

October 2015  
Volume 6, Issue 4

Eating Disorders Institute  
of New Mexico

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## EATING DISORDERS QUARTERLY

[www.EatingDisordersNM.com](http://www.EatingDisordersNM.com)

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### As the year rolls to a close ...

There is nothing like writing a quarterly newsletter to emphasize how quickly a year rolls by — and what a year it's been! We have been gifted with participating in the lives of many wonderful people. Working with our patients and their loved ones enriches our lives as much as we hope our clinical skills enrich theirs.

This has been a growth year for our clinic. Once again I have the pleasure of introducing new clinicians.

Beverly Garrett MS LPCC NCC joined us in September. In addition to her work with eating disorders, she brings particular expertise in Dialectical Behavior Therapy (DBT).

In July, Amber N. Vigil RD CDE joined our team. Her

dietetic expertise and gentle interpersonal style makes the difficult task of changing food choices a little easier for our anxious patients.

In the last EDO we invited you to spread the word about two important studies. The ANGI study, which is making important contributions to our understanding of the genetic underpinnings of eating disorders, is still looking for participants so their flyer is included again (p 7).

This EDO edition includes a new study seeking participants. The scientists are examining 'gut biome' (i.e., the bacteria living in the gastrointestinal tract) of people with eating disorders. This study links with the work of the ANGI group.

If you haven't already shared the attached flyers with your patients, please do so today. Even when they do not kill, eating disorders rob their victims of quality of life. The better we are at detecting and understanding them, the lower the risk that someone you love will be hurt.

The New Mexico Psychological Association is seeking a new Executive Director (our "old" one is retiring — she will be missed!). You can view the posting by clicking [here](#).

Finally, we are participating in the Albuquerque Journal Fall Wellness Fair at Cottonwood Mall on Saturday, October 24th. We'll be there all day so come say hello!



**Quick Fact**  
**Approximately**  
**25% to 35%**  
**of people with**  
**Bulimia Nervosa**  
**attempt suicide**  
**over the course of**  
**their lives.**

(Franko & Keel 2006)

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### Do what works — Evidence-based treatment for Eating Disorders

Eating disorders (EDs) are not the most common of mental disorders, but they are the most deadly. Hence, they are not disorders for which it is acceptable to "try" treatment modalities because they "sound" good. If the modality does not have sound science behind it, those of us who have watched good people die would argue that its utilization is unethical.

There is a solid body of evidence supporting the use of Cognitive-Behavior Therapy (CBT) for eating disorders. While not perfect, CBT outcomes are approximately double that seen with other modalities. Moreover, with no means of predicting which patients

will and will not respond to CBT, beginning with CBT is the only reasonable strategy. If the patient does not respond to correctly delivered CBT, then it certainly makes sense to consider other modalities.

CBT is one of those things that is easy to explain; everybody 'gets it' as we talk about challenging maladaptive beliefs and shaping behavior. It lends itself to self-help books and worksheets — and as a result, many clinicians believe they are 'doing CBT' when they hand out worksheets and ask patients to keep a journal. Those are components of CBT but they are not CBT. (cont'd p 4)

## Impact of Anorexia Nervosa & Bulimia Nervosa on cognitive function

It is a consistent clinical observation that Anorexia Nervosa (AN) is marked by impaired cognitive function. Those in the grips of AN have a tendency to perseverate on details, be easily distracted, process information awkwardly, and generally appear “foggy.”



Neuropsychological studies with AN have indeed found deficits in central coherence and aspects of executive (frontal brain) functioning. In the current study, Weider et al examined the neuropsychological profiles of patients with AN or Bulimia Nervosa (BN)

compared with Healthy Controls (HC).

Excluding those with confirmed brain damage, neurological disease, neuropsychiatric disorders (e.g., ADHD), Tourette's, autism spectrum, and chronic fatigue, Weider et al enrolled 79 patients from an inpatient treatment unit — 40 with AN and 39 with BN. (None began study participation before they were adequately re-nourished.) A group of 40 HC subjects matched for age, sex, and education were also recruited. Participation entailed completion of a comprehensive battery of widely-used, standardized tests covering a broad spectrum of cognitive function.

As expected, the AN group scored significantly lower across the battery than the BN group, which scored lower than the HC subjects. Both ED groups scored significantly below the HC group on verbal learning and memory, visual learning and memory, visuospatial ability, working memory, executive function, and motor functioning. AN subjects scored lower than BN on visuospatial ability and executive functioning. Finally, AN patients scored below HC in speed of information processing and verbal fluency.

Interestingly, while current Body Mass Index (BMI) did not mediate performance for either AN or BN, lowest lifetime BMI did predict impairment.

— S Weider, MS Indredavik, S Lydersen, K Hestad (2015). Neuropsychological function in patients with Anorexia Nervosa or Bulimia Nervosa. *Int J Eating Disorders*, 48: 397–405.

## 2015 Conferences & Trainings

Institute for Contemporary Psychotherapy & Center for the Study of Anorexia and Bulimia [2015 Webinar series](#).

Oct 14 — Countertransference & the ED client: Making it work. Heather Russo. [Renfrew Center Foundation webinar](#).

Nov 12 — [Transdiagnostic CBT for EDs: A overview and update](#). Christopher G. Fairburn, ABCT conference, Chicago, IL.

Dec 9 — Comida y Cultura: Cultural differences when working with Hispanic eating disorder patients and their family. Yaneth Beltran & Carolina Gaviria. [Renfrew Center Foundation webinar](#).

## Bulimia Nervosa increases suicide risk in Borderline Personality Disorder

Self-harm and suicidality is a risk among patients with Bulimia Nervosa (BN) and with Borderline Personality Disorder (BPD). Given that BN and BPD often co-occur, it is important to determine whether co-occurrence increases the risk of suicide beyond that of the individual diagnoses.

Reas et al assessed 483 adult women entering long-term treatment for BPD. Using a standardized battery, Reas et al identified 57 (11.8%) who also met criteria for BN. The total sample was divided into two groups — those with BPD and BN (BPD-BN) and those with BPD and a non-BN comorbidity (BPD-O).

Approximately 50% of all patients had engaged in self-harm over the 12 months preceding the assessment, and the somewhat higher rate of lifetime self-harm among BPD-BN than BPD-O (70.9% v 58.2%) was not statistically significant.

Self-harm and suicide attempts during treatment were both significantly higher for BPD-BN than for BPD-O. Over one-third (39.3%) of BPD-BN self-harmed during treatment, in comparison with 15.7% of BPD-O. Actual suicide attempts during treatment occurred among 10.9% of patient with BN versus 4.1% patients with BPD without BN.

Reas et al concluded that “the presence of a comorbid diagnosis of BN in the context of BPD is significantly and uniquely associated with increased risk of recent suicidal ideation at intake and self-harm and suicide attempts during treatment after controlling for mood, anxiety, and substance-related disorders.

— DL Reas, G Pedersen, S Karterud, Ro (2015). Self-harm and suicidal behavior in borderline personality disorder with and without bulimia nervosa. *J Consulting & Clinical Psychology*, 83: 643-648.

### Eating Disorders Institute of New Mexico <sup>SM</sup>



#### IOP is designed for patients who ....

- Have been unable to reduce disordered eating or exercising with standard outpatient treatment
- Need more structure and support for eating than is available in their natural environment
- Are not actively abusing drugs or alcohol and are not acting out on suicidal ideation
- Are medically stable with BMI no lower than 16 for adults, 80% of expected for teens

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## Eating Disorder Myths Debunked

1. **Eating disorders are the problem of young, rich, white women.**
  - Wrong! EDs are equal opportunity killers. Neither age, color, gender, nor income guarantees protection. Although historically EDs did tend to predominate among Anglo females, the last several decades have seen dramatic increases in prevalence among ethnic minorities and men. It is no longer safe to assume that because a patient is not white and/or female, there is no need to screen for an ED.
2. **You can tell whether someone has an eating disorder by his/her appearance.**
  - Wrong again. Most people with EDs blend right in (visually) with the rest of us. Where the disorder shows is in their thoughts and behaviors, and in their medical problems.
3. **Eating disorders reflect poor will-power; making the decision to quit is all it takes to recover.**
  - How wonderful if this were true! The fact is that EDs are driven by the interaction of genetics and environment so even when the person is willing and motivated to make healthy choices, there remain significant hurdles to overcome. Recovery is built on a multi-faceted attack on the disorder. Motivation, social support, education, psychotherapy, nutrition therapy, medical management — all play a part in recovery.
4. **Eating disorders are about the person trying to control his or her life.**
  - This is a popular myth. While true in some cases, for most sufferers the explanation is not so simplistic. ED behaviors are a complex result of maladaptive coping skills, inadequate interpersonal skills, obsessive thinking style, neuropsychological impairment (see Research Corner), genetic vulnerability, and an environment that facilitates the use of disordered eating to express psychological pain.
5. **Eating Disorders are caused by poor parenting or dysfunctional families.**
  - As explained above, it takes genetics and environment to create an ED. If lousy parents and/or nutty families caused EDs, the prevalence of these disorders would be considerably higher than they are. We would also never see ED cases come from loving, high-functioning homes — but we do.
6. **Recovery is impossible.**
  - Wrong, wrong, and wrong! Recovery may not be simple or easy but it is possible. Early detection and active intervention saves lives.



EDQ

## Morning, 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 (Adult groups early morning and evening; Adolescent/young adult group late afternoon)

Private check-ins as well as 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

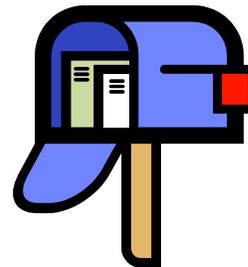


## Notices

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: [EDOnews@gmail.com](mailto:EDOnews@gmail.com)

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

[EDOnews@gmail.com](mailto:EDOnews@gmail.com)



<u>Edition</u>	<u>Deadline</u>	<u>Edition</u>	<u>Deadline</u>
April 1st	March 15	July 1st	June 15
October 1st	September 15	January 1st	December 15

### *What Works – continued from Page 1*

Effectively implementing CBT with EDs begins with understanding the psychopathology of eating disorders. Regardless of idiosyncratic etiology, if the individual develops an ED, psychological pain expresses itself by distorting his/her experience of body. The resulting psychopathology rests on two cognitive errors. First is the over-valuation of the importance of body shape/size/appearance – what the individual looks like is believed key to how well his/her life can unfold. The other error is the disproportionate power believed to be inherent in every bite of food – where the non-ED person understands the rough correspondence between amount of food ingested over time and body-size, the ED individual believes that his/her body will dramatically enlarge regardless of the amount of food taken. As a result, the patient develops a host of physical and mental behaviors designed to control body-size/appearance and manage the anxiety associated with perceived threats to that control.

CBT properly implemented for EDs incorporates five core components:

- Weighing patients** – Although this might reasonably be subsumed under Exposure and Monitoring, because weight is a marker for behavior and physical status, it is essential the therapist weigh the patient weekly (more frequently if concerns about malnutrition and accuracy of self-report are present). Whether or not the patient should be made aware of his/her weight is subject to some debate with the default being ‘yes’ unless there are extenuating circumstances that contraindicate this. Discussing weight with the patient also allows therapist and patient to identify problematic cognitions that might otherwise go undetected and undermine therapeutic progress.
- Exposure** – Keeping in mind the ED patient’s over-valuation of body size/appearance and the catastrophic predictions associated with (even minimal) food intake, it is helpful for the clinician to think of the ED case as analogous to a phobia or obsessive-compulsive disorder. ED fears and behaviors are best addressed with similar exposure and response-prevention protocols. Weighing the patient despite associated anxiety, eating “fear foods,” looking in the mirror if body avoidant, enduring the anxiety of not vomiting after a binge, etc. are integral components of the therapeutic process.
- Monitoring** – Effective CBT is built on good data and good data analysis. Hence, monitoring by both therapist and patient are non-negotiables in the therapeutic process. Therapist and patient together monitor weight, and patient keeps food and thought diaries which the therapist reviews with the patient and utilizes to correct cognitive errors. Monitoring also often serves an exposure function as it forces patients to acknowledge experiences to which their ED symptoms had heretofore numbed them.
- Behavioral experiments** –Catastrophic predictions driven by the cognitive distortions of ED paralyze the patient with anxiety. Identifying the fearful predictions associated with doing or refraining from a behavior and then testing those predictions allows the patient to learn for him/herself that the ED symptoms are not necessary.
- Cognitive restructuring** – The heart of treatment is helping the patient to correct the erroneous beliefs that appearance is the deciding factor in how the world values him/her and that the impact of food on his/her body does not follow the same rules of nature as for other people. As the patient learns to monitor his/her behavior, tolerate and attenuate anxiety, and test faulty predictions, it becomes easier to correct those broken cognitions.

### Recommended Reading

- Fairburn, C.G. (2008). *Cognitive behavior therapy and eating disorders*. New York NY: Guilford.
- Gowers, S. G., & Green, L. (2009). *Eating disorders: Cognitive behaviour therapy with children and younger people*. London, UK: Routledge.
- Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., & Russell, K. (2007). *Cognitive-behavioral therapy for the eating disorders: A comprehensive treatment guide*. Cambridge, UK: Cambridge University Press.
- Waller, G., & Mountford, V. (2015). Weighing patients within cognitive-behavioral therapy for eating disorders: How, when and why. *Behaviour Research and Therapy*, 70:1-10.



## FREE UBIOME GUT KIT FOR EATING DISORDERS

uBiome is teaming up with Dr. Cynthia M. Bulik of the University of North Carolina (UNC) Center of Excellence for Eating Disorders to learn more about whether eating disorders could be linked to changes in gut bacteria.

**If you currently have or have ever had anorexia, bulimia, or binge eating disorder:**

- ① Sign up to learn more and help research move faster.
- ② **Participation in the study is free.**
- ③ All participants will get a detailed report on their own microbiome as well as learning how they compare to other study participants.

Sign up now at:

<http://ubiome.com/pages/eds>

### HOW IT WORKS

1

#### Sample

We'll send you a home sampling kit that takes less than 2 minutes to use (and is not gross). It's super easy!

2

#### Sequence

Our lab uses cutting-edge next generation DNA sequencing technology to identify your bacteria.

3

#### Citizen Science

UNC and uBiome will share findings about the microbiome and eating disorders, to help research go faster.

### AM I ELIGIBLE?

You are eligible to participate if:

- ① You currently have, or at any time in the past have had an eating disorder.
- ② You are 18 years of age or older.
- ③ You don't have or haven't had cancer, HIV, or other diagnosed gut diseases.



### WHAT HAPPENS NEXT?

After ordering, we'll send your kit straight to you. Collect your sample with a quick swab, and mail it back to us in the prepaid envelope. We will keep you posted on the results!

**Thank you (and your bacteria) so much for being part of this study.**

### FEATURED IN

TechCrunch

WALL STREET JOURNAL

Forbes

MIT Technology Review

npr

SCIENTIFIC AMERICAN

WIRED

CNN

TEDMED

FASTCOMPANY

The New York Times

# ANGI

The logo graphic for ANGI features a stylized DNA double helix in green and white, positioned over a dark blue square. To the right of the DNA helix is a light blue square.

## Anorexia Nervosa Genetics Initiative

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An Initiative of the Klarman Family Foundation

The Anorexia Nervosa Genetics Initiative (ANGI) is the largest and most rigorous genetic investigation of eating disorders ever conducted. Researchers in the United States, Sweden, Australia, and Denmark will collect clinical information and blood samples from over 8,000 individuals with anorexia nervosa and individuals without an eating disorder.

ANGI represents a global effort to detect genetic variation that contributes to this potentially life-threatening illness. The goal of the research study is to transform our knowledge about the causes of eating disorders to work toward greater understanding and ultimately a cure.

If you have suffered from anorexia nervosa at any point in your life, you can help us achieve this goal. Your contribution would include a brief 30-minute interview and a blood sample. If you have never had anorexia nervosa, but still want to contribute, we invite your participation as well.

Only with your participation can we achieve our goal of eliminating this devastating illness.

Participants receive a \$25 Amazon gift certificate.

**To see if ANGI would be a good fit for you, please complete the survey found [here](#).**

**Or, scan the code below:**



**If you are seeing this notice on a paper flyer, the website is:**

**[https://unc.az1.qualtrics.com/jfe/form/SV\\_b7KDMDd8SuM1oNv](https://unc.az1.qualtrics.com/jfe/form/SV_b7KDMDd8SuM1oNv)**