July 2016
Volume 7, Issue 3

To receive notice of EDQ publications, email EDQnews@gmail.com

Join us on Facebook

Eating Disorders Institute of New Mexico

# EATING DISORDERS QUARTERLY

www.EatingDisordersNM.com
505-884-5700

## EDINM is Hiring!

**Licensed Psychotherapists Wanted**

If you have strong CBT clinical skills and want to expand your expertise to eating disorders and obesity, read on!

We are a small, evidence-based clinic with the most interesting caseload in the state. (You may think this is over-sell — but experiencing will be believing!)

*Seeking:*

Mental health therapists independently licensed in New Mexico (LPCC, LISW, PHD) to work with adolescent and adult patients with eating disorders, and mood and anxiety disorders.

- Minimum of two years post-licensure clinical experience providing Cognitive Behavioral Therapy
- Candidate must be open to training in the treatment of eating disorders/obesity
- Retirement plan available after one year of employment
- Hours are flexible
- Part-time to full-time depending on caseload and your preferences

*Resumes must include:*

- Licensure type and NM state license number
- Completion dates of all education/training
- Start/end dates of work history

*Cover letter must:*

- Highlight relevant experience

*Submit cover letter & resume to:*
Brenda Wolfe via fax (505--884-5701) or email (blwolfe@swcp.com)

**Quick Fact**

**25% of college-aged women engage in binge-eating and purging**

**CONTENTS**



## How to help a friend with eating and body image issues

Starting the conversation about eating and body issues with a friend you are worried about is tricky. On the one hand you desperately want to interrupt disordered behavior that is harming your friend. On the other hand you risk having him or her become defensive and pull away from you, thereby killing any chance you have of helping.

While there are no guarantees, there are better and worse ways of approaching your friend. The better way is:

*Prepare* — Familiarize yourself with signs of eating disorders (EDs) and understand that no one chooses to have an ED. If your friend is engaging in ED behavior, s/he is suffering considerably more than any distress you feel witnessing the illness.
— For the conversation, have on hand printed information about EDs and where help can be found.

*Speak* — Privately, honestly, and kindly tell the person your concerns, what you've seen and what you fear. Tell your friend that what s/he is experiencing is not uncommon and that help is available. Remind your friend that s/he has people who care about her/him; s/he is not alone.

*Listen* — Allow your friend time to express him/herself. Be prepared for the possibility of anger or denial, keeping in mind that even if your friend says hurtful things to you, that reaction is about what s/he is feeling and not really about you. Stay calm.

*Respond* — If at the end of this conversation you remain concerned that your friend has an ED, summarize your concerns in light of what s/he has told you and again offer your help.

# Online Program for Preventing Eating Disorders

Excessive weight and shape concerns have consistently been empirically associated with the onset of eating disorders (EDs). Additionally, critical comments by significant others (e.g., coach, sibling) and depression further increase the risk.

Taylor et al enhanced the existing, validated StudentBodies™ online intervention for ED prevention to address both weight/shape concerns *and* the additional risk factors of critical comments and depression. The online program consisted of 10 sessions released over 10 weeks along with 24/7 access to a moderated discussion board.

Participants were 206 high-risk for EDs, college-aged (18 to 25) females randomized to either the treatment or waiting list (WL) condition, and followed for two years. The researchers hypothesized that two years after treatment, the treatment group would have a lower rate of ED onset and lower scores on ED risk and depression measures than would the WL.

Despite finding that treatment participants had a greater reduction in risk factor scores than WL participants at the two-year mark, Taylor et al did not find a statistically significant lower rate of ED onset (24% for treatment, 31% for WL). However, when they examined outcomes for those participants who began the study with the highest risk scores, those receiving treatment did indeed have significantly lower ED onset rates (20%) than those in the WL (42%).

Among the potential avenues for improving the impact of the program, Taylor et al discuss the need for determining how to elicit better program adherence; not all participants engaged in all the sessions assigned. That said, there is good news in this study as it did have an impact on those at highest risk for the onset of ED and at the low price of $26.00 per participant.

— CB Taylor, AE Kass, et al (2016). Reducing eating disorder onset in a very high risk sample with significant comorbid depression: A randomized controlled trial. J Consulting & Clinical Psychology, 84(5), 402–414.

# 2016 Conferences & Trainings

Jul 8 — Exposure & response prevention in ED treatment: using in vivo and imagine techniques to cultivate safety in the midst of fear. IAEDP Webinar, NH Kim PHD & Larroyas RD

Aug 11 — What is ARFID and how do we get rid of it: RED FEET therapy proposal. IAEDP Webinar, Mary Sanders PHD

Aug 12–13 — Eating Recovery Center Foundation Annual Conference, Denver, CO.

Sept 14 — Rituals for renewal: Treating Jewish patients with eating disorders, Renfrew Center, West Nyack, NY.

# Mortality in Eating Disorders

Over the years, several studies have reported mortality rates for eating disorders, particularly Anorexia Nervosa (AN), to be among the highest of all mental disorders. However, few studies have had large enough sample sizes to examine the various ED diagnoses separately as well as look at predictors of mortality in EDs.

Maximilian et al examined death rates of 5,839 patients who had been hospitalized for severe ED in a German specialty hospital between 1985 and 2005. They examined mortality rates of patients with AN, Bulimia Nervosa (BN), Binge Eating Disorder (BED), and ED Not otherwise specified (EDNOS).

Overall mortality rate was 3.9% with the greatest number of deaths occurring for patients with AN. Mortality rates for AN were five times higher than those in the general population matched for age and sex. BN rates were 1.5 times that in the matched general population. The rate of death among patients with BED was not statistically significantly different from the general population. EDNOS rates were higher than for BN but lower than AN.

Most causes of premature death in AN were related to low body weight (circulatory collapse, organ failure, cachexia). Of the six non-natural cases of AN deaths, four were the result of suicide. All non-natural causes of death among BN and BED patients were due to suicide.

— M Maximilian, MD Fichter, N Quadflieg (2016). Mortality in eating disorders — Results of a large prospective clinical longitudinal study. Intl J Eating Disorders, 49:4, 391–401.

# When OCD clouds the ED diagnosis

It is commonly known that Eating Disorders (EDs) travel with anxiety disorders. In fact, Anorexia Nervosa and Bulimia Nervosa look much like food/weight phobias, as patients frantically scramble to avoid food intake and weight gain. Moreover, the behaviors exhibited in EDs are often hard to distinguish from Obsessive-compulsive Disorder (OCD) as patients obsessively track their food intake and calorie expenditure, and obey a host of 'rules' about how, what, when, where to eat and/or exercise.

Estimates of EDs among OCD patients range from 10%–17% (e.g., Sallet at al, 2010; Kaye et al 2004), with11%–69% of ED patients estimated to meet criteria for OCD. Also documented is an elevated risk of Anorexia Nervosa among those with OCD (Meier et al,2015).

Our clinical experience has been that when ED patients present with concurrent OCD, the prognosis suffers. In part this is due to the increased severity of the comorbid presentation, but also in part due to sometimes missing the OCD diagnosis. The difficulty lies in how very much like OCD the 'rules' of Anorexia appear. ED 'rules' typically focus on the patient's core ED concerns (food, exercise, body). And, expecting OCD-type thoughts and behaviors in our ED patients, our default interpretation is that the symptoms are ED and our assessment sometimes ends prematurely.

**Suzie's Anorexia Rules**

I cannot eat it if I didn't prepare it
At supermarket, stay at least 3 feet away from the breads
Never touch food with hands
Only eat at designated times
Must eat exactly 6 grapes
Always drink 12 oz water before eating

In the box to the right, a small subset of Suzie's more than 50 Anorexia rules. She presented with Anorexia, motivation for recovery, a good support system, and should have responded more quickly than she did. What became evident was that our assessment had fallen short. Further questioning revealed the following:

| | |
|---|---|
| What other things can you not do or touch if someone else prepares/handles them? What is the risk if you do? | Door handles, plates, chairs — get infected by germs and if food-related, absorb calories and get fat |
| What happens if you get close to the breads? Touch food with your hands? | Lose control and touch/binge-eat/do dangerous things … absorb calories, get infected |
| What other activities need to happen at specific times? | Water plants at 10:30 AM every Saturday, fill my gas tank between noon and 1:00 PM, walk my dog at exactly 7:00 AM and 7:00 PM |
| What other areas of life require you to do a specific number of things? Count? | Brush teeth exactly 100 strokes, proof-read my emails 5 times before sending, check my door lock 4 times, … |

With this additional information, we see the presence of OCD beyond that expected within an ED and the treatment plan accordingly broadened to address both the cognitive distortions and behaviors driven by the ED, as well as the non-ED avoidance behavior of OCD. With the broadened perspective, Suzie's response to treatment improved.

*References*

Sallet et al. Eating disorders in patients with obsessive-compulsive disorder: Prevalence and clinical correlates, IJED, 43(4), 315–325 (May 2010)
Meier et al . Diagnosed Anxiety Disorders and the Risk of Subsequent Anorexia Nervosa: A Danish Population Register Study, IJED, 23(6), 524–530, (Nov 2015)
Kaye et al. Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *Am J Psychiatry,* 2004; 161 2215-2221.

# 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 |

To automatically receive an email notice when each new edition of the EDQ is available, email your request to:

EDQnews@gmail. com