, UK, email: l.hudson@ucl.ac.uk. **Dasha Nicholls**, Consultant Adolescent and Child Psychiatrist, Feeding and Eating Disorders Team, Great Ormond Street Hospital, London, UK. **Debra Katzman**, Professor of Paediatrics, Division of Adolescent Medicine, The Hospital for Sick Children and University of Toronto, Canada. **Andrew Kennedy**, Consultant Paediatrician, Department of Paediatric and Adolescent Medicine, Princess Margaret Hospital, Perth, Australia.

doi: 10.1192/pb.36.11.437

Author's reply: I fully agree with the authors that a careful definition of context is all important. So it was disappointing that they took my comment on being reassured out of the context in which it was placed; every death of a teenager is a tragedy. To note that the observed annual death rate for anorexia nervosa is around a tenth of that for the paediatric conditions they cite, and far less than the rate of death by suicide in young patients with schizophrenia, is not to be relaxed about risk in anorexia nervosa, nor to imply that specialised treatment for anorexia nervosa is not required.

In my response to Robinson's article I did not sufficiently well position my own observation about medical complications, which would have been better phrased as 'the only common complication of clinical significance'. Morbidity, which I was seeking to distinguish from the biological response to starvation, sometimes goes beyond bone mineralisation problems, and often does when chronicity becomes established. However, unlike Wentz *et al*'s prospective outcome study,[1] which reported no deaths over an 18-year

follow-up period, the study of brain structure and function cited[2] was not based on a community sample. Their findings were derived from a cohort of acutely ill hospitalised adolescents, and were most evident in those who remained at low weight in their 20s.

I am grateful to learn about the Junior MARSIPAN report, and hope that most readers recognised that I was situating my response to Robinson's article from a community perspective, including how 'risk' may be constructed by those responding to newly presenting patients with anorexia.

1 Wentz E, Gillberg IC, Anckarsäter H, Gillberg C, Råstam M. Adolescent-onset anorexia nervosa: 18-year outcome. *Br J Psychiatry* 2009; **194**: 168–74.

2 Chui HT, Christensen BK, Zipursky RB, Richards BA, Hanratty MK, Kabani NJ, et al. Cognitive function and brain structure in females with a history of adolescent-onset anorexia nervosa. *Pediatrics* 2008; **122**: e426–37.

Robert M. Wrate MDBS DPM FRCPsych, psychiatrist, NHS Shetland, Edinburgh, UK, email: robertwrate123@btinternet.com

doi: 10.1192/pb.36.11.437a

Mental health awareness can learn from the promotion of the Paralympics

It is clear from the Olympic-themed articles in the August 2012 issue of *The Psychiatrist* that we are all agreed on one thing: sport is good.[1] Whether this be in the context of promoting physical activity in the general population as part of an Olympic legacy pledge, or as a means of battling the social exclusion that many people with mental illness experience. We are currently riding on the crest of an Olympic-induced wave. But what has impressed me most is the way in which the Paralympic Games have been promoted. From the 'Meet the Superhumans' slogan of the Channel 4 advertising campaign, the message from the outset has been one of personal strength, resilience and determination, and ultimately, triumph through adversity. We have heard stories of athletes who have endured great personal tragedy, but have managed to turn their experience into success. The positive way in which such awe-inspiring individuals have been presented has captured the public's imagination. This should serve as a beacon of hope to mental health professionals who are determined to challenge the stigma which our service users experience. After all, do they not have equally inspirational stories of human spirit in the face of mental illness and disability? It is our duty to find equally effective ways of presenting their life stories in such a positive light, with the hope that this will help in the battle against mental health stigma.

1 Currie A. The London 2012 Olympics – will there be a legacy for mental health? *Psychiatrist* 2012; **36**: 281–3.

Aashish Tagore, Specialist Registrar, Mersey Deanery, UK, email: aashish.tagore@nhs.net

doi: 10.1192/pb.36.11.438

Spirituality and psychiatric patients

Having studied both the Book of Job and the Bhagavad Gita, I find it difficult to agree with John Price that either Job or Arjuna 'suffered from depression'.[1]

These mythical, rather than historical, characters were temporarily unhappy, yes; even miserable; but by no means hopeless, helpless or worthless. They were not described as experiencing diurnal mood variation, sleep or appetite disturbance, or reduced concentration. In terms of emotion, a healthy degree of awe and wonder can be deduced, particularly in the case of Arjuna. It is equally unwise, in my view, to read as much into the text as to say that Arjuna 'had a typical panic attack'. There is very little that is typical about either Job or Arjuna!

Nevertheless, although I take issue with Dr Price on questions about diagnosis, I do consider valid and valuable his observation that 'those treating depressed agnostics should look for a secular equivalent to joyous total surrender to God'.

For a number of years I acted as an independent medical examiner for insurance companies, and assessed dozens of people claiming income protection insurance through being unable to work on the grounds of psychiatric illness and disability. Often, feeling undervalued and exploited in an occupation which was central to their sense of identity, they were now (with few exceptions) without any vital sense of purpose; beaten, angry, resentful and bewildered, sure only that they could not go back into the workplace to risk further humiliation and insult. Many avoided human society altogether, with symptoms of anxiety, depression, panic attacks while away from home, agoraphobia and social phobia. They also avoided psychiatric services, and therefore help, deeming it further humiliation to be considered mentally ill.

Men and women were more or less equally represented, and it was also striking that not one expressed any religious belief or connection, or undertook any kind of even secular spiritual practice on a regular or frequent basis.

I believe that human experience needs interpreting according to five seamlessly connected dimensions: physical, biological, psychological, social and spiritual. I further believe in routinely including the spiritual dimension when assessing psychiatric patients. John Price seems to be pointing in a similar direction.

Spirituality and religion are linked, but can be distinguished and detached from one another. People tend to take relatively fixed positions on both and concerning the relationship between them, but the distinctions are subtle. It can often boil down to a question of language, rather than substance. The words 'God', 'religion' and 'spirituality', for example, have very different meanings for different people. A person's spirituality concerns whatever is most meaningful to them, at the deepest level, whether couched in terms that are religious or secular. If there is a void, then that too is part – often a key part – of the presenting problem. Such a void first needs detecting and then healing. In this, even if it does not reach the magnitude of Price's 'joyous total surrender', some kind of improved degree of acceptance in the face of adversity and loss is frequently the first and most decisive step.

1 Price JS. Lessons from sacred texts. *Psychiatrist* 2012; **36**: 357.

Larry Culliford, retired psychiatrist and author, West Sussex, UK, email: auud26@dsl.pipex.com

doi: 10.1192/pb.36.11.438a