

Risk assessment template

Part 1: Identify the risk:

Risk

It is highly likely that PB is/has been diagnosed with Anorexia Nervosa. PB fulfils Criteria A-C in the DSM5, showing restriction in energy intake leading to low body weight, PB has an intense fear of gaining weight and shows a persistent lack in the seriousness of her low body weight. Specific indicators such as low bone density, depressive episodes and being socially withdrawn are also present. PB is also in the general age range for Anorexia (American Psychiatric Association, 2013).

The risk of self-harm is severe. The risk of self-harm is through a significantly reduced food intake and high exercise levels. This has led to health complications, including cardiac issues, low bone density, fatigue, and a low pulse. Her mental health has been affected by causing bouts of depression, loss of social network, the loss of her swimming activities and feeling anhedonic. Patty shows that she is in denial and is angry and frustrated with the doctors. PB also wants to maintain her goal of a weight of ninety-five pounds which equates to sixty-nine per cent of her body weight, well under eighty-five per cent required to maintain her health. This indicates that without treatment, PB would maintain her dangerous practice of weight loss and over-exercise.

The risk of suicide in this definition, is through the repeated strain caused by significant food reduction and overexercising. No suicide attempts or ideation were disclosed. However, Due to the nature of Anorexia Nervosa, it should be noted that suicide attempts can occur (Thornton et al., 2016). Moreover, the risk of a psychiatric breakdown is moderate. This is indicated through PB's denial of her disorder, being socially withdrawn, increased frustration and feeling anhedonic.

The risk of Self-neglect is moderate with treatment. Self-neglect by depriving her body of essential calorie and nutrient intake. Without treatment, this is severe due to her continued motivation to lose weight to her goal of ninety-five pounds. Poor self-care is demonstrated as PB is aware of the damage inflicted on her body due to Anorexia. This is evident with cardiac issues, low pulse, low bone density and fatigue. These health issues have not deterred PB from continuing her food restriction and over-exercise. Her fear of gaining weight is still contributing to her continued poor self-care. Given the combination of these factors, PB poses a severe and immediate risk to herself.

Risk factors/risk assessment

Static and dynamic factors

The desire to lose weight is evident as PB has maintained her intention to lose weight despite treatment. There is constant dieting and although PB has gained weight for university she has not changed her goal to weigh ninety-five pounds. Her exercising compulsion is evident through brisk walking when unable to exercise more vigorously.

Some of the dynamic factors include an instability in mental health, with depressive episodes, feeling anhedonic and feelings of anger and frustration. PB is extremely self-critical, dissatisfied, and unhappy with her weight/shape. These all contribute to unstable/poor mental health in addition PB is non-compliant with treatment, she demonstrates resistance and feels anhedonic which could prevent motivation in continued treatment. This is exacerbated by anger and frustration directed towards the doctors/treatment.

Trigger/precipitating factors

Triggering factors include the association with her ex-boyfriend as she seeks his attention – Studies like Robinson et al. (2015) indicate that self-worth is low in patients with Anorexia. Any attention from a person one cares for can have a significant effect. In addition, he cheated on her which may contribute to feelings of rejection potentially leading to a depressed state of mind. Other relationship factors could stem from the competition with her sister. Studies suggest that when antagonism and jealousy are high for one sister against another, there is a greater chance of an eating disorder developing in the sister that demonstrates these negative traits (Zohar et al., 2016).

Loss of friends – Social-emotional deficits have been indicated in the development of Anorexia, with the loss of social support as a preceding factor in the development of eating disorders (Monteleone et al., 2020). This could be exacerbated by going to university- stressful life events can increase the likelihood of Anorexia developing, such as leaving home or going to college (American Psychiatric Association, 2013).

Perfectionist personality traits – are often associated with Anorexia Nervosa. This can be persistently around food but is often seen in other areas of their lives (American Psychiatric Association, 2013). For example, her fear of gaining weight does not reduce when weight is lost. The opposite can be true as the person loses weight and the fear of weight gain increases. A perfectionist personality requires perfection in all aspects of their life.

Maintaining factors

Maintaining factors include a resistance to engage with the treatment effectively. Prevailing attitudes to losing weight have not changed and denial, frustration and anger indicate a lack of engagement. Moreover, her resistance to treatment due to her belief that the doctors are overreacting will make matters worse.

Protective factors

Protective factors include the family support that she has. Indeed, family support has been an indicating factor in decreasing dropout and increasing overall positive outcomes for patients (Pereira et al., 2006). Friends can provide a sense of identity and support. Friends are especially important due to the increased difficulties in interpersonal skills and social isolation (Malmendier-Muehlschlegel et al., 2016) in PB's case.

Going to University, whilst potentially stressful, in this can be a form of the motivation to continue and engage with treatment. The success is evident in PB's weight gain. Finally, having a good rapport with her clinician will increase the likelihood of a more positive outcome (Pereira et al., 2006).

Part 2: Risk formulation and management:

Risk formulation

The purpose of risk formulation is to produce a risk assessment protocol that can be disseminated amongst each member of staff working with or supporting an individual under their care. The British Psychological Society (BPS, 2021) expects that psychologists conduct risk assessments that identify whether people are vulnerable, what kinds of risks exist, and which

factors increase risk. They also expect that psychologists and practitioners incorporate safeguarding into their practice, following the relevant local/institutional protocols for reporting concerns, sharing information, and referring to appropriate agencies when needed.

In addition, the BPS expect practitioners to ensure their practice is designed to avoid causing harm, providing support, ensuring clarity of consent and thereby ensuring understanding. Practitioners are expected to be trained and competent in recognizing vulnerability, capacity issues, safeguarding procedures, and their ethical responsibilities. The duty of a psychologist is to make decisions that balance promoting autonomy with protection from harm. In aiming to support PB, her clinician will need to identify and set out a risk assessment protocol that can be used to support her transition into university life and ensure a safe and supportive environment for PB's health to improve.

Risk management protocol

Risk assessments are live documents that need to be updated and changed as situations can change and factors may vary and fluctuate. When reading this document, this needs to be considered as if, for example, PB discontinues treatment, then there will be a need to re-evaluate the current risk assessment.

To reduce risk, while PB is at university, student services will need to be informed of PB's diagnosis and continued treatment. A copy of this risk assessment needs to be made available to the relevant persons within the university. This must include lecturers and relevant support personnel that can monitor and flag a potential decrease in self-care and academic performance as well as any other potential issues. A nominated person within the support staff will need to be appointed to PB to ensure that a point of contact exists and that services adequately monitor any changes in behaviour. Conditions of study need to be agreed upon and implemented as a driving factor to ensure compliance with treatment and that PB's health is adequate to the strains of her academic studies.

A risk assessment will also need to be completed at the university to ensure all potential risks are covered. As PB will be living in dormitories, it is necessary to inform the individuals that she directly lives with to ensure that they can flag changes in behaviour and decrease stress for PB exasperated by the concealment of her mental health condition.

PB's parents are considered a protective factor and ideal for encouraging compliance with treatment methods. In this regard, liaising with the parents on the current and future treatments is essential. This should be made evident in all risk assessments, and lines of communication need to be agreed upon. An agreement must be made to continue the specialist clinic while at university will need to be made before PB starts attending university. The agreement should be part of the conditions of the study and include not only current treatment but the consideration of therapies, including treatments like cognitive behavioural therapy, medication, and a monitoring/ check-up schedule at one-week intervals to start. This can be adjusted when evaluated by the clinician as treatment continues.

Before university begins, PB will need to comply with her current treatment to ensure no weight loss or relapse. The parents are encouraged to keep using the university as a motivator for PB to comply with treatment. Also, the transition to PB's new university life could be stressful. All reasonable measures should be taken to lower stress levels, such as meeting roommates before moving into the dormitories.