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### The psychiatrist and the interpreter

I am glad to see such a positive response to the editorial on interpreting practice.<sup>1</sup> Psychiatry and speech and language therapy are two of the most challenging areas of practice for interpreters.

Australia has an honourable tradition in the field of language support for its diverse population, as I experienced in New South Wales a few years ago. Andrew Firestone's description of using a triangular seating arrangement but having changed to sitting the interpreter next to him is interesting.<sup>2</sup> I have found that if I sit next to either the clinician or the patient, problems in the doctor–patient relationship can still occur. If closer to the patient, it is more likely that they will address questions directly to me, trying to draw me in 'on their side', such as 'Are you married?' or 'Do you have children?' If closer to the clinician, my impartiality can seem to the patient to be compromised.

In the UK almost all interpreters in the public sector are independent freelance workers. Being seen by the service user as directly employed by a state institution, whichever it is, can cause them to distrust our interpretation, especially if they have arrived from a totalitarian state. Seating the interpreter at the apex of an isosceles triangle, in which the clinician and patient are closest together and directly facing one another, allows eye contact to be maintained between them, and keeps the interpreter out of direct line of sight. Interpreters who are taking notes will be busy with their notebooks and not available for eye contact. They still need to be able to see the speakers' faces, of course.

It would be interesting to know whether interpreters and clinicians maintain direct speech during clinic sessions, such as 'How are you feeling?' rather than 'Ask her how she feels'. This is another way of keeping the interpreter out of a direct relationship with either party during the interview. It is very important that the interpreter introduces themselves and briefly explains how they work, at the beginning of the session. This, and everything else that is said, should be done in both languages. If the patient is reminded at the outset that 'I will interpret everything I hear' and 'I will speak to you as the doctor does, with "I" and "you"; they are his words', ownership of what is said remains with the primary interlocutors, not the interpreter.

- 1 Cambridge J, Singh SP, Johnson M. The need for measurable standards in mental health interpreting: a neglected area. *Psychiatrist* 2012; **36**: 121–4.
- 2 Firestone A. The psychiatrist and the interpreter. *Psychiatrist* 2012; **8** June ([http://pb.rcpsych.org/content/36/4/121/replypbrcpsych\\_el\\_14509](http://pb.rcpsych.org/content/36/4/121/replypbrcpsych_el_14509)).

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### Death and risk in adolescent anorexia nervosa

Responding to Robinson's article on avoiding hospital deaths from anorexia nervosa,<sup>1</sup> the most helpful context to consider this in relation to teenage patients is to place it within a broader concern about risk. Robinson states that a 'very unwell' patient should be admitted, but crucially, the definition of that is still not sufficiently clear. How risk is perceived, including what is severely disabling as well as what may be 'life-threatening', is a key issue.

Using death certificate data provided by the Office for National Statistics about 18 years ago, I observed 112 certified deaths in England and Wales over a 5-year period; however, only 7 of these individuals had been below their 18th birthday. Notwithstanding the uncertainty of death certificate methodology,<sup>2</sup> in this instance, suggested by the observation that a third of the 112 deaths had occurred after the person's 65th birthday, these 7 deaths approximate to only around 1 in 5000 adolescents with anorexia – an important finding to set in context fears about these young patients.

That death-data enquiry had been to establish a better empirical understanding about risk following our team's decision (which I supported) to recommend the de-commissioning of a psychiatric in-patient unit that had often provided long-term treatment for teenagers with anorexia. It had previously participated in the UK's first prospective multicentre study of adolescent psychiatric admissions, which demonstrated disappointing treatment effects for those with anorexia nervosa.<sup>3</sup> But without such a facility, might there be a local increased risk of fatal outcomes for this condition? Reassured that the probability of death was unlikely to be significantly increased by closing the unit, a substantial change in practice was possible, relocating therapeutic skills to enhance outpatient treatment capacity. Gower *et al*'s subsequent treatment study<sup>2</sup> confirmed our view that without hospitalisation the disorder should not usually be regarded as hard to treat, untreatable or life-threatening.

Declining death rates observed for anorexia nervosa over the past two decades have been attributed to its more effective and earlier introduced treatment, but not necessarily because the treatment was hospital based.<sup>4</sup> A careful review of the literature provides two lessons less prone to grab media headlines than premature deaths. First, in adolescence at least, chronicity rather than death is by far the more likely adverse outcome of failing to effectively treat the condition. In comparison with adults, in whom medical complications are not uncommon and excess mortality rates have been observed compared with the normal population, the only significant medical complication (as opposed to biological adaptation to starvation) during adolescence is progressive loss of bone mineralisation. Yet published studies on adolescent admission imply that hospitalisation was most often considered essential

to avoid a youngster's possible death, not to divert them from a pathway into chronicity. The COSI-CAPS multicentre study of adolescent psychiatric hospitalisation is particularly instructive in throwing light on how risk in these patients is constructed.<sup>5</sup> Anorexia nervosa was the single most frequent diagnosis at admission (108/403 patients); only a sixth of those patients were detained but two-thirds nevertheless were considered at risk to themselves. The cohort was disproportionately White, female, aged 15–17, living at home, and with an over-representation of single parents. The body mass index (BMI) of all patients with anorexia on admission was within the ICD-10 diagnostic threshold (of 16, for adults), but most were not far below it (14.8; s.d. = 1.8,  $n = 108$ , 95% CI 14.3–15.4). Since the normal range of BMI for adolescents aged 15–17 is also less than for adults, it seemed that a relatively low threshold for admission was occurring.

This study had usefully included a number of independently provided units (private hospitals), accounting for a third of their non-eating disorder cases. Such youngsters were significantly less likely to have been receiving any psychiatric treatment before admission ( $P < 0.001$ ), emphasising the part community concerns play in hastening hospitalisation. In short, the second lesson taught me that risk often seems to have been 'socially constructed' rather than medically evidenced, a concept developed by Mary Douglas, the distinguished anthropologist who died last year. This concept has also been important for the support I provide to clinical practice in remote and rural communities.

Robinson posed questions for further research, for example: (1) how to manage severely physically ill patients who resist nutritional treatment; and (2) what is the best model of cooperative care between medical and specialist psychiatric services. In my experience, any request for medical care of these patients must be very carefully defined, usually circumscribed to stabilising metabolic problems. Nasogastric refeeding is not required for that, however self-evident the case might seem for rapidly improving poor nutritional state (it does not directly stabilise a patient's illness and might instead produce other medical problems, as I have observed and Robinson has indicated, as well as to adversely affect the therapeutic alliance).

Addressing his question on 'how to manage severely physically ill patients who resist nutritional treatment', my experience suggests that it is important to distinguish between what is being 'resisted': normalising metabolism, restoration of metabolic rate in particular (since this directly affects cognition, mood and exercise intolerance), or the additional caloric requirement to improve absolute weight gain or BMI, which frighten these patients. Teenagers often develop anorexia nervosa in response to otherwise unaddressed, perhaps previously unrecognised, psychological distress (problems that might have first resulted in compensatory overeating and excessive weight gain). So nutritional treatment addressing metabolic rate, and thus general well-being, is a far more readily agreed first treatment goal between the patient and their professional carer. Securing collaborative care is an unarguable vital step towards eventual recovery.

1 Robinson P. Avoiding deaths in hospital from anorexia nervosa: the MARSIPAN project. *Psychiatrist* 2012; **36**: 109–13.

- 2 Gowers SG, Clark A, Roberts C, Griffiths A, Edwards V, Bryan C, et al. Clinical effectiveness of treatments for anorexia nervosa in adolescents. Randomised controlled trial. *Br J Psychiatry* 2007; **191**: 427–35.
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**Author's response:** I am grateful to Dr Wrate for raising the issues he has. I would point out, first, that the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) report<sup>1</sup> was intended for clinicians caring for adult patients over 18 with severe anorexia nervosa. It was clear during the preparation of MARSIPAN that a further document for children and adolescents was required. The work was done and the junior MARSIPAN report<sup>2</sup> is the result. I think that the main issue raised by Dr Wrate, namely the appropriateness or otherwise of specialist hospital care for children and adolescents with anorexia nervosa, needs to be addressed by a child and adolescent psychiatrist such as those involved in the junior MARSIPAN report. However, I should be grateful if I could comment on some of the other issues discussed in the letter.

Assessing whether a person is at a risk high enough to warrant hospital treatment is one such problem. In adults, current opinion suggests that a body mass index (BMI) of  $< 13 \text{ kg/m}^2$ , electrocardiographic abnormalities, low potassium (especially  $< 3.0 \text{ mmol}$ ) and severe anorexic myopathy constitute a serious threat to life. In one study, the patients who died from malnutrition had BMI between 9.1 and 12.9.<sup>3</sup> In adolescents, junior MARSIPAN recommends that a BMI  $< 0.4$ th percentile indicates high ('red') risk. This turns out to be more conservative, as a BMI at the 0.4th percentile in a 15-year-old is 15. I hope that my child and adolescent psychiatrist or physician colleagues will take the opportunity to give a view on this. From my practice, the most reliable sign that a patient requires admission is when I feel my own heart sinking. This usually accords with the high-risk parameters in the patient, quoted in the MARSIPAN report.

Dr Wrate correctly notes that the past two decades saw a decline in death rates for anorexia nervosa, but argues that this is due to the fact that treatment is now more effective and introduced earlier, not necessarily because it is hospital based. It is uncertain whether patients presenting with very high risk would have similar survival rates outside hospital with community care. The Scottish Anorexia Nervosa Intensive Treatment Team (ANITT; www.anitt.org.uk) provides community care for adults of very low weight, but no evaluation of that or any other similar service has been published, nor are there randomised trials of care in this very high-risk group of (adult) patients.

On the question of chronicity, Dr Wrate identifies progressive loss of bone mineralisation as the only significant