NHS SCOTLAND

EEATS. eating disorders education, & training scotland.

SEDIG Scottish Eating Disorder Interest Group

Eating Disorder Education & Training – Scotland

Accreditation Pack

October 09

Name:

Candidate No:

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INTRODUCTION

A number of developments in recent years have highlighted the need to promote improved training for those providing care and treatment for eating disorders.

The Framework for Mental Health document on eating disorders (Scottish Executive Health Department, 2001) and the Quality Improvement Scotland (QIS). Recommendations for Management and Treatment for Eating Disorders in Scotland (2006) both highlighted the need to develop improved training.

NHS Education Scotland (NES) have supported the development of a curriculum and an accreditation system for multidisciplinary training across the age range in eating disorders. This has led to the setting up of a steering group chaired by Dr Jane Morris, Consultant Psychiatrist at the Royal Edinburgh Hospital, with administrative support from Linda Keenan, Manager of North the Scotland MCN for Eating Disorders.

It is proposed that the training outlined will be appropriate for a range of different professional groups and will be open to those from any clinical background who wish to develop an accredited level of knowledge and expertise in the assessment and management of eating disorders. It is expected that over time it will become a basic requirement that those working in specialist services for eating disorders should hold – or be working towards – this accreditation. Reaccreditation programmes and higher levels of accreditation are being developed for more experienced and specialised practitioners.

Multi professional training has great strengths but the detailed approval of training will be tailored to each applicant's relevant professional discipline. It is intended that the accreditation will be fully compatible with systems developing under the Knowledge and Skills Framework.

INSTRUCTIONS FOR APPLICANTS

Our aim is to offer you the greatest possible flexibility in the timing of your Eating Disorders training without compromising on quality and standards. We ask that all the work you submit for the Accreditation be completed within a 3 year period or less, ending at some point after the date of registration.

For example, a candidate who registered in January 2010 may present a body of work that dates back to the Spring of 2007 and is completed – perhaps by taking the online MCQ test – in early February 2010. In contrast, another candidate who registers at the same time, January 2010 may start their eligible Eating Disorders training only in the spring of 2010, perhaps sitting the MCQ test early in the summer, and going on to complete Accreditation at any point from 2011 to 2013, depending on the pace of progress and available training.

If this description is unclear, or you need further clarification, please do contact the Core Group through the Secretary of EEATS, for advice and information. Contact details can be found on the back page of the pack.

The training which counts towards your accreditation can include attendance at conferences, workshops and other training events. It may also include some electronic and distance learning activities. It must total a minimum of 100 hours and include the acquisition of both knowledge and skills.

If the training is not selected from our register of accredited trainings we suggest that you check with EEATS to ensure that it will be valid.

In addition to the acquisition of knowledge and skills there is the crucial component of clinical practice. This is the basis on which your supervisor (or their appointed deputy) will assess whether you have demonstrated competence.

Clinical experience should be in a setting which provides regular, at least weekly, clinical work with eating disorder patients. There must be a signed reference from the clinical team leader (who may not be the accreditation supervisor).

- A reference must be provided from the supervisor (or deputy) and the supervisor's details have to be made available to be approved by EEATS before starting a period of clinical placement to be accredited. Supervisors need not themselves be accredited by EEATS but should in this case submit a CV with details of their experience in the field of Eating Disorders.
- There must be evidence of continuing availability of supervision of eating disorder cases from a named supervisor for a least one hour monthly. It is strongly recommended that supervisors attempt to offer one hour weekly or 90 minutes every two weeks. Group supervision should offer more than one hour monthly in view of the 'dilution' effect of a group setting.
- There should be evidence of significant clinical involvement with and direct clinical responsibility for eating disorder patients. This may be, and usually will be, as part of a shared responsibility within a multidisciplinary team and should include long term work (minimum of 6 months) with at least one patient. This will include experience of working with a spectrum of patients.
- A brief summary, signed by the supervisors, must be provided on the applicant's work with at least 5 patients, demonstrating the range of clinical experience. Each case must have brief learning points highlighted.
- At least one case must be written up fully according to the guidelines appropriate to the applicant's professional discipline and signed by the supervisor.

GUIDANCE FOR SUPERVISORS

Examples of supervisors

- Senior members of Eating Disorder Teams (Consultant Psychiatrists or Psychologists, senior occupational therapists and dieticians, Charge nurses) or
- Clinicians with specialist knowledge of Eating Disorders, not necessarily working in specialist Eating Disorders Services (eg in General Child & Adolescent Mental Health services, or in Psychotherapy services) Supervisors should submit a brief CV detailing their eligibility for the role. Supervisors may deliver the clinical supervision and provide the clinical experience or alternatively organise that this may be undertaken by a suitably qualified deputy e.g. they may approve a clinical placement in a different setting.

We recommend that supervisors and their supervisees complete our 'supervision contract' and in cases where the supervisor is not the usual line manager, or where patients are accessed from a different service, also the 'Accountability and responsibility' form.

Guidance regarding suitable training placements

Specialist Eating Disorders Services are the obvious preferred choice for placements. Clinicians working within a general setting, such as general Practice or General Adult Psychiatry may request to take suitable cases from their own caseload provided these are supervised by an EEATS approved supervisor and provided that some time is spent observing practice by specialists.

SECTION 1

Eligibility to apply for Accreditation

To be considered for the certificate applicants must fulfil the following basic general criteria.

	Criteria	Tick if completed	Signature of supervisor or Clinical Manager
1	Have a relevant professional training to degree level or equivalent. (Please provide evidence e.g. membership of professional body.		
2	To have been accountable for their own professional practice to a senior member of their profession for at least 2 years full-time or equivalent, since professional qualification. If already in a senior role, demonstration of an appropriate responsible peer group is acceptable.		
3	Adhere to a recognised ethical code and be willing to be scrutinised in this adherence as required. This code could include the following:- (Please either give reference to your ethical code or supply a copy of your code) • Respect for the patient and acknowledgement of the importance and the seriousness of the eating disorder. • Avoiding being dismissive or hostile. • Be able to foster an attitude of hope. • To make the patients' interests your first priority. • To be polite, considerate, open and honest with patients, particularly if mistakes have been made and in any financial dealings with patients. • To treat patients with dignity and as individuals. • To have due respect for the skills and contributions from colleagues • To be involved in audit or other activities which involve scrutiny and reflection on clinical practice (please give details on a separate sheet).		
4	Demonstrate knowledge and understanding of the therapeutic relationship and competence in the development, maintenance, transferring and ending of such relationships.		

	Criteria	Tick if completed	Signature of supervisor or Clinical Manager
5	Show evidence of sustained commitment to the study of the theory and practice of management of eating disorders which includes continuing professional development.		
6	Have regular and sufficiently frequent clinical supervision (minimum 1 hour per month) (Please specify time, frequency & whether individual or group supervision).		

NB: Deliberate false statements, if discovered, will result in removal from the accreditation lists and reporting to the clinician's professional and disciplinary bodies.

Initial accreditation is for a period of 5 years and accredited members will be required to reapply for each subsequent 5 year period. Reaccreditation will have slightly different requirements.

SECTION 2

Knowledge

There is an online test of knowledge comprising a number of multiple choice questions taken from a bank of questions. This may be taken at any stage between registration and completion of application for accreditation. The test may be attempted as many times as necessary to achieve the pass mark of 80%, however the test will be locked to the applicant for one month after each unsuccessful attempt.

Mandatory Requirements

(At least 5 hours study on each of the following i.e. a minimum of 35 hours)
Please submit a log of work undertaken to achieve this section.
Note that the level and perspective of knowledge in different sections will vary according to the applicant's core discipline. In some cases it will include knowledge of when to seek referral to a colleague of another discipline.

	Subject	No. of mandatory Hours Completed	No. of Optional hours completed	Please state form of training e.g. attendance at conference/workshop (please provide evidence of attendance at event, together withcompleted feedback form)
1	Psychopathology – Symptoms and diagnosis a) Core Symptoms of eating disorders necessary to meet the diagnostic criteria of ICD10 or DSM IV, and awareness of the overlapping nature of eating disorders. b) Knowledge of a variety of other symptoms commonly found in eating disorders and the psychiatric syndromes which can co-exist with eating disorders.			
2	Have a working knowledge of the psychological theories which provide an understanding of the aetiology, development and experience of eating disorders.			
3	Physical features a) Knowledge of nutritional principles and the biology of starvation. b) Knowledge of the physical characteristics of eating disorders including areas of particular risk.			
4	Knowledge of the social and family factors involved in the development of eating disorders and social and family consequences of eating disorders.			
5	Knowledge of the principals of clinical assessment of patients with eating disorders.			
6	Knowledge of the main treatment options in eating disorders including psychotherapies, medical treatments and the role of intensive treatments including hospital admission. This should include the role of mental health legislation in the treatment of some patients.			
7	Have a sound knowledge of guidelines such as the QIS and NICE guidelines on eating disorders.			

Signature of Supervisor/Clinical Manager _____

Date _____

SECTION 3

SKILLS: Mandatory Requirements

(NB: The person ticking the column may be your supervisor/clinical team leader or nominated deputy – your supervisors should counter sign if this is the case).

You must have demonstrated awareness of and appropriate competence in the following areas (within limits of professional training) and demonstrate awareness of when and how other professionals should be consulted:-

	Subject	Tick once satisfactorily completed	Signature of supervisor/ Clinical Manager
1	Assessment a) To take an appropriate history from a patient with eating disorders. b) To appropriately involve the family and other relevant informants in the gathering of clinical information. c) To assess the mental state of patients according to the conventions of the applicant's discipline, together with knowledge of when to refer to psychiatrists for formal mental state assessment, if relevant. d) To understand the circumstances in which physical assessments should be undertaken. e) To know which medical investigations should be conducted to contribute to the physical assessment of patients with different eating disorders of varying severity or depending on professional background know when to refer for further physical assessment. f) To undertake a risk assessment, to include both psychological, social and physical risk. g) To understand the role of standardised interviews/questionnaires. h) To be able to make a formulation of the patient's problems in a form appropriate to the applicant's professional discipline. (Please see examples on page 27).	Please submit an anonymised example	
2	Management and Treatment a) To formulate a management plan (or to contribute appropriately to a multidisciplinary plan) to include physical risk management, the correction of nutritional deficiency, psychological therapies, interpersonal and family considerations,	Please submit an anonymised example	

	Subject	Tick once satisfactorily completed	Signature of supervisor/ Clinical Manager
2	pharmacological management, and the provision of information and support to patients and carers. b) To implement a comprehensive management plan with the aid of colleagues. c) To develop a positive and collaborative therapeutic alliance. d) To promote motivation for change. e) To be able to discuss with patients and, where appropriate, relatives the role of different therapeutic approaches including self-help, medication, specific psychotherapies and hospital admissions. f) Be aware of the difficulties and dangers of transitions between services and elements of services and demonstrate steps to minimise harm.		
3	Communication & Documentation a) To appropriately document clinical encounters, summarise findings and write timely letters of referral or progress to clinical colleagues. b) To liaise and communicate with other clinicians involved in the management and treatment of patients. c) To recognise limitations of experience and expertise and consult with colleagues when appropriate.		

Signature of Supervisor/Clinical Manager _____

Date _____

SECTION 4

Reading and Private Study

Tailor Made Training (65 hours – 35 of which must be "taught" training)

In addition to the mandatory requirements above some of the training requirements can be made up of optional elements. This could include additional training and experience in the mandatory elements or any of the following:--

- Research and audit involvement in the field
- Specialist dietetic medical, psychological or other professional expertise as applied to eating disorders
- The study of psychological and psychiatric aspects of obesity
- The study of psychological and psychiatric aspects of childhood feeding disorders
- Experience in specific psychotherapies such as family interventions, group work, cognitive behavioural therapy etc.
- The psychopharmacology of eating disorders
- The study of exercise and activity in relation to eating disorders
- Specific therapeutic work on body image/body checking, motivational interviewing etc.
- Application to the learning disabled population
- Preventative programmes and work in schools
- Caring for chronic (and older) patients
- Supervision for eating disorders
- Use of telemedicine, electronic and other technological resources, including a guided self-help and computerised therapy
- The development of mealtime supervision techniques
- Addressing milieu, community and team dynamics and work with eating disorders (including staff support, professionals with an eating disorder, use of protocols, ICPs and programmes)
- Working with co-morbid personality disorders
- Training and techniques for assisted re-feeding by artificial means

This is not an exhaustive list – please discuss further alternatives with your supervisor.

*Reading and Private Study

Applicants wishing to claim for reading and private study to be counted towards accreditation should attach a list of articles/books read together with a brief summary of content, as evidence. You are advised to consult the EEATS list of books, journals, websites and other resources, in selection of your material, and to agree your choice with your supervisor.

PLEASE NOTE: You will have already completed 35 hours of mandatory training. This leaves up to 65 hours still to be completed. You may claim a maximum of 30 hours of reading or private study towards your final accreditation.

Please detail tailored training undertaken below

	Tailored Training – Subject Area	Number of hours

Signature of Supervisor/Clinical Manager _____

Date _____

SECTION 5

Clinical Placement and Supervision

Clinical experience should be in setting which provides regular, at least weekly, clinical work with eating disorder patients. There must be a signed reference from the clinical team leader (who may not be the accreditation supervisor).

	Tailored Training – Subject Area	Tick once satisfactorily completed
a	A reference must be provided from the supervisor (or deputy) and the supervisor's CV and contact details have to be made available to be approved by EEATS before starting a period of supervision to be accredited	Please submit a letter of approval from your supervisor.
b	There must be evidence of continuing availability of supervision of eating disorders cases from a named supervisor/supervision group for at least one hour monthly	Please submit a log of supervision.
c	There should be evidence of significant clinical involvement with and direct clinical responsibility for eating disorder patients. This may be, and usually will be, as part of a shared responsibility within a multidisciplinary team and should include long term work (6 months or more) with at least one patient. This will include experience of working with a spectrum of patients (e.g. low weight AN, BN, patients with co-morbid depression, OCD, or borderline disorder, patients with diabetes, pregnant women etc).	Please submit a reference from your supervisor.
d	A brief summary must be provided on the applicant's work with at least 5 patients demonstrating the range of clinical experience. Each case must include brief learning points.	Please submit a summary highlighting learning points.
e	At least one case must be written up fully according to the guidelines appropriate to the applicant's professional discipline or the example provided, and signed by the supervisor.	Please submit a case study.

Signature of applicant for accreditation _____

Date _____

APPENDIX 1

Clinical Supervision Contract

This is a document to trigger discussion around various issues. Once you have reached agreement, then make a note of it in the boxes provided. Both the student and supervisor should sign it and both should have a copy.

Timing & Learning Environment:

EEATS recommends that ideally you arrange 90 minutes of supervision per fortnight or a minimum of one hour a month. Applicants who are supervised in dyads or small groups will require longer supervision time.

Please arrange dates, times and venue. Consider the need to keep the boundaries of the session without interruptions. How personal/social is it appropriate to be in supervision – will refreshments/smoking be allowed during supervision? Please also discuss how to let each other know if you cannot make it. A "Clinical Supervision Record" should be completed by the supervisor for each session – there is no formal template for this, but we expect at least a brief note of times and topics covered. Trainees are also encouraged to keep their own records of supervision.

Patients To Be Supervised:

Please refer to our Responsibility and Accountability form.
We suggest that trainees work with a range of patients, and may wish to bring vignettes from all this work to supervision (provided this has been agreed with line managers). However only one or 2 cases can be supervised in detail within the supervision slot. These cases should be firmly identified. It is helpful if some sessions can be audio or video taped (with permission). Cases which continue beyond the end of the supervision contract should be discussed before this date and arrangements made to transfer of supervisory responsibility if necessary.

Ethics, Boundaries And Confidentiality:

EEATS suggests you review your discipline's and organisation's guidelines. This is even more important if supervisor and supervisee do not work in the same discipline or service. Particular discussion is needed to relate these issues to the developmental stage of younger patients and those still living at home, and to the needs of parents and other carers. Think about audio and video recordings, the informed consent of patients and families, and the need to anonymise any written case material, especially if this is to be submitted for evaluation.

Learning Styles & Methods:

Learning Methods:

What are your preferred learning styles? Are they similar or different? How much preparation ('homework') are you both comfortable with? Will you prepare by listening to recorded sessions/ presenting cases and case extracts/writing up cases in logbook form? Which methods of teaching and learning will be highlighted? (For instance role-play, hearing edited highlights of recordings, watching commercially available videos, etc).

Feedback:

EEATS expects both supervisors and supervisees to give constructive and supportive feedback in the course of supervision. Establish how feedback will be given from session to session. In writing? Orally? How direct would you like to be? What wouldn't feel comfortable with either of you? We urge both parties to think about and discuss practice which is unethical, disrespectful, unwise, or insensitive. If students are being supervised in a pair or group, all parties will need to be happy with the way in which feedback is openly discussed.

How Much Do You Need To Know About Each Other?

It may be helpful to have some idea of each other's background. For instance, what has been your preferred model of therapy? Do you have any particular beliefs or fears that may need to be particularly respected during supervision? Are there any recent or expected life events that will affect the supervision process. Are your own body image concerns or your own experience of eating disorders likely to affect your ability to work with this patient group?

Is There Anything Else Either/Any Of You Would Like To Add?

Dates Of Start And End Of Supervision Contract:

From _____ / / _____ To _____ / / _____

Signed _____

Date _____

Supervisor _____

Supervisee _____

APPENDIX 2

Responsibility And Accountability In Supervision

It is often the case that therapists obtain training cases from specialist services where their supervisor has clinical or managerial links with that service. In other cases, the trainee takes on cases from either the supervisor's own caseload or from a service outwith both people's usual caseload. In these cases there may be 2 or even 3 agencies involved:

1. EEATS Supervisor.
2. Supervisee's Employer (where relevant).
3. Referring Team providing the clinical cases

It is essential that there is a clear policy about clinical responsibility for the cases being treated.

Requirements

- The supervisee (EEATS accreditation applicant) has the prime responsibility for keeping both or all three agencies informed about difficult clinical situations, high risk patients.
- The overall clinical responsibility is retained by the service which has supplied the training cases. It is useful to have a named contact identified.
- The Supervisor may need to contact the clinical service providing the patients. This will almost always be done in conjunction with the supervisee. There may be circumstances where the supervisor has concerns about the competency of the trainee and may need to make direct contact with the referring service if patients are considered to be at risk.
- A copy of this document, together with any agreed variations to the policy, should be filed in the patient's notes. Copies should also be kept in supervision and reference files.
- It is the trainee's responsibility to set up an Honorary Contract with the referring team should the referring team deem it necessary.

Please Print Your Name Clearly In Capitals And Sign Below:

Therapist (EEATS Applicant, supervisee): _____

Date: _____

Supervisor: _____

Date: _____

EEATS Applicant's line manager/Employer (where relevant): _____

Date: _____

Identified Clinician from Referring Team: _____

Date: _____

APPENDIX 3

Suggested Case Template

(May also be used to structure letters)

- Patient's Name (anonymised), age, occupation

- Referral and Presenting complaint
- Background
- Previous medical and psychiatric history
- Family background and history
- Personal History
- Social circumstances
- Mental state
- Physical examination and investigations

- Differential diagnosis

- Formulation
- Predisposing
- Precipitating
- Perpetuating
- Protective

- Management plan
- Physical
- Nutritional
- Psychological
- Social

- Progress

- Outcome

- Prognosis

- Commentary
- Particular learning points
- Use of supervision
- Further discussion

- Appendices – correspondence, graphs and measures, other illustrations

APPENDIX 4

Case Example 1

Mary Bee, a 19 year old ballet student, was referred to the Eating Disorders clinic by her GP, who flagged her case as urgent, as her weight was continuing to fall, and the family were already concerned that she would soon need hospital admission.

Mary herself was dismissive of their concern but did agree to attend the outpatient clinic. She had lost about 10kg over the past 6 months since starting ballet school, and was now amenorrhoeaic, with a BMI of 15.5. She admitted to gradually reducing her daily food intake whilst increasing exercise, training and ballet practice. She had been suspended from ballet school on health grounds and was back at home, but continued to exercise obsessively and to run for an hour night and morning.

Background

Mary had never been overweight and was tall, lean and muscular, but rather more sturdily built than the ballet dancers she met at her specialist academy. After two years at the school she began to lose weight deliberately and at first believed this was a successful strategy as she was offered parts when she auditioned.

At the start of her final year she was no longer achieving the results she wanted and had been advised to diversify into drama and other performance arts or at least consider careers other than ballet. She was devastated and continued to lose weight. Soon, the school doctor, who monitored students' weight regularly, asked her to take time out to regain her health, and she returned home.

She denied self-induced vomiting, laxative abuse of use of any other substances or weight loss methods. Her parents validated these claims but had noticed that she continuously used sugar free chewing gum.

Previous medical and psychiatric history

No previous psychiatric history
Tonsillectomy aged 4, done as a day patient, no complications

Family background and personal history

There was no known family history of any psychiatric disorder or in particular any eating disorder. However, the family is a small one - both parents were only children and little is known of the extended family of previous generations.

Mary is the only child of older, professional parents, and is highly academic as they are. She was a much wanted child, born when the family had despaired of having children. She was born in Oxford, but came to Scotland at the age of 2, when father obtained university post. She was described as a 'fretful baby', constantly beset by respiratory infections, but these cleared up dramatically after the tonsillectomy, as did her sleep and temperament. She had not attended nursery, partly because of health concerns, but now settled well into the local primary school. She was popular, 'sport mad' and managed to excel at gymnastics, dance and also academic work.

She was much less happy at High School and suffered from teasing about her early physical maturity. There was a short period of weight loss around this time, but at the end of first year she sat the scholarship examination for a girls' private school, and was successful. Her mood and eating both improved and there was another stable period of contented achievement. She spoke very warmly of her time at school. She had enjoyed the all-female environment but had one or two boyfriends, though these were not physical relationships.

She had entered Ballet School together with a friend and classmate, and this had disappointed her parents, who hoped she would attend a prestigious university. This had led to quarrels in which Mary blamed them for being 'snobs' and they insisted (untruthfully) that they were perfectly happy with her chosen career. The quarrels had now broadened into conflict over her failure to eat, and Mary only reluctantly allowed her mother to describe the parental view of the situation

Social circumstances

She is again living with parents in large comfortable house in an affluent suburb in the University area of the city. She has no financial concerns, no forensic history and neither drinks nor smokes. She has lost contact with most of her former friends but sees something of the neighbours' young children for whom she babysits. She has two pedigree cats and adores them. She has no religious beliefs and denies any particular interests or hobbies apart from sport, gymnastics and dance, which are all currently banned by doctors.

Mental state

Mary appeared more healthy than her weight would suggest – perhaps because of the relatively recent weight loss and perhaps because of a round, childlike face and pretty features. She was well fashionably dressed, carefully made up and superficially disdainful, but soon became warmer and more talkative.

During our first meeting she was cooperative and polite but wary. She physically fidgeted throughout the interview. She was highly articulate – she clearly had experience of other girls' Eating disorders and extreme body image concerns and constantly referred to much worse cases than hers. She thought it unfair that she was 'being punished for losing weight'. There was no evidence of hallucinations or delusions apart from the overvalued idea that she would benefit from still losing more weight.

Her mood was flat – she had lost interest in previous interests and said that former school friends contact her on Facebook but she 'can't be bothered' to make contact. She no longer went to the cinema or theatre and her mother believed this was because she would have to sit down. She had not noticed any loss of concentration or fatigue, and asserted that she had never been particularly interested in sex. She denied feeling suicidal at any point, but did admit to feeling 'fed up'.

There were some obsessive compulsive symptoms around exercise, eating and body checking (weighing, measuring and mirror gazing), but these did not predate weight loss and did not extend to other areas of life.

She appeared to be an intelligent girl, though we did not conduct formal tests of memory or intelligence.

I suspected she had more insight into her predicament than she was prepared to admit, as she agreed to attend for further regular therapy despite protesting that nothing was wrong.

Physical examination and investigations

Mary had been thoroughly examined by her GP. He reported low blood pressure, slow pulse rate, and 'a loud systolic heart murmur, attributed to blood flow through the valves of a shrunken heart'. Her ECG was normal apart from bradycardia. Blood tests showed normal biochemistry but a mild neutropaenia. A bone scan was later arranged and showed bone density within the normal range.

Psychological measures

Her scores on the EDE-Q were compatible with a diagnosis of anorexia nervosa. She also scored 29 on the BDI-II, suggestive of a moderate level of depression.

Differential diagnosis

Mary met criteria for anorexia nervosa, restrictive type but with compulsive over exercise. She also met some but not all the criteria for major depressive disorder. It was impossible at that stage to decide whether the depression was secondary to starvation or whether the eating disorder was secondary to depressed mood.

Formulation

Predisposing factors

As a female only child of older, middle class parents, attending an all girls' private school, Mary is in the demographic group seen to be at highest risk for developing anorexia nervosa. Whilst there is no known family history of eating disorders, she does not know many details about her family members. She herself appears to have suffered from a brief episode of weight loss around the time of puberty, so she may be vulnerable to using weight loss as a coping mechanism at times of distress.

Precipitating factors

Her leaving the school where she was happy, to attend ballet school away from home and to the disappointment of her parents, seems to have gradually precipitated significant weight loss, and her loss of achievement and suspension from ballet school may have further precipitated low mood and more weight loss.Perpetuating factors include the self-perpetuating downward spiral of the 'starvation syndrome', as well as of obsessive-compulsive exercise, the quarrels with her family and onset of low mood.

Protective factors

Mary's low weight is less dangerous physically than it would be if she were also purging or abusing substances. She has been monitored medically and so brought for treatment relatively early on in the disorder. She is intelligent, there is no sign of any personality disorder or impulsivity, and she is well-supported by family. All are motivated to help her avoid the need for a hospital admission.

Management plan

Physical & Psychological

It was agreed in supervision to start with motivational enhancement techniques, to continue, medical monitoring and to arrange a meeting with the dietician to negotiate a food plan. Later in therapy it was envisaged that the model of Fairburn's CBT-E would be appropriate. Her parents were provided with details of carers' support group. Mary agreed that they could meet separately with me, but she did not want to be present.

Social – Mary was offered a meeting with the OT to consider less active pastimes and occupations such as voluntary work since obliged to take a year out of ballet school. She declined this, but agreed to reconsider later.

Progress

The second meeting was devoted to drawing up a contract for 12 weekly sessions of individual therapy followed by a review, and to setting goals. She agreed reluctantly to work towards slow weight gain or at least to not lose any more weight during the first phase of therapy. We agreed that I would weigh her early in each session and that she would stop weighing herself at home. Her own goal was to be healthy enough to return to ballet school to repeat her final year. She also wanted to be allowed to undertake exercise openly so that she would not 'need' to resort to secretive exercise.

She attended every session, tolerated a slow weight gain surprisingly well, but looked increasingly depressed despite her assurances that things were much better. Around half way through the agreed block of sessions she appeared to suddenly lose several kilograms and admitted shamefacedly that she had been 'waterloading'. We spent the rest of that session discussing the dangers of this practice and the need for openness and honesty. Mary agreed that she would not continue to 'fake' her weight. However, she did not attend the following two sessions. Her mother phoned on each occasion to say that she had a sore throat.

My supervisor helped me to examine the way in which my handling of the last session may have triggered an 'alliance rupture' and helped me to see that Mary had been brave in confessing what she had done, when she was also afraid that she would be put into hospital if she lost weight. I therefore wrote a letter to Mary, thanking her for her honesty, recognising her fear of admission and suggesting that we meet to discuss how to proceed.

Mary did attend the meeting and explained that she was worried that she would no longer be able to 'protect' anorexia now that I knew her tricks. It turned out that her weight was now considerably lower than on referral and her neutrophil count was worryingly low, especially since it was now winter and there was influenza around.

The use of Mary's white blood counts rather than relying solely on weight as a measure turned out to be helpful. Mary's mood had also worsened, and she now said that she couldn't see a future for herself in the world of ballet. She now felt she would like to become a psychologist working with people with eating disorders and asked whether there was any voluntary work she might do in this area. After further discussion in supervision we asked Mary to postpone decisions and leave all options open until she was further on in recovery.

In particular it would not be appropriate for her to volunteer around Eating Disorders at this stage. There was very serious discussion about hospital admission, but this was not possible because of a shortage of available specialist beds. I therefore visited Mary at home for the next two sessions, at which Mary allowed her mother to be present. Mary also started antidepressant medication.

From this point onward, for no discernable single reason, Mary began to very slowly and reluctantly regain some weight, and her blood count also improved in parallel with the weight gain. Her mood remained low, despite an increase in the dose of fluoxetine, but her parents reported an improved atmosphere in the home.

Outcome

At the time of writing Mary is taking a therapeutic break after the block of 12 sessions, ten of which she attended. Her weight continues to improve – her BMI is now over 16, but she is still amenorrhoeaic. Compulsive exercise is still a problem and she insists this is important so that the weight she gains will be 'all muscle'. She has officially left her ballet school and is preparing a portfolio in the hope of applying for a local Art College in a year's time. The GP who monitors her physical state tell us that she has a new boyfriend.

Prognosis

Mary remains quite disabled by anorexia nervosa, and made surprisingly little physical progress during the course of therapy. Functionally, though, she is making progress, and has managed to rescue herself from a situation that was not really 'her'. She is still experimenting with careers and relationships, now from the security of the parental home. In general Anorexia nervosa often takes between 2 and 6 years for recovery to occur so she may be considered to be at an early stage of recovery.

Good prognostic features include the good and trusting relationship she made after a 'rupture' in the therapeutic alliance and the fact that she avoided hospital admission, which is associated with worse prognosis. The improvement in her relationship with her mother and her permission for mother to join two of the sessions may also point to improved capacity to accept support.

Commentary - Particular learning points - Use of supervision - Further discussion

My supervisor had identified this as a relatively straightforward case, so I was embarrassed that my input did not bring about better results. I found it mortifying that Mary had even lulled me into a false sense of security, and that then I had been unable to refrain from speaking disapprovingly to her.

It was invaluable to receive empathic, kindly reassurance from my supervisor and also to attend a workshop on Motivational Approaches. I am unsure whether these actually motivated my patient but they allowed me to continue to work in the face of Mary's ambivalence and deterioration without becoming despairing or angry with her.

After the break in treatment I sometimes made the opposite error of not challenging Mary at all, and 'walking on eggshells' like her parents. I have wondered whether the fact that the 'threatened' hospital bed failed to materialise allowed her to believe that there were no consequences to her unhealthy behaviour.I enjoyed the experience of using Fairburn's CBT manual to guide and inform therapy, but did not find it possible to use it as a manual in this case. The most outstanding lesson I have learned is simply how long it takes to even start recovery from anorexia and how distressing it must be for carers who witness the effects of the illness day to day.

CASE HISTORY NUMBER 2

Patient A aged 25. Single mother on benefits.

Referral and Presenting Complaint

Patient A was referred by a local Psychiatrist who was concerned by her eating behaviour. She was being assessed and treated for a depressive disorder and a history of a chaotic dietry pattern emerged.

Background

Patient A describes eating large quantities of carbohydrate rich food especially during the evening once her 5 year old daughter is put to bed. She tends not to eat during the day and in fact will choose to avoid to do so taking mostly small quantities of fruit and sugar free juices. Episodes of over-eating tend to last for around half an hour and will usually be one an evening but currently they are taking place on most evenings a week. Consist of carbohydrate rich foods and sweets including crips, chocolate and cake. She will tend to eat multiple packets of a food item. She eats until she feels uncomfortably full and after a brief period of resisting this feeling will make herself vomit by putting her fingers down towards the back of her throat. Patient A describes pre-occupation about food and fears gaining weight.

At initial assessment her BMI was 21.5. She denies abuse of laxatives or other substances designed to aid losing weight to prevent weight gain. She denies over-exercise saying that she is too busy looking after her daughter. Patient A describes a variety of ongoing symptoms of depressive disorder including still impaired concentration, sleep reduced early morning awakening by two or three hours per night, feelings of worthlessness. Also described a degree of low energy and motivation impaired interested in pleasure although the last three symptoms in particular seem to be beginning to resolve on an increase of Fluoxetine. Current medication – Fluoxetine 40mg.

Previous Medical and Psychiatric History

Patient A described an episode lasting about six months when she was aged 14 when she engaged in similar behaviours in response to some criticism and bullying at school. The episode subsided when she moved school. She has a history of post-natal depression on the birth of her five year old daughter which was treated with SSRI's by her GP and more recently has been re-started on the same SSRI Fluoxetine by her Psychiatrist. Current episode of depressive type symptoms lasts for the same amount of time that her eating behaviours have deteriorated i.e. for around 12 months. There is no past medical history of note otherwise.

Family Background and History

Patient A throughout most of her childhood was conscious of the dieting behaviours of her mother who was obese and was constantly on and off different diets. Aside from this there is no family history of eating disorders. She has a sister and a brother both older both of whom appear well. She feels they are achieving better than herself. Mother and Father split up when she was aged 15. She maintains good relationships with both her mother and her father.

Personal History

Patient A was born in the Glasgow area. There were no complications at her birth. At the age of 5 she and her family moved because of her father's job to the Aberdeen area. They have all lived in that area ever since. She remembers primary school as being a good time but during the middle years of secondary school felt she was bullied due to her weight and body shape.

She met the father of her daughter while she was still at school and they had an on and off relationship thereafter for eight years. They split up two years after the birth of her daughter. The relationship had been troubled for some time. This partner did have a problem with alcohol and was frequently verbally critical though never physically or sexually violent. No history of abuse in her background otherwise.

Social Circumstances

Patient A was recently laid off from a job that she had taken about the same time her daughter begun primary schooling. She was working at a shop as an assistant, the shop chain just having closed down. She is currently managing on benefits and does get a lot of help from both her sister and her mother in terms of day to day coping. She has more recently been tending to isolate herself and not go out so much and thus the eating disorder behaviours have had more opportunity. There is no history of significant drug use although she did use cannabis on and off during her later teenage years.

Mental State Examination

Patient A was casually but appropriately dressed at interview. She shows good eye contact but was occasionally tearful when talking about her current circumstances. Speech was of normal rate and rhythm with no abnormalities of forma thought. There was no evidence of psychosis or suicideality. Cognitively she was in tact on basic testing including her concentration and short term memory and she appeared to have good insight into her difficulties. She also expressed the fact that she would like to improve things because she didn't want her daughter to begin to grow up knowing she had difficulties with her eating.

Physical Examination

Patient A showed some mild perrotted enlargement and some damage to her tooth enamel. Aside from this unremarkable with no abnormalities within routine blood tests.

Differential Diagnosis

1. Bulimia Nervosa.
2. Eating Disorder symptoms secondary to depressive episodes.

Formulation

Patient A appears almost certainly to be suffering from Bulimia Nervosa. There are pre-disposing features to her background which include her mothers' obesity and the past history of eating disorder behaviours at a time of stress. It may be that some family dynamic factors that relate in part to the break-up of her parents marriage may be significant. More recent precipitants may be partly due to transitional issues with her daughter having begun school in the last year which matches very closely with the onset of the illness. Also the depressive disorder itself may have acted as a trigger. Perpetuating the illness could be social pressures and stresses as well as features of the depressive disorder and the adaptive behaviours including the increased withdrawal.

Other underlying psychological features such as low self esteem may well be significant in the background and would need further assessment. The classic cycle of maintenance of bulimic symptoms will probably be significant with a wish to lose weight leading to the fasting behaviours and then the impulse to binge leading to further lower self esteem following the compensatory behaviour of making herself vomit. In terms of protective factors appears to be the fact that she is complying with her treatment of her depression and that she in fact in many respects has a good relationship with other family members who do provide her with help. She also appears motivated to try and get help and try and manage her symptoms better.

Management Plan

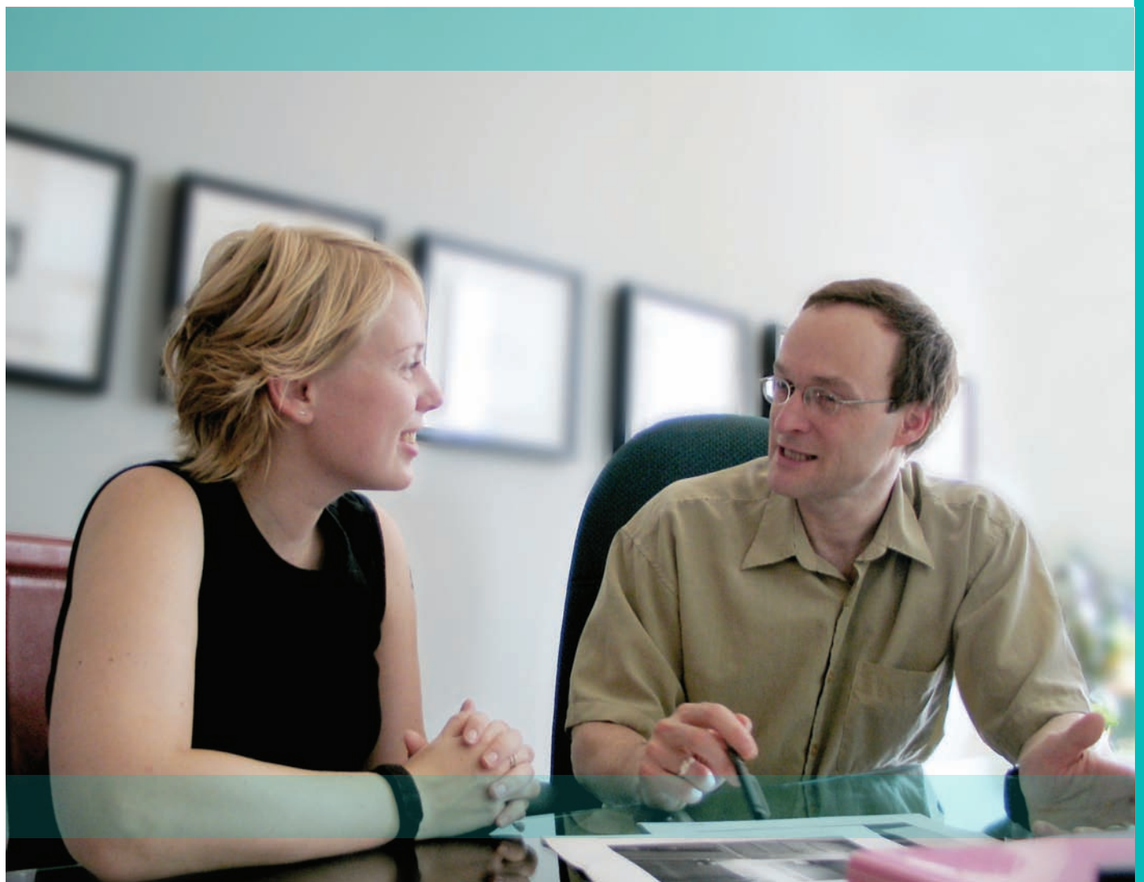
Physically Patient A should be monitored for as long as her eating disorder behaviours continue by three monthly Us and Es, creatinine, LFT, calcium and a full blood count. Needs to be advised on not brushing her teeth after inducing vomiting but instead using a non-acidic mouth wash. Evidence of severe esophagitis then appropriate medication may need to be considered. As part of the physical management nutritional advice may well be beneficial via Dietetics to help her deal with her average dietary routine which is perpetuating in part her Bulimia Nervosa.

Her psychological management given her motivation level may well benefit from Cognitive Behavioural Therapy but perhaps given her responsibilities currently might better be delivered by an individual therapist rather than just purely self help. Further discussion and consideration should be given as to whether any further help should be given on a social setting by way of social work intervention that could maybe make her ability to attend appointments for treatment more possible for example. Having said that her daughter has started at school.

Progress

Patient A made good progress with standard CBT for Bulimia delivered over 16 sessions. She missed a few sessions due to parental responsibilities but always seemed motivated and keen to make progress especially since her depressive symptoms appeared to respond very quickly to Fluoxetine. Fluoxetine was also raised to 60mg that appeared quite rapidly to alleviate the frequency of her binge eating episodes. Twelve months on Patient A's case was completely closed to the Eating Disorder Department after a later review since it was seen that she was continuing to maintain her progress. She was discharged back to the General Psychiatrist who was still monitoring her as regards to her depressive symptoms.

> "I enjoyed the experience of using Fairburn's CBT manual to guide and inform therapy, but did not find it possible to use it as a manual in this case. The most outstanding lesson I have learned is simply how long it takes to even start recovery from anorexia and how distressing it must be for carers who witness the effects of the illness day to day."



Prognosis

Patient A is perhapsw to future relapses in her eating disorder at times of stress. However this likelihood will be mitigated by her greater understanding of her vulnerability to it through psycho-education and the CBT based treatment. Likewise future episodes of depression would make future relapses more likely aswell. Overall however the prognosis is likely to be reasonable given the patient's good insight and motivation to this particular episode of treatment.

APPENDIX 5

Index Of Sample Clinical Placements & Contacts

Inclusion in this list does not oblige services or clinicians to accept professionals for placement but merely offers suggestions to those seeking accreditation as to the settings envisaged for their work.

Specialist Adult Eating Disorders Services

Inpatient

- Royal Cornhill Hospital Aberdeen – Eden Unit
- The Priory Hospital Glasgow
- Huntercombe Hospital, Edinburgh

Day/Outpatient/Intensive Outreach

- Royal Cornhill Hospital Aberdeen – Eating Disorder Service/Eden Unit
- Royal Edinburgh Hospital - Cullen Centre and ANITT
- NHS Tayside Eating Disorders Service (Constitution House, Dundee)
- Glasgow Eating Disorders Service

Child & Adolescent services with expertise in Eating disorders

Inpatient

- Royal Hospital for Sick Children, Yorkhill, Glasgow – DCFP (Children under 12)
- Stobhill Hospital Glasgow – Skye House (adolescents)
- Royal Edinburgh Hospital – CAMHS IPU (adolescents)
- Dundee YPU, Dudhope House (adolescents)
- Huntercombe Hospital Edinburgh (adolescents)

Day/Outpatient

- Edinburgh Forteviot House (under 14s)
- Royal Edinburgh Hospital – CAMHS Day Programme (14 – 18)
- To be completed at a later stage

Specialist Child & Adolescent Eating Disorders Services

Inpatient

- Huntercombe Hospital Edinburgh

APPENDIX 6

List of books & other recommended resources

Please Let Us Know Of Any Notable Ommissions From This List That You Would Strongly Recommend.

Books aimed primarily at professionals

General Eating disorders textbooks

(note that some general mental Health textbooks will carry helpful chapters on Eating Disorders, but these are unlikely to provide sufficient detail for specialists)

1. **The ABC of Eating Disorders**
   Ed J Morris
   Blackwell (2008)

2. **The Essential Handbook of Eating Disorders**
   J. Treasure, U Schmidt, E van Furth.
   Wiley (2005)

3. **Helping People with Eating Disorders**
   A Clinical Guide to Assessment & Treatment
   Robert Palmer
   Wiley Blackwell (2000)

4. **Handbook of Eating Disorders, Theory, Treatment and Research**
   Eds J Treasure, U Schmidt, Evan Furth,
   Wiley (2003)

Specialist areas within eating disorders

1. **Cognitive Behavioural Therapy for Eating Disorders: A Comprehensive Treatment Guide**
   Glenn Waller, Helen Cordery, Emma Corstorphine, & Hendrik Hinrichsen
   Cambridge University Press (2007)
   (In fact covers far more than CBT)

2. **Cognitive Behaviour Therapy and Eating Disorders**
   Christopher G. Fairburn
   Guilford Press (2008)

3. **Eating Disorders in Childhood and Adolescence 3rd Edition**
   Eds Bryan Lask, Rachel Bryant-Waugh
   Routledge (2007)

4. **Eating Disorders in Children and Adolescents**
   Eds Tony Jaffa, Brett McDermott
   Cambridge University Press (2006)

5. **Treatment manual for Anorexia Nervosa, a Family- based Approach**
   J Lock, D Le Grange, WS Agras, C Dare
   Guilford 2001

6. **Medical Management of Eating Disorders, A Practical Handbook for Healthcare Professionals**
   C. Laird Birmingham & Pierre J. V. Beumont
   Cambridge (2004)

7. **Body Image, a handbook of theory, research & clinical practice**
   Eds T Cash & T Pruzinsky
   Guilford Press (2002)

BOOKS AIMED AT BOTH PROFESSIONALS AND LAY PEOPLE

(usually sufferers and carers) - may be particularly useful in a guided self-help setting.

1. **'Breaking Free from Anorexia Nervosa' - A Survival Guide for Families, Friends and Sufferers**
   Treasure J (1997)
   Psychology Press

2. **The Wish to Change**
   A. H. Crisp, Neil Joughin, Christine Halek, Carol Bowyer
   Psychology Press (1996)

3. **Overcoming Binge Eating**
   Fairburn C G (1995)
   The Guilford Press

4. **Getting Better Bit(e) by Bit(e) - Self Help Book and Clinician's Guide**
   Treasure J & Schmidt U (1998)
   Psychology Press

5. **Overcoming Anorexia - Self Help Book using Cognitive Behavioural Techniques**
   Freeman Christopher
   Constable and Robinson (2001)

6. **Bulimia Nervosa and Binge Eating - A Guide to Recovery**
   Cooper P J (1995)
   Robinson Publishing Ltd

7. **Skills-based Learning for Caring for a Loved One with an Eating Disorder, The New Maudsley Method**
   Janet Treasure, Gráinne Smith, Anna Crane
   Routledge (2007)

8. **Making Weight: Healing Men's Conflicts with Food, Weight, and Shape**
   Arnold Andersen, Leigh Cohn, Tom Holbrook
   Gurze books (2000)

9. **Boys get anorexia too. Coping with male eating disorders in the family**
   J. Langley
   Lucky Duck Books (2006)

JOURNALS AND PERIODICALS

International Journal of Eating Disorders,
The journal of the American Academy of Eating Disorders,
Wiley

European Eating Disorders Review
Wiley

Web-based resources and learning materials
(This list is continually evolving – please send us details of web-based learning in the field which you feel is relevant and of good quality)

Royal College of Psychiatrists
www.rcpsych.ac.uk

BEAT (formerly EDA)
www.b-eat.co.uk

Something Fishy website
www.something-fishy.org

Scottish Eating Disorder Interest Group (SEDIG)
www.sedig.co.uk

Managed Clinical Network for Eating Disorders
www.eatingdisorder.nhsgrampian.org

Anorexia Nervosa Intensive Treatment Team
http://www.anitt.org.uk

EVIDENCE REQUIRED FROM CANDIDATES – CHECK LIST

All Evidence submitted should clearly state the Section and item Number it pertains to.

Please attach this check list to your submission

Name: _____ Candidate Number: _____

Date of Submission: _____

SECTION 1

Eligibility to apply for Accreditation

Item Number	Evidence Required	Included with submission Y/N (if no please give reason)
1	Evidence of membership of professional body	
3a	Copy of Ethical Code	
3i	Evidence of audit/scrutiny and reflection on clinical practice	

SECTION 2

Knowledge - Mandatory Requirements

Item Number	Evidence Required	Included with submission Y/N (if no please give reason)
	Knowledge Log (see page 5 of pack)	
1a	Psychopathology - Symptoms and Diagnosis	
1b	Psychopathology - Symptoms and Diagnosis	
2	Knowledge of Psychological Theories …	
3a	Physical features – nutritional principles and biology of starvation	
3b	Physical Characteristics of Eating Disorders…	
4	Social and Family Factors …	
5	Principles of Clinical Assessment	
6	Knowledge of Main Treatment Options …	
7	Knowledge of QIS/NICE guidelines …	

SECTION 3

Skills - Mandatory Requirements

Item Number	Evidence Required of knowledge on topics below	Included with submission Y/N (if no please give reason)
1g	Anonymised Example of a formulation (appropriate to your discipline)	
2b	Anonymised Example of a management plan	
3a	Communications & Documentation – documentation of clinical encounters/clinical findings and letters	

SECTION 4

Tailored Training

Please complete details of Tailored Training in the relevant section in the pack. If you have submitted any additional sheets please indicate here by ticking this box. ☐

SECTION 5

Clinical Placement & Supervision

Item Number	Evidence Required of knowledge on topics below	Included with submission Y/N (if no please give reason)
1a	Clinical Placement & Supervision – Supervisors approval letter	
1b	Supervision Log enclosed	
1c	Clinical Placement & Supervision – Supervisors reference.	
	Summary including Learning Points	
1e	Clinical Placement & Supervision – Case write up	

CONTACT DETAILS:

EEATS Administrator

c/o MCN for Eating Disorders
Bennachie Building
Royal Cornhill Hospital
Cornhill Road
ABERDEEN
AB25 2ZH

Email: nhsg.eeatsadministrator@nhs.net

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