NAME: Lisa Smith.

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QUALIFICATIONS: Diploma in Advanced Optimum Nutritional Therapy (DipAONT).

TRAINING: I originally qualified as a nutritional therapist in 2006 after training with Premier Global. This was a four-year course, part residential and part distance learning.

After establishing and developing my Nutriology practice, in 2010 I then went on to study The Functional Medicine Education Series - a two-year course via the IFM.

Around the same time, I attended a course run by PRISM Braining Mapping. This introduced me to neuroscience and not only gave me a better understanding of how behaviours can be influenced by certain hormones and neurotransmitters, but also how genetic and environmental forces can influence the brain functions that produce personality, and so an interest in genetics developed.

I then completed both the DNALife and DNAMind certification courses with Nordic Laboratories to further enhance my learning and understanding.

I am also a senior lecturer for the renowned College of Naturopathic Medicine (CNM).

"I want to not only solve the puzzle, but find out the physiological, psychological and nutritional influences and establish why the problem arose in the first place"

Tell us something about your training.
I always say that when you qualify as a Nutritional Therapist, the real learning is just beginning. I was very fortunate as shortly after qualifying I was offered the opportunity to work within the Dr Marilyn Glenville Clinics, initially in St John's Wood and later Harley Street. Being surrounded by the huge wealth of experience and knowledge Dr Glenville has at her fingertips and has access to, created an inspirational learning environment.

How long have you been in practice?
Since 2006.

Where do you practise?
Before the pandemic, 80% of my consultations were face to face, both in Kent and London, however during the pandemic I moved all of my consultations to online and have continued to consult this way ever since.

What's your main therapy/modality and why?
I am a functional nutritional therapist, although with most of my clients I tend to talk about nutrients and not about food.
Many of my clients have some form of disordered eating, often due to restriction, or binge/overeating, maybe triggered by anxiety, stress, hypersensitivity, poor interoception etc, and so initially talking about food can be very challenging for them. By talking about the nutrients and potential health gains of ensuring the brain and body are not deficient in key nutrients, I can subsequently introduce food as part of the solution, instead of it being seen as part of the problem.

Why did you decide to become a practitioner?
I always had an interest in health and nutrition, having been a keen sports person all my life and so in 2001, just after my daughter was born, I decided to take the opportunity to retrain.

Who or what has been the main influence/inspiration on your practice?
Dr Colin Wallace, then the Cognitive Behavioural Neuroscientist with PRISM Brain Mapping, had a huge influence upon my thinking and learning, helping me to question and broaden my understanding of the many influences impacting behaviour, especially around food choices.

What conditions or types of client do you see most?
The majority of my clients mainly present with eating disorders, disordered eating and/or neurodiversity, accompanied by a mix of the usual co-existing conditions such as low mood, anxiety, insomnia, GIT issues and stress.

What do you find the easiest to work with?
Physiological stress - the world we live in can be a stressful and challenging place for many. The concept of stress connects nutrition, genetics, biology, medicine and psychology, and while many think of stress as being simply anxiety, or worrying about something, at a physiological

level any physical or psychological stimuli that disrupts homeostasis will result in a stress response. It then depends upon how we react to it - which can be dictated by our nutritional status, the intensity of the stressor and how long we have been exposed to it.
Genetic and functional testing can help to identify predispositions and offer an insight into how the body is currently adapting and/or coping.

What is your favourite type of client?
Hmm…. that's a tricky question. As nutritional therapists we all like the compliant client, the one who is open to change and takes on board our recommendations - but do I favour these clients? Not really - I like a challenge, and luckily for me many of my clients present with additional challenges alongside their presenting conditions, such as autism and ADHD, or perhaps eating challenges including ARFID and poor interoception.

What is the most challenging type of symptoms/illness/problem that you get presented with?
Working with sensory issues can be problematic at times, as food provides a multimodal stimulus using five of the senses, while with poor interoception, the concept of satiety and hunger can be a real issue - if you don't ever feel sensations of hunger or fullness, how do you know how much, or when to eat?

What one thing is absolutely essential to you in your practice?
To maintain my own work/life balance. Making time to exercise, relax and looking after my own health can help to ensure I am able to be as effective a practitioner as possible, to maximise clinical and client outcomes.

Why do you do what you do?
I often hear people say they like to help people, to improve their health etc, but if I'm honest, while that is a great reward in itself, it is not a driving force for me. I want to not only solve the puzzle, but to find out the physiological, psychological, and nutritional influences and establish "why" the problem arose in the first place. (Although, at times this can take me down rather long rabbit holes!)

Which CAM book has helped or inspired you most, so far in your career?
The original book that provided me with those "lightbulb" moments was *Why Zebras Don't Get Ulcers* by the neurologist Dr Robert Sapolsky. This book considers the evolution and biology of stress and looks at why chronic stress is so harmful to us both physically and psychologically.

How has COVID impacted your practice?
COVID fundamentally changed many things for me. Since 2008 I had been working closely with Bernie Wright, a BCAP registered Psychotherapist and then clinical lead for the National Centre for Eating Disorders (NCFED), offering support to her clients, as well as being a guest speaker on her in-person training courses for mental health professionals working with clients presenting with eating disorders and disordered eating.

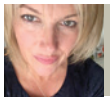
As a result of the pandemic, these courses then moved online and we found the numbers of attendees greatly increased, as did their referrals to me for their clients seeking nutritional interventions. As COVID continued, the reasons clients sought help also changed, as its impact upon fatigue, anxiety, depression, and other mental health conditions became more apparent.

How did you adapt personally and professionally to the COVID-19 climate – and have things gone back to "normal" for you?
After COVID, I continued to work online, as I found this did not restrict my clients to a particular geographical area, especially as my referrals were not limited to the UK.

If money, time, and effort were no object, what one thing would you change about your practice or integrative medicine in general?
On a personal note, I would love more hours in the day!

What piece of advice would you give to newly-qualified practitioners who are just setting up a business?
There are two pieces of advice I offer to my students.
• Just say "yes" to all opportunities that come your way. This may throw you in at the deep end at times, but opportunities are great for learning and experience, and you never know what they may lead to.
• Don't specialise in an area until you know your market, as doing so can close many other doors and restrict your potential client base.

What is the biggest challenge you face as a practitioner?
Time management. While working online does have some wonderful advantages, it also creates a heavier workload due to the email summaries that follow all consultations. I do pencil admin days into my working week, but keeping them as such is a different matter altogether!



We know our practitioners are quietly getting on with changing people's lives, every day — and we want to celebrate and share the inspiration. In Practice is coordinated by regular contributor Rebecca Smith, who runs a successful practice of her own, established 20 years ago. Contact her direct to be part of the feature: **rebecca@newportcomplementaryhealthclinic.co.uk**, and follow her on Twitter: **@NCHealthClinic**.

Case study: obesity, anxiety and binge eating

A female, aged 47, married with two children, was referred from a psychotherapist.

Her presenting concerns were

- Obesity – BMI @ >45 - weight loss the key aim
- Anxiety
- Binge eating

Additional considerations highlighted during consultation were:

- Suspected ADHD
- Idiopathic hypertension
- Insomnia
- Hypermobility
- Acid reflux
- Fatigue
- Low libido
- Severe PMS, seven days prior to menstrual bleed.

She was on several medications: Losartan (for high blood pressure), Bisoprolol (beta blocker – also for hypertension), Indapamide (diuretic), and HRT (hormone replacement therapy). Relevant previous history: Hydradentis superativa ("a long term, recurrent, and painful disease in which there is inflammation (redness, tenderness and swelling) in areas of skin containing apocrine sweat glands"). currently under control, a history of nicotine dependency (in an attempt to help to manage stress) and professional burnout at 42.

According to findings from her recent annual GP blood test, historic and current results showed TSH (thyroid stimulating hormone) at the bottom end of normal, but T4 top end – no actions taken. Blood pressure, although medicated, was slightly elevated. Previous testing all non-conclusive, included 72-hour urine collection, Renin / aldosterone ratio, CT scan and MRI. Dx of idiopathic hypertension given.

Her diet was erratic. Breakfast could be:

- Multiple bars of chocolate and bags of crisps
- McDonald's breakfast roll
- Salmon and avocado on sourdough.

Lunch:

- May miss due to hyperfocus and forget to eat
- Steak baguette and salad
- Shop-bought sandwich

Dinner:

- Bowl of vegetables with some grated cheese

Post-dinner binge 3-4 days a week:

- Combination of chocolate / crisps / salted peanuts / cakes & biscuits

Fluids:

- 3 litres of water a day
- 2-4 diet colas
- 4 caffeinated coffees

Assessment

Her son had recently been diagnosed with ADHD and the client was in the process of obtaining an assessment as she recognised many of her traits in him, including intense sugar cravings, impulsive and compulsive eating behaviours, poor concentration and focus, yet coupled with selective hyperfocus. Clients' previous history of nicotine dependence could also be seen as an ADHD trait.

As ADHD can also associated with hypermobility and an increased sensitivity to hormonal fluctuations, this was a key area for focus.

Testing

Those with ADHD usually have variations in the DRD genes, specifically DRD 2 and DRD4. This can make it difficult for neurons to respond to dopamine. The COMT gene is responsible for degrading dopamine and adrenaline (as well as oestrogen), which can lead to impulsive and compulsive eating habits.

Addictive behaviours such as binge and compulsive eating, as well risks for nicotine dependence are complex in their aetiology and are influenced by both genetic and environmental factors, and I selected the DNA Health and DNA Mind genetic tests.

Previous GP tests had focused upon hypertension and thyroid functions (basic testing) and so I requested the client get a full thyroid screen - TSH, T4, FT3, and TPO and TG antibodies (private testing), and from her GP to ask for tests for Iron, Ferritin, Folate, B12, CRP, Vitamin D and HbA1c.

Intervention

The client was going through difficult sessions with a psychotherapist to address some emotional factors and it was decided to make some small but significant changes while waiting for the test results.

- Look to reduce caffeine by buffering caffeinated coffees with a collagen and ashwagandha mix or replacing with decaffeinated.
- Reduce diet cola consumption by replacing some with alternative drinks - kombucha was suggested, as I have had previous successes with this.
- Set alarm on clock to remember to eat lunch
- Ensure adequate quality protein was eaten with each meal
- Boost vegetable/fibre intake at each meal

As supplements:

- A blended coffee, collagen and ashwagandha mix
- A targeted multi-nutrient with ingredients including methylated Bs, magnesium, iron, iodine and zinc, as well as a blend of herbs including ashwagandha, rhodiola, black pepper, l-theanine, lavender, passionflower, and chamomile.

Outcome – 4 weeks later

- Confirmed diagnosis of ADHD
- Client reported feeling less anxiety, with improved sleep and energy
- Combined with the work she was doing with the therapist, binge episodes had reduced to fewer than once a week.
- Client had reduced caffeine to two buffered coffees a day, with food
- No longer drinking any diet cola – loved kombucha
- She was now eating lunch regularly and as she was sleeping better, this had a knock-on, beneficial impact upon her breakfast choices.

Test results

Genetic tests showed:

- SNPs on
  - Heterozygous DRD2 & homozygous DRD4
  - COMT (fast)
  - Homozygous MTHFR c677t
  - Fast phase 1 and deleted phase 2 detox pathways
  - VDR & CYP2R1 (vitamin D genes)
  - Positive for 2 x HLA DQ genes relating to gluten intolerance
  - Homozygous FUT 2 (B12 absorption and transportation)

GP tests highlighted

Folate	-	2.5	("normal" = 3.1 – 20)
B12	-	196	(189 – 883)
Ferritin	-	13	(5 – 204)
Iron	-	9	(7 – 26)

All low end of normal ranges and no allowance in iron/ferritin reference range for menstruating female!

Private thyroid test – all within ranges, however TSH still at lower end of normal.

As the synthesis of dopamine and thyroxine require iron as a co-factor, this could be key in aiding some of the ADHD symptoms, as well as the fatigue and PMS. In addition, the low folate and B12 would also be adding to symptoms experienced.

Additional focus point:

- Eliminate gluten

New supplements included:

- Additional iron and methylated folate/B12 (for three months then review)
- Inclusion of a supplement to support the body's natural production of dopamine (L-tyrosine, phenylalanine, green tea and quercetin)

Outcome

A further four weeks on and the client was a much calmer, less anxious individual with much more control over her food choices. She had already achieved some small weight loss, but this she said was a bonus to how well she now felt in herself.

How did they feel about it?

Client finally felt listened to and said the combination of the psychological, physiological and nutritional support had given her some logic and reason to why she was feeling the way she had been, and also why the changes were needed. She also reported that she stopped feeling as much shame and blaming herself for her situation.

How long did it take to get this result?

This client will be on a long journey, and while initial results were seen quickly, there is often a "honeymoon period" with ADHD individuals, therefore we will have regular check-ins to help to maintain focus.

Review

This case was a good reminder to see beyond the initial presenting conditions/concerns. Had I tried to tackle the weight loss and binge eating without understanding the additional considerations of the ADHD and dopamine influences, I could have led the client down another failed weight-loss attempt; it was not a simple matter of balancing glucose levels to help with cravings, this was a combination of nutrient deficiencies, genetic and brain chemical imbalances that were driving food choices and behaviour.

References and resources

Having worked in this area for years and realising that training is very poorly represented in an ever-growing community of individuals, last year, alongside Bernie Wright (BCP registered psychotherapist and eating disorder specialist) we formed NEDDE Training.

As a company we specialise in training mental health and nutritional professionals, helping to highlight the aetiology of disordered eating/eating disorders and give an understanding of the additional considerations and complexities the neurodivergent individual face in a neurotypical world.

See www.neddtraining.co.uk for course outlines and details.

• A list of key books and references to relevant studies is online at www.ihcan-mag.com/references.

• Obesity, eating disorders, nutritional therapy, genetic testing, functional medicine and more - join Lisa on our September 9 virtual conference (see page 16 for details).

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