Specialist Supportive Clinical Management for anorexia nervosa: what it is (and what it is not)

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Abstract

Objective: Specialist Supportive Clinical Management (SSCM) is a psychotherapy comprising a clinical management focus addressing anorexia nervosa (AN) symptoms and a supportive therapy component. SSCM has been an active control therapy in randomised controlled trials for AN, but has proven to be an effective therapy in its own right. There has been speculation about how this relatively straightforward therapy works. Some of the commentaries and descriptors used for SSCM, however, do not reflect the content or principles of SSCM. This paper clarifies areas of misunderstanding by describing what SSCM is and what it is not, particularly in relation to commentary about its constituent characteristics.

Conclusions: SSCM utilises well established clinical management for AN (with a sustained focus on normalised eating and weight restoration) coupled with supportive therapy principles and strategies. Common factors across both arms include core counselling skills and a positive therapeutic alliance to promote adherence and retention in treatment for AN. Compared to other comparator therapies to date, SSCM is a simpler therapy without unique or novel theoretically derived strategies. Comparable outcomes with more complex psychotherapies raise the question of whether the combined core components of SSCM may be sufficient for many people with AN.

Keywords: Specialist Supportive Clinical Management, psychotherapy, anorexia nervosa, eating disorders, common factors

Specialist Supportive Clinical Management (SSCM) is a psychotherapy comprising a clinical management focus addressing anorexia nervosa symptoms (AN) and a supportive therapy component. It was developed as a non-specific active control for a randomised controlled trial (RCT) for AN.[1]* Against hypothesis, SSCM was more effective than two specialised psychotherapies: cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT).

SSCM has been found to be efficacious, but not significantly different, on primary outcomes and most secondary outcomes from the more complex, theoretically informed psychotherapies in five subsequent RCTs.[2–6] In addition to the original comparison with CBT and IPT, SSCM has been compared to the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) three times[2–4] and with enhanced cognitive therapy (CBT-E) once.[4] It has been adapted twice, being compared with adapted CBT for severe and enduring AN[5]; adapted for eating disorders (not just AN); and compared with a mentalisation-based treatment in those with comorbid borderline personality disorder and eating disorders.[6]

*The Southern Regional Health Authority Ethics Committee (Canterbury) approved the trial.

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Table 1. Distinct and overlapping features of SSCM compared to other therapies in the original trial.[1]

SSCM	*CBT*	*IPT*
• **Atheoretical SSCM model**	• CBT model	• IPT model
• **Patient-driven focus in supportive therapy**	• Sustained focus on cognition and behaviour	• Sustained interpersonal focus
• **Clinical management focus on normalised eating and weight restoration**		
• **Psychoeducation**		
• **Positive therapeutic alliance**		
• **Other non-specific therapy factors**		

SSCM: Specialist Supportive Clinical Management; CBT: cognitive behaviour therapy; IPT: interpersonal psychotherapy.

SSCM has been found to be effective in six RCTs and now appears in treatment guidelines in four countries.[7] The current evidence base for SSCM has led to curiosity about why it might work and about its active ingredients. Compared to other more complex therapies, SSCM is relatively simple and less defined. Indeed in the RCTs, SSCM has been defined more by what *isn't* included.

Recently, several commentaries on SSCM have described SSCM using terms not used by the originators. Waller and Raykos for example included SSCM in a review of behavioural interventions.[8] Gutierrez[9,10] has described SSCM as a placebo and a non-specific treatment in our RCT. In SSCM training workshops, some speculate that due to tailoring the focus of supportive therapy to the patient need, that it could be seen as eclectic. Others have speculated that the effectiveness of SSCM might be just due to common factors. Given the potential for confusion, it is important to address these issues point by point and to clarify what SSCM is and what it is not.

Aim

The aim of this paper is to respond to these commentaries and clarify what is included (or not) in this effective therapy.

SSCM: what it is

SSCM is an outpatient psychotherapy for AN, designed to be delivered by a clinician with knowledge of basic psychotherapy skills and the features and core clinical management tasks for AN. The origins and content of SSCM have been described previously by the original team[11] and recently for SSCM-severe and enduring.[12] As its name suggests, SSCM comprises two core elements, and both are delivered within each session: clinical management for AN (focusing on normalising eating and weight gain, addressing other AN-related behaviours and effects, psychoeducation, and support to enhance adherence), and the supportive therapy element (focussed on life issues raised by the patient). Overlapping and distinct components in the original trial[1] are illustrated in Table 1.

Clinical management modules were common across SSCM and CBT in the original trial. All therapies used common factors such as establishing and maintaining a trusting therapeutic alliance to retain patients in therapy and facilitate change. The patient-driven supportive therapy focus was unique to SSCM.

SSCM has three phases. Phase 1 orients the patient to SSCM, building shared understanding through the use of the straightforward atheoretical model (a linear path from dieting and weight loss to AN, with resulting physical, psychological and psychosocial effects); establishing target symptoms, setting target symptom and goal weight ranges; and commencing the provision of relevant psychoeducation about physical and psychosocial aspects of AN. Phase 2 has a sustained focus on normalised eating and weight gain. The final phase continues core tasks, but includes a termination focus, reflecting back on helpful aspects and strategies, highlighting patient strengths, looking ahead at maintaining change, anticipating hurdles and how to deal with them, and the process of saying goodbye. The supportive therapy aspect of each session continues throughout the treatment.

SSCM is a pragmatic, transparent, adopting a commonsense, responsive approach to the needs of the patient. The therapist stance utilises characteristics of effective therapists: attentiveness, warmth, empathy, authenticity, non-judgmental, affirming and supportive stance, respecting and working with patient defences. The therapist is active and a change focus is present in both arms.

SSCM: what it is not

SSCM does not have:

- a theoretical model of causation or theory-driven strategies;

- formal motivational strategies, although clinical management and supportive therapy use encouragement, awareness of physical and psychosocial costs of AN and of desired areas of life change;
- homework, apart from the expectation of progress on normalised eating goals.

SSCM is not:

- a placebo therapy: SSCM was designed as a *bone fide* active control therapy.
- just common factors or generic psychotherapy: clinical management has a highly specific AN symptom focus.
- behaviour therapy: SSCM focuses on behavioural change in normalising eating and some principles apply (e.g. breaking goals into small steps); however, it does not reference behavioural principles or require systematic self-monitoring. Supportive therapy does not overlap with behaviour therapy.
- eclectic: Although goals for a problem will be similar across therapies, SSCM is not eclectic in adopting approaches from other therapies. Any similar strategies would be implemented in the SSCM manner i.e. pragmatically, without referencing theory or using technical aspects of other therapies.

Possibly effective components of SSCM

The consistent dual focus on the disorder and the person may contribute to the success of SSCM. The direct symptom focus is arguably the most effective factor. Recovery from AN is hard and weight gain is difficult, but non-negotiable. Although some have criticised existing psychological models for AN for focussing on epiphenomena of starvation,[10] there is little argument that reversing starvation by directly focussing on normalised eating and weight gain is a necessary component across therapies.[8]

Those with AN though often complain about too much focus on eating and weight. SSCM supports patients through the challenging process of weight gain, while simultaneously recognising their other issues. SSCM's atheoretical model leaves room for the patient's own model and the spaciousness (uncluttered by complex technical aspects and modules of other therapies such as MANTRA and CBT), and allows more room to listen and address their current life issues. Supportive therapy, an under-rated modality,[13] employs the undoubtedly essential common factors[14] with active strategies to address patients' psychological needs. This collaborative, respectful broader life focus may be attractive and remove barriers to engagement for some.[15]

Advantages and disadvantages of SSCM

Advantages of SSCM include that the dual focus components are familiar and widely used clinically. The atheoretical, straightforward model and strategies are easy to teach, so more easily disseminated to a range of disciplines. Working *with* patient defences allows flexibility in how tasks are approached, potentially enhancing patients' sense of control and lowering resistance (compared to CBT where some patients dislike some strategies such as self-monitoring). Disadvantages include that the manual does not provide explicit guidance in *how* to manage all eating disorder behaviours compared, for example, to CBT which has theoretically driven modules for specific behaviours such as thought challenging or exposure tasks. The simplicity of SSCM means that it does not include potentially engaging modules like cognitive remediation in MANTRA. The sustained focus on eating and weight is difficult for some patients and therapists; however, that issue is not unique to SSCM. The dual focus and yet relative simplicity of SSCM have led to some mischaracterisation as other writers have tried to position SSCM in relation to other psychotherapies.

Conclusions

SSCM has a dual focus incorporating clinical management for AN (strong, persistent focus on normalised eating and weight restoration) with supportive therapy (patient-driven focus). SSCM is a streamlined therapy without unique or novel theoretical-derived strategies, so the somewhat puzzling comparable effectiveness against more complex psychotherapies in six RCTs raises the question of whether the combined core components of SSCM may be sufficient for many with AN, and if so why.

Knowledge is lacking about effective elements of SSCM and other evidence-supported therapies for AN. Further research is needed to compare and examine the relative potency of therapy components within and across contemporary psychotherapy models to contribute to improving outcomes for AN.

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