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Eating Disorders Institute of New Mexico

EATING DISORDERS QUARTERLY

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Spring Happenings

The Eating Disorders Institute of New Mexico will be out and about in the community this Spring. We will have exhibitor booths at:

- **Head 2 Toe Conference** at the Albuquerque Convention Center on April 20 through 22
- **New Mexico Academy of Nutrition and Dietetics** Annual Conference & Exhibition at the Hilton Santa Fe Historic Plaza on April 26
- **New Mexico Counseling Association** Spring Conference at the Albuquerque Center for Spiritual Living on June 3 and 4

If you are at any of these gatherings, please come say hello! I have communicated with many of you online over the years. It would be wonderful to put a face to the name!

In addition to exhibitor booths, I (Wolfe) will be presenting the following workshops. If you are there, come say hello!

- **Eating Disorders at School: Identification, Referral, & Support** — Rio Rancho Public Schools, District Office, Apr. 6
- **Eating Disorders: Making Schools Part of the Solution** — Head 2 Toe Conference, Apr. 21
- **The Psychology of Eating Disorders** — New Mexico Academy of Nutrition and Dietetics Conference, Apr. 26

Wishing you all a lovely Spring.

Quick Fact

13% of women over age 50 have eating disorder symptoms

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Calming the Chaos: DBT Skills Group for Adult Women

We are pleased to announce the addition of a new therapeutic group available in our clinic. Designed for adult women who struggle with emotional dysregulation and its impact, ***Calming the Chaos*** teaches self-regulation skills in a setting that promotes the practice needed to turn *learned* skills into *applied* skills.

This group is for any adult female patient whose work with you could be enhanced by this Dialectical Behavior Therapy-based (DBT) training. Although many of our eating disordered patients benefit from this work, the group is designed to meet the more general needs of women who struggle with emotional dysregulation. ED patients who participate in this group use their individual work or the Intensive Outpatient Program to focus explicitly on ED issues, and practice DBT emotional regulation skills in this group.

Calming the Chaos will be led by Beverly Garrett LPCC NCC who has extensive training in DBT and has successfully implemented this program in other states. The group sessions are 1.5 hours each and run for 12 consecutive weeks. This is a closed group so patients will need to call for the next start date.

If you would like more information about this treatment before referring your patients, please call either Dr. Wolfe (extension 101) or Beverly Garrett (extension 107).

If you are referring a patient, please have her call extension 105 to speak with Eric Meyer who takes care of scheduling and insurance.

Predictors of treatment outcomes in EDs

There is a scarcity of robust and consistent findings regarding predictors of treatment outcome among individuals with eating disorders (EDs). To address this void, Vall & Wade conducted a review and meta-analysis "to systematically examine the existing literature across all eating disorders and present a rigorous summary of the evidence for predictors of treatment outcome in individuals with an eating disorder (p. 948)."

Specifically, Vall & Wade were interested in identifying three particular predictor variables:

i. Simple predictor — a variable measured at baseline that predicts outcome at treatment conclusion or follow-up

ii. Mediator — a variable that may change over the course of treatment and thereby affect outcome (e.g., a change in depression may affect the impact of treatment)

iii. Moderator — a variable that identifies for whom and/or under what circumstances the strength of the predictor is modified (e.g., males respond more strongly to treatment X than do females)

Using search terms to capture treatment studies addressing all eating disorders, Vall & Wade identified 126 studies that met inclusion criteria. There were insufficient studies that addressed moderator variables so no results are presented here, although the authors do provide a narrative description in the article.

Simple predictors:

- Lower pre-treatment weight predicted faster weight gain during treatment (likely due to medical focus on weight restoration) and a higher rate of subsequent binge/purge behavior
- Higher pre-treatment weight predicted better overall outcomes (most of this data was from studies examining Anorexia Nervosa)
- Higher rates of pre-treatment binge/purge behavior were associated with worse outcomes
- Lower rates of pre-treatment compulsive exercise predicted better outcomes
- Lower levels of overall ED pathology at pre-treatment predicted better outcomes
- Higher motivation, less depression, and higher self-esteem was associated with better outcomes
- Older age of onset, shorter illness duration, and better interpersonal functioning at pre-treatment predicted better outcomes
- More problems in the family predicted worse outcomes

Mediators

- Patients who responded earlier in treatment had better overall outcomes
- Higher discharge weights predicted better follow-up outcomes

The authors synthesis of their findings resulted in recommendations to:

- Invest greater effort in achieving early symptom reduction
- Put in place safeguards to minimize the likelihood of early drop-out among patients with greater psychopathology (ED as well as other) at pre-treatment
- Given the variability in the 'motivation' findings, assess motivation at multiple points during treatment and focus not only on motivation but on enhancing self-efficacy.

— E Vall, TD Wade (2015). Predictors of treatment outcome in individuals with eating disorders: A systematic review and meta-analysis. Int'l J Eating Disorders, 48: 946–971.

2016 Conferences & Trainings

Apr 8 — Bariatric Surgery and the Psychologist, Kamila Cass, Ph.D. NMPA Friday Forum seminar, 1:00 PM to 4:00 PM Albuquerque. RSVP required.

Apr 13 — When Allergies and Eating Disorders Collide: Using a Case Study Approach to Explore Special Diets. Renfrew Foundation Webinar, 12:00 pm to 1:00 pm EST.

June 8 — But it's Just a Glass of Wine! — A Closer Look at the Intersection of Alcohol Use and Eating Disorders. Renfrew Foundation Webinar, 12:00 pm to 1:00 pm EST.

Clinical Psychology or Pop Psychology—What's the Difference?

Clinical Psychology as it is practiced in the United States is largely based on a scientist-practitioner model. In a nutshell, this means that psychologists are trained in the science of psychology as well as its application. Theoretically, the result is that the interventions we adopt are based on empirical design and evaluation. Theoretically.

The reality is that science-based interventions take tremendous resources (time, money, patience) to develop and evaluate, while nonsense can be dreamt up over a glass of wine. Much of what makes it into the media is nonsense, or what we call Pop Psychology .

The recipe for Pop Psychology is fairly straight-forward. You take one part psychological science, one part dream-fulfillment, and mix it up with a generous dose of marketing.

Differentiating Clinical from Pop Psychology can sometimes be tricky because the Pop pieces that make headlines typically include enough science-talk to lull our nonsense radar. However, if you keep in mind the following guidelines when you assess new therapeutic offerings, you will be less likely to find yourself on a bandwagon that goes nowhere.

Pop Feature	Reality
Quick dramatic results	If it sounds too good to be true, it is not true. Developing the problem took time — often a lifetime of learning and practice. If it resolves in a flash, either the condition or its resolution are faked.
Quick & easy to learn	Consider for a moment the complexity that is the human mind. Reflect on the multiple biological and environmental forces that shape your response to even a simple stressor. Now ask yourself whether 'quick & easy' makes sense. While the steps of a procedure may be simple to learn, applying them to your patients could never be a no-brainer.
No complicated research results to understand	Conducting studies that control for all the factors that are likely to produce erroneous results is complicated. Making sense of the data from these complex designs is complicated. If the new program offers only 'clinical evidence' (e.g., these doctors like it, that patient got better), you have the equivalence of 'my neighbor added garlic to her eggs and got pregnant.' Nice to hear but useless as a treatment for infertility. Ask to see the research — and if need be, ask for help understanding it.
Famous spokesperson	Think back to your classes on Media Literacy. Marketers lull us into believing their product is terrific by linking it to someone we admire. Ask yourself whether this spokesperson has training in psychology or knows how to make sense of complex research findings? Or does s/he just like the money? Then change the channel or pick up a different magazine.
Requires minimal effort by patients	Psychotherapy is about changing how an individual makes the decisions that determine how s/he lives life. In the world of science fiction, we can dramatically alter people's thought patterns. In the real world, we can at best guide them in rethinking their thinking. For therapy to happen, the patient must do the lion's share of the work. Anything less is placebo.

Afternoon & Evening Intensive Outpatient Programs

Our IOPs provide intensive psychotherapy for eating disorders that do not respond to standard outpatient care. Built upon evidence-based practices and delivered in a warm, client-centered style, our IOP is waiting to help your most challenging patients. New patients are welcomed when they are ready to start, treatment plans are always individualized, and we work closely with you to ensure our work complements yours as seamlessly as possible.

Program Features

Mondays, Tuesdays, and Thursdays
Private check-ins and individualization of therapeutic focus
Shared therapeutic meal
Group sessions address eating-related anxiety, challenge the distorted over-evaluation of shape and weight, promote mood regulation, improve ability to identify nutritional misinformation, counter cultural pressures to attain thinness, and much more. For the afternoon groups, age-appropriate emphasis is placed on developmental tasks and the negotiation of patients' emerging young-adult roles in the family.
Cognitive-behavioral therapy complemented by DBT and ACT skills training
Biweekly care-coordination reports sent to patient's treatment team with additional team consultations as needed

Notices

In keeping with the intent of this newsletter to connect our local clinical community with the world of eating disorders, we have dedicated this space to alert you to local opportunities for research, employment, and miscellaneous other things related to obesity and eating disorders. To use this free forum email: EDQnews@gmail.com

Edition	Deadline	Edition	Deadline
April 1st	March 15	July 1st	June 15
October 1st	September 15	January 1st	December 15

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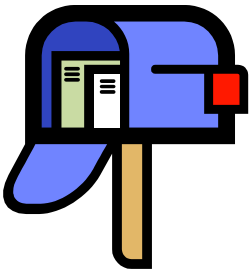

Criteria for Hospitalization

Treatment ambivalence is a mainstay of eating disorders (EDs). Hence, it is the rare patient who requests a higher level of care; and we always try to help patients towards recovery without having to leave home. However, EDs have the potential to kill and there are times that inpatient ED treatment is the only safe way to go.

For patients who have severely restricted their intake or lost a considerable amount of weight, the immediate risk associated with treatment is that of Refeeding Syndrome (RS) — a metabolic response to food intake that results in low serum phosphorous and potential death. Risk for RS means refeeding should be conducted on a specialized inpatient unit. The National Institute for Clinical Excellence defines elevated risk of RS as shown in the box to the right.

RS RISK IF:	One or more	Two or more
BMI	< 16	< 18.5
Weight loss over 3-6 mo	> 15%	> 10%
Minimal food intake	> 10 days	> 5 days
Other	Low potassium, phosphorus, or magnesium	Substance abuse, including insulin, laxatives, or diuretics

In addition to RS risk, hospitalization for medical stabilization and monitoring is recommended when the following (below) criteria occur.

Anorexia Nervosa	Bulimia Nervosa
• Weight < 70% expected IBW • Cont'd weight loss despite intensive outpatient tx • Unstable vital signs: pulse < 40, temp < 35^{C}, SBP < 80mmHg • Arrhythmias • Suicidality	• Potassium < 2.4 mmol/L • Bicarbonate > 38 mmol/L • Excessive edema, history of edema with cessation of purging behaviors, severe constipation despite laxatives

Complications of Food Restriction	Complications of Purging
Bradycardia	Hypokalemia (low potassium)
Hypothermia	Hyponatremia (low sodium)
Hypotension	Severe edema after purging cessation
Hypoglycemia	Severe constipation or atonic (floppy) colon
Hepatitis of starvation	Gastroesophageal reflux disease
Bone marrow suppression	Sialadenosis
Gastroparesis	Dental decay and infections
Constipation	Volume depletion & risk of syncope
Fall risk	Cardiac arrhythmias
Osteoporosis	Seizure
Dysphagia & risk for aspiration pneumonia	