

**EATING DISORDERS SECTION**

**ROYAL COLLEGE OF PSYCHIATRIST**

**December 2011**

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## 1- FOREWORD FROM THE EDITORS:

It's us again-we have been asked to step in for the Autumn Newsletter to allow the new committee members time to settle in and agree roles. We are delighted that Dr Rebecca Cashmore, Dr Philip Crockett and Dr Irene Li will be taking over from us as of the next Newsletter. We wish them all the best!

In keeping with the usual format we have an update from our Chair outlining the Committee's work on our behalf.

The bursary winners of a place at this year's annual academic meeting, which was in November, were Foundation Doctor Dr Georgina Fozard, Core Trainee Dr Carol Kan and Higher Trainee Dr James Nelson. Read Georgina's and Carol's articles on what motivated them to apply and what they got out of attending. James's article will appear in the next newsletter.

We have also included the winning and runner up poster presentations from the annual academic meeting of the section in November.

Dr Frances Connan and her group have successfully concluded their work on the Guidance on HoNoS for patients with eating disorders. Look it up on the ED section web page. (<http://www.rcpsych.ac.uk/members/sections/eatingdisorders.aspx>)

In October, Dr Paul Robinson has lead on the submission of the ED Section's application for Eating Disorders Psychiatry to be recognized as a sub-specialty of Adult and Community Psychiatry. The GMC have asked us to provide some more information and Paul has collected these on our behalf. A decision is expected next year.

Finally, do please start thinking of writing for next year's editions of the newsletter in anticipation of the formal invitation to contribute. Letters, book reviews are also welcomed.

With best wishes for a happy and healthy 2012.

*Dr Sylvia Dahabra*

Editor

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## 2- FOREWORD FROM THE CHAIR

'Once again, our Section continues to grow in size and purpose. We punch above our weight, and produce copious policy and guidance to improve the quality of Eating Disorder service provision across the United Kingdom.

We are indebted to Ulrike as the outgoing Chair. She bestows on us a gift of a remarkably friendly, cohesive Section. The potency of Sections and Faculties can so easily be diminished by internal wrangling. The Executive Committee of EDSECT is not hamstrung in this way, and our voice is louder for working with a broad range of external agencies.

We recently enjoyed an excellent range of speakers at the Eating Disorders Section Annual Conference 2011, and particular gratitude goes to Frances. Jane also continues to manage our finances with an iron grip that would well be employed in the Exchequer.

But sadly it is likely to be the economic downturn that drives much of our activity. The Executive Committee will be focusing primarily on four key areas over the next year; Commissioning, PbR and care pathways, Quality assurance of eating disorder services and Sub specialty status. As clinicians, increasingly we will be asked to provide more with less, and the Section's responsibility is to guide on the quality of services and training of their staff. We should be proud of our unique skills as eating disorder specialists, and unafraid of preserving and asserting our standards.

As Chair and Vice Chair we look forward to serving you in difficult times, but also with a tremendous sense of optimism for the future of our Section. We are more than the sum of our parts. '

*Dr John Morgan*  
*Chair EDSECT*

*Dr Pipa Hugo*  
*Vice Chair*

### **3- WHAT IS THE ROLE OF THE EATING DISORDERS CONSULTANT PSYCHIATRIST IN DBT LED SERVICE? AN ST5 PERSPECTIVE.**

In 2008 I undertook a six month placement at the Haldon Eating Disorder Service in Devon. This is a tertiary referral unit that provides residential and non-residential treatment to the Devon area. It also accepts out of area referrals. At the time the unit was a medically led service. It had a full time consultant psychiatrist, a CT psychiatrist and FY1 doctor. There were also allied disciplines including clinical psychologists, OTs, art and family therapists, nurses, a full time dietician and nursing assistants. There were a number of psychological interventions delivered by small group of trained clinicians.

I was then an ST2 with a curiosity about the practice of psychodynamic psychiatry. It soon became apparent that this was an interesting placement, full of excitement and challenges.

Three years later and having undertaken other training posts, I decided to return to the same unit, only this time as an ST5. I was certain that on my journey to becoming a consultant in general adult psychiatrist capable of leading and containing a team it was paramount I had a comprehensive insight in managing patients troubled by Eating Disorders.

Upon returning I discovered that the welcoming unit, just like me, had undergone some changes. It has a part-time consultant psychiatrist and the unit had become a Dialectical Behaviour Therapy (DBT) led service. That is to say that the unit works within the DBT principles and that it is the main therapeutic modality delivered. Every clinician independently of their discipline undertakes training in this modality. DBT as delivered by the Haldon is a modified version for Eating Disorders. The therapy is delivered as a package including one-to-one, groups and telephone support. The course of therapy is delivered in eight-week cycles and patients could progress through a number of cycles. The therapeutic benefits of DBT at the Haldon are highly regarded by many patients and team members. There is an emerging body of research evaluating DBT for Eating Disorders (for details see *Bankoff et al 2011*).

It is understood that DBT to succeed requires a flat hierarchy, where patients and therapists are seen as equal. It is therefore felt that the role of a

consultant psychiatrist could pose an inherent hierarchical power perceived as detrimental to the DBT therapeutic principles. This could apply in many areas but is particularly evident when dealing with more complex patients or those detained under the Mental Health Act. Challenges can lie in the tensions generated between the expected roles of a consultant psychiatrist (Bhugra 2010) and a milieu where those very qualities of leadership and clinical expertise could at times be seen incompatible with the model of therapy.

This placement has also offered thought-provoking experiences. As a psychodynamic psychiatrist, I have found that working within a different modality has at times generated interesting processes. One wonders if there is a risk of falling short when addressing patients' difficulties from a single therapeutic modality, this is true for a therapy of any persuasion.

However there are also opportunities provided by this placement; such as learning of a therapeutic intervention novel to eating disorders and therefore widening my psychotherapeutic skills. It has also furthered the practical application of my existing group analytic and organizational psychoanalytic ideas. It has once again allowed me to work with highly complex cases within inpatient and community settings. I have been able to work within the MDT and I am involved in the development of a community ED service with other colleagues. There are formidable teaching and research opportunities within the local university and the Peninsula Medical School. However it is the experience of working with a dedicated and highly skilled team that I appreciate the most.

I would like to encourage other registrars to take the opportunity to undertake placements in less mainstream environments.

*Dr Amaury Delgado Hernandez*

*ST5 in General Adult Psychiatrist (Eating Disorders)*

### **References**

1-Bankoff, S.(2011). *A Systematic Review of Dialectic Behaviour Therapy for the treatment of Eating Disorders. Eating Disorders: The Journal of Treatment and Prevention (In press)*

2- Bhugra, Dinesh (2010). *Occasional Paper OP74; Role of the consultant psychiatrist Leadership and excellence in mental health services, June 2010 RCPsych.*

#### **4- The EDSECT Annual Conference- TRAINEE BURSARY 2011**

The annual trainee bursary allowed me to attend the Eating Disorders Section Annual Meeting “Time’s arrow: Targeting Anorexia Nervosa Early & Effectively” in London this year. My interests in Eating Disorders (ED) started when I encountered patients with eating difficulties as a junior doctor working at A&E. I remembered the recurrent admission of a 24 years old female with Type 1 Diabetes. She alternated between dietary restriction and bingeing episodes, with the former leading to severe Diabetic Ketoacidosis which required urgent hospital treatment. Her disordered eating was never fully discussed at the department, and she received very limited psychological input. I did not receive any formal training in ED until I was a CT2 psychiatric trainee at the EDU of Bethlem Royal Hospital under Professor Ulrike Schmidt. This experience has led me to appreciate the potentiality for chronicity in the clinical course of Anorexia Nervosa (AN) without adequate intervention and support. I also observed the devastating impacts it can have on the clients and their families at the medical, emotional and social levels. The “Prevention & Early Intervention” section of the conference further my understanding of the value in promoting the early involvement of family and teachers in supporting an individual with AN.

When I was a CT2-3 trainee, I also had the opportunity to undertake some researches under Professor Janet Treasure at the Institute of Psychiatry. We have been working on the use of video podcast (Vodcast) and virtual reality as meal supports for patients with AN. The fascinating presentations and discussions by various world-leading ED experts on the difficulties faced by published/ongoing “Randomised Controlled Trials” informed my research interests, instigating me to re-evaluate and improve the Vodcast further. The sections on “Service Models for Severe ED” and “Alternative to Inpatient Care” were particularly helpful in boosting the morale of a trainee psychiatrist, as it is easy to become discouraged by services reduction or closure in the current economic climate. The speakers promoted the idea that there are alternatives models available and presented the evidences to support them.

The conference has been tremendously enjoyable and it has also informed my clinical practise, as I am undertaking a CAT therapy with a patient with Diabetes and Psychogenic vomiting and developing a research interest in Diabetes

and Disordered Eating. The complexity and multifaceted nature of ED is intellectually intriguing and the conference reminded us the importance of targeting it “Early and Effectively”.

Carol Kan

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## **5- REGIONAL UPDATE 2011: NORTHERN IRELAND**

Within Northern Ireland, we have adopted a ‘bottom-up’ approach to eating disorders service development, with the initial priority being to establish specialist outpatient teams within each of the 5 main Trust areas. We have made good progress over the past 5-6 years and both adult and CAMHS services have been set up in each area, although some teams are still seeking to recruit their full complement of staff. Both the adult and CAMHS services have their own clinical/special interest networks with regular meetings to present and discuss cases, keep abreast with the academic literature and provide mutual support for the challenging work that we do. Service development as a whole is overseen by a Regional Eating Disorders Network Group which includes representation from commissioners, senior managers and voluntary organisations.

During the past year, there has been an emphasis on trying to develop more intensive treatment options at a local level in an attempt to reduce the number of patients who have to be sent for treatment outside the country. Within adult services, more patients have been admitted to general psychiatric units where their management is supported by inreach from the specialist community teams. Within CAMHS, patients requiring hospitalisation can be admitted to the regional adolescent unit in Belfast, which has been gradually building up expertise in the treatment of severe eating disorders. Regional training events over the past year include a conference on day treatment led by Dr Blake Woodside from the Toronto General Hospital and a series of days on multi-family therapy taught by a team from the Maudsley Hospital. CAMHS services have been able to recommence regular consultation/supervision with Dr Rachel Bryant-Waugh from Great Ormond Street Hospital through funding arising from a cross-border initiative with the Republic of Ireland.

Within adult services, priorities for the near future include the production of a regional integrated care pathway, standardising the measurement of outcomes across the country and the potential development of day treatment approaches. It is realistic for us to assume that in the present economic climate, new financial investment is unlikely to ensue although there may be an invest to save opportunity if we can present a proposal describing an enhanced model of community care that can likely reduce the need for out-of-area treatments.

*Dr Ken Yeow*

Regional Representative for Northern Ireland

## **6- THE EDSECT ANNUAL CONFERENCE:**

### **A TRAINEE PERSPECTIVE OF THE DAY**

“What do you want to specialise in?” was the question that greeted me as a medical student at the start of each rotation, and now as an FY2 Doctor I am fast approaching the moment when I need to come up with a real answer, rather than the obligatory, “Whatever it is you do!”. It was with this in mind that I applied for a bursary to attend The Royal College of Psychiatrists Annual Eating Disorders Conference. I happened upon the opportunity following a browse of the RCPsych website and since I am interested in a career in psychiatry and know little about eating disorders, it seemed worth applying. All they needed was a single-page CV and 200 words about what I thought I’d get out of it, and I was in.

The conference was not as I expected, but in a good way. It was research orientated, it was a place where calls to arms could be made by leading experts in the field, it was a forum where specialists came together to celebrate their newest treatment successes but also, to put their heads together and admit to not always knowing the way forward. It was this that made the experience exciting to me...I had the sense that these doctors and researchers, many with a lifetimes work behind them, still felt there was so much more to learn. This is the sort of work that will need to be taken on by a new generation of psychiatrists and I think it is vital that these conferences are attended by the younger generation who are still to choose where their career will take them.

Admittedly, much of the finely tuned debate about the relative merits of various treatment approaches went over my head. But with so much of foundation year medical education being ploddy and lowest common denominator, this was not. Whilst no-one would advocate trying to run before you can walk, with the aid of some surreptitious Googling on my smartphone I was able follow talks on some interesting topics and treatments I'd never even heard of previously. I left with more questions than answers, but that's no bad thing.

These are the sorts of opportunities the Royal College should be offering more of if they want to attract young Doctors into Psychiatry and rectify the appallingly easy competition ratios that have recently beset the profession. If only to lure in further those who already have a keen interest in Psychiatry, they are a good thing. I found out about it of my own accord but if the college emailed out information of these sorts of bursaries to the coordinators of each medical school's Psychiatry rotation, and each hospital's FY1/FY2 programme that would be a good start. It is vital that the top of the profession acts aggressively to engage with those at the bottom of the medical hierarchy, otherwise there is a risk that for all the fascinating work people are doing now, patients will not be served in the future by the passionate, progressive and perfectionist doctors they deserve.

*Dr Georgina Fozard*

FY2, currently on Psychiatric post at Goodmayes Hospital, Essex

## 7- WINNER AT POSTER PRESENTATION



# Mealtime support in anorexia nervosa: a within-subject comparison study of a novel vodcast intervention

Institute of Psychiatry

at The Maudsley

Dr Carol Kan<sup>a</sup>, Ma Valentina Cardi<sup>a</sup>,  
Ma Maria Romero<sup>a</sup>, Dr Amy Harrison<sup>a</sup>,  
Ma Naima Lounes<sup>a</sup>, Dr Kate  
Tchanturia<sup>a</sup>, Dr Caroline Meyer<sup>b</sup> & Prof  
Janet Treasure<sup>c</sup>

<sup>a</sup> Institute of Psychiatry, UK

<sup>b</sup> Universidad de Valencia, Spain

<sup>c</sup> Loughborough University, UK

### Background

There is uncertainty about the best form of treatment for Anorexia Nervosa (AN). Treatments targeting the processes involved in its maintenance such as food avoidance may benefit patients (Treasure et al., 2011). Vodcast is a mobile self-directed care intervention developed at the Institute of Psychiatry and has showed promise as a form of meal support in a small case series.

### Vodcast:

- short video clip played on a handheld media device (iPod/iMP4 play/mobile phone)
- using auditory and visual imagery to target food-related avoidance.

### Aim

To examine whether a vodcast provides improved meal support to patient with AN compared to a music condition.

### Methods

- Participants recruited from the volunteer database.
- Inclusion criteria:
  - Females
  - 18 – 55 years old
  - fluent in English
- Structured Clinical Interview for DSM-IV was used to:
  - screen HCs for a participant mental health disorder (n)
  - confirm diagnosis of AN

- Participants were randomised to either vodcast/music condition first. The paradigm was repeated a week later with exposure to the alternative condition.

### Measures:

- Eating Disorder Examination Questionnaire
- Depression Anxiety Stress Scale
- Dot-probe task for attentional bias towards food images
- Visual Analogue Scales (-5 to +5) assessing subjective feeling of:
  - anxiety
  - unpleasant body sensations
  - preparedness to eat
  - fullness
  - hunger
  - levels of intrusive thoughts
  - positive mood
- Test meal:
  - chose from 3 different flavoured smoothies (250ml) for consumption whilst listening to the vodcast/music

The experimental paradigm is summarised in the diagram below.

### Result

- Sample size:
  - 18 participants with AN
  - 19 healthy controls (HCs)
- Comparing the vodcast condition to music condition, AN group:
  - consumed significantly more of the test meal (ES=0.40)
  - improvement in mood (ES=0.48)
  - reduction in:
    - anxiety (ES=0.43)
    - intrusive thoughts (ES=0.40)
- HCs:
  - Significant reduction in attentional bias towards food in the music condition (ES=0.40)

### Summary

- AN consumed significantly more of the test meal in the vodcast than music condition.
- AN has significant improvement in mood and reduction in anxiety and intrusive thoughts in the vodcast condition.

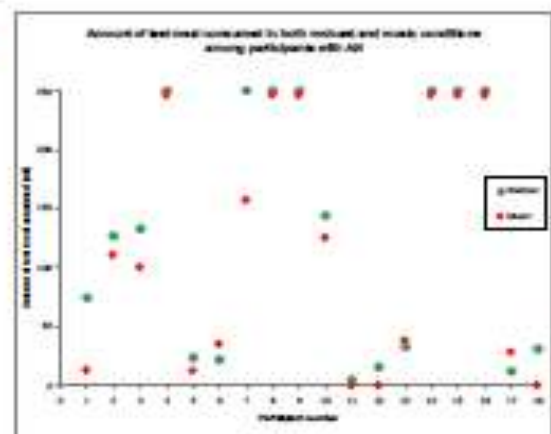
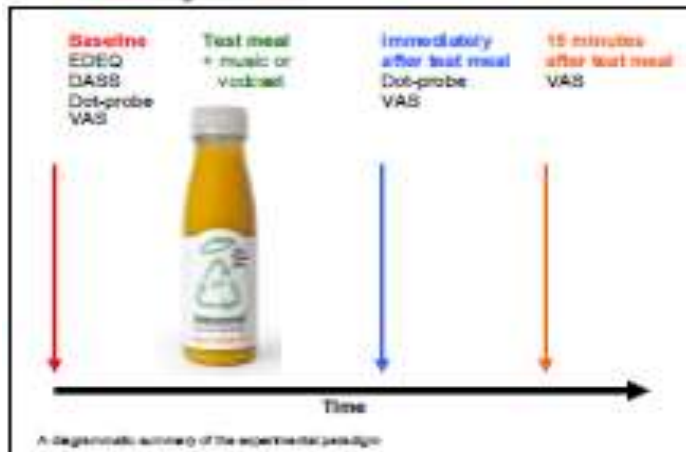
### Discussion

- The specific finding was only observed in participants with AN, suggesting that the vodcast did not purely function as a non-specific form of distraction (as represented by the music control condition). The eating disorder specific visuospatial imagery of the vodcast could have contributed to the positive findings observed.
- Although the increase in test meal consumption was modest (14.6ml, graph), the cumulative effect over time could significantly impact on the clinical outcome of AN. Recent studies using new ecological momentary interventions have been shown to be effective in reducing emotional eating in obese patients (Manzoni et al., 2008). Further research will help to clarify the mechanism of change involved in the vodcast as a meal support for people with eating disorders and difficulties.

### Reference

Treasure, J., Cardi, V. & Kan, C. (2011). Eating in eating disorders. *European Eating Disorders Review*. doi: 10.1002/erv.1090

Manzoni, G.M., Gorini, A., Preziosa, A., Pagnini, F., Castellnuova, G., Molinari, E. & Riva, G. (2008). New technologies and relaxation: an explorative study on obese patients with emotional eating. *J Cyberther Rehab*. 1:182-192



## 8- RUNNER-UP WINNER AT POSTER PRESENTATION

# Mental Health Clustering Tool in Eating Disorders

Dr Mark Silvert, Dr Sarah Cornick, Dr Frances Connan

CNWL NHS Foundation Trust  
Vincent Square Eating Disorder Service, 1 Nightingale Place, London

### Introduction

- The Mental Health Clustering Tool (MHCT) is a trans-diagnostic tool for categorising the clinical severity and needs of patients accessing mental health care
- Care pathways and associated tariffs for Payment by Results (PbR) will be developed for each cluster
- Aim of this pilot study is to explore the clinical utility of MHCT with an eating disorder sample.

### Methods

**Participants:** 54 consecutive patients assessed at referral to a comprehensive ED service (accepting GP referrals across the range of severity of ED)

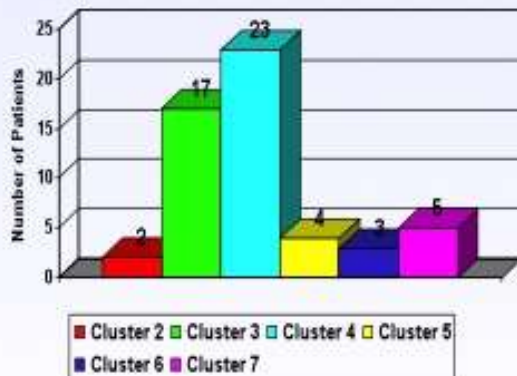
### Measures

- Three self-report questionnaire measures:
  - EDE-Q (Eating Disorders Examination Questionnaire)<sup>1</sup>
  - BSI (Brief Symptom Inventory)<sup>2</sup>
  - PBQ (Personality Beliefs Questionnaire-Short Form)<sup>3</sup>
- MHCT rated by clinicians using the EDSECT guidance for the use of the MHCT in ED

### Statistical analysis

- Spearman's rank correlation used to assess associations with clusters
- Due to small sample size, clusters were combined into 3 groups (<=3, 4 and 5+)
- ANOVA and Dunnett's test used to assess differences between cluster groups

Patients by Individual Cluster



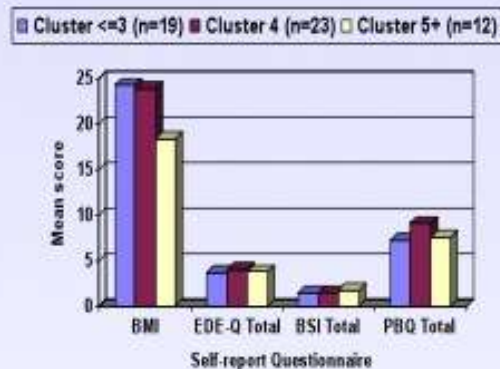
### References

- Eating Disorders Examination Questionnaire: Fairburn and Beglin, 1994
- Brief Symptom Inventory: Derogatis, L.R., 1975
- Personality Beliefs Questionnaire-Short Form: Butler, Beck, Cohen, 2007

### Results

- ED patients sampled fell into clusters 2-7 (non-psychotic disorders)
- Higher clusters were associated with lower BMI, higher BSI anxiety scores, higher PBQ Schizoid personality scores ( $p < 0.05$ )
- In comparison of cluster groups
  - BMI and PBQ dependent score differed significantly ( $p < 0.05$ )
    - Lower BMI in higher cluster group
    - Increased PBQ Dependent score in
  - EDE-Q and BSI total scores do not differ significantly between groups

Symptom Score by Cluster Group



### Summary and conclusions

- Higher severity clusters were associated with lower BMI and some markers of greater non-specific psychopathology.
- No association was observed between cluster and severity of specific ED psychopathology, as measured by EDE-Q.
- Larger samples are needed to further describe clusters in ED
- This work is necessary to provide an evidence base for the development of care pathways for PbR.

## 9- REGIONAL REPRESENTATIVES

<b>Eastern:</b>	Jane Shapleske
<b>London (all regions):</b>	Eric Johnson-Sabine
<b>Northern &amp; Yorkshire:</b>	
<b>North East:</b>	Melanie Temple
<b>Yorkshire:</b>	John Morgan
<b>Northern Ireland:</b>	Ken Yeow
<b>North West - Mersey:</b>	Jessica Morgan
<b>North West :</b>	Sonu Sharma
<b>Scotland:</b>	
<b>South East -Oxfordshire:</b>	
<b>South East - Kent, Surrey &amp; Sussex:</b>	Neil Joughin
<b>South East - Wessex:</b>	
<b>South West:</b>	Hugh Herzig
<b>Trent:</b>	
<b>West Midlands:</b>	Agnes Ayton
<b>Wales:</b>	Izabela Jurewicz

## 10- EXECUTIVE MEMBERS OF EDSECT

Member	Year of joining	Position
Dr John Morgan	2011 (E)	Chair
Dr Jane Shapleske	2007 (E)	Financial Officer
Dr Christina Barras	2011 (A)	Psychiatric Training Committee Rep
Dr Rebecca Cashmore	2011 (E)	Elected Member
Dr Frances Connan	2007 (E)	Academic Secretary
Dr Philip Crockett	2011 (E)	Elected Member
Dr Christopher Freeman	2011 (E)	Elected Member
Dr Philippa Hugo	2011 (E)	Vice Chair
Ms Veronica Kamerling	2011 (C)	Co-opted Member
Dr Nikola Kern	2011 (E)	Elected Member
Dr Adrienne Key	2007 (E)	Elected Member
Dr Jessica Morgan	2011 (E)	Elected Member
Dr Elizabeth Morris	2011 (E)	Elected Member
Dr Sandeep Ranote	2011 (C)	Co-opted Member
Dr Lorna Richards	2007 (E)	Elected Member
Ms Susan Ringwood	2008 (C)	Co-opted Member
Dr Paul Robinson	2007 (E)	Elected Member
Dr Christine Vize	2011 (E)	Elected Member
Dr Irene Yi	2011 (C)	Co-opted Member

### For Your Diary:

*The ED Section will be organising a one day event for EDSECT members at the college in spring to work together on PbR and care pathways in eating disorders. Keep an eye on the website for the date*



*Good-bye from the Editor and Co-Editor*