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Eating Disorders Institute of New Mexico

EATING DISORDERS QUARTERLY

www.EatingDisordersNM.com
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Introducing our newest clinicians

Although not quite at our target staffing level (still hiring — page 4), we are finally to a point that the wait for services is shorter than ever. So, without further ado, allow me to introduce:

Vanessa A Irizarry, MA, LPCC has many years of experience counseling adolescents and adults struggling with a variety of challenges. In addition to her work with eating disorders, she has expertise in the treatment of substance and alcohol abuse, anger management, grief and bereavement, and spiritual issues. Originally from New York, then Florida, and having moved to New Mexico eight years ago, Ms. Irizarry has fallen in love with our people and landscape. For fun, she enjoys a variety of hobbies which include sewing, gardening, hiking, cooking, baking, furniture remodeling, and drawing.

Marita Campos-Melady, PhD. is a Clinical Psychologist specializing in Eating Disorders, substance abuse, trauma, and health psychology. She divides her time between Presbyterian Medical Services and our clinic, and serves as part-time faculty in the Dept. of Psychology at UNM. She is dedicated to empowering patients to use evidence-based techniques to improve their lives. A native New Mexican, Dr. Melady enjoys exploring our beautiful state as well as the rest of the U.S. Her explorations typically involved hiking, and writing short stories about her travels in the Southwest.

A Good Question — What's the best goal weight?

Setting goal weights, whether for weight restoration or loss, is tricky. Despite the ubiquity of BMI charts and calculators, the fact of the matter is that our bodies are complex. You are correct in assuming that body weight is determined by the balance between caloric intake and output. However, each body's efficiency in utilization of calories is unique — influenced by genetics, environment, and lifestyle. Thus, when we approach target weight setting armed with BMI tables, nutrition labels, and calories-per-exercise charts, we approach the task with incomplete information.

For patients with Anorexia Nervosa, the minimum "healthy" BMI of 18.5 is insufficient. They will most likely need to restore to a BMI well into the 20s in order to stay off the precipice of maintaining weight just a few pounds away from the slippery slope of relapse. You will also find as they increase food intake to begin weight restoration, they often lose weight (contrary to what those charts and tables predict). The greater intake increases metabolic rate, and so they burn the additional calories more quickly than predicted by generic equations.

The charts are also of limited value when setting targets for weight reduction. Although a "normal" BMI is certainly desirable, the fact is that not all bodies, psyches, and lifestyles are able to achieve it. Hence, it is best to encourage these patients to focus on behavior management with the understanding that weight follows behavior, albeit never in a lock-step fashion.

ED IOP

ACCEPTING

ADULT & ADOLESCENT PATIENTS

See website for details.

CONTENTS

Enhance your understanding of Anorexia Nervosa. In just 18 minutes and 48 seconds, Dr. Laura Hill of the Center for Balanced Living in Ohio explains the brain (dys)function and prognosis for this disorder. She also does an extraordinary job of relating the subjective experience of those afflicted with this disease. Click here for Dr. Hill's TEDx talk.

The myth of comfort food

Wagner et al conducted a controlled study to evaluate the impact of "comfort food" on mood. Over a series of four studies, they induced negative mood (via video compilations) in 237 participants and assessed the relative impact on mood of providing participants with their favorite comfort foods, equally liked neutral food, or with no food at all.

In three of the studies, Wagner et al first induced the negative mood and then provided participants with one of the three food options (comfort, neutral, no food). Expecting both food conditions to improve mood more than the non-food conditions, and the comfort foods to have the greatest positive impact, the researchers were surprised. They found that not only was comfort food not more effective at improving mood than an equally liked neutral food, neither food condition had any greater impact on mood than the no-food condition.

In the fourth study, Wagner et al compared a no-food group with two conditions in which participants were given chocolate before the negative mood induction, one group being allowed to eat before the film and the other having to wait until afterward. They found that receiving food prior to the negative mood induction reduced the impact of the film compared to the non-food condition, and eating the chocolate had a stronger protective effect than receiving but not eating it. The food, however, did not cause the (attenuated) negative moods to resolve any more quickly than in the non-food condition.

A particular strength of these studies was Wagner et al's attention to participants' food preferences and expectations with respect to the impact of the comfort foods. Despite everyone's certainty that their chosen comfort foods would make them feel better, the data clearly argues that this is not true. The scientists conclude, " Beyond showing that intuition about comfort food is misguided, ... empirical evidence clinicians need to inform patients that comfort foods will not make them feel better."

— HS Wagner, B Ahlstrom, JP Redden, Z Vickers, T Mann. (2014). The myth of comfort food, Health Psychology, 33: 1552–1557.

2015 Conferences & Trainings

International Association of Eating Disorder Professionals Symposium 2015 March 19–22, Phoenix, AZ

Academy of Eating Disorders International Conference on Eating Disorders, April 23–25, Boston, MA

Institute for Contemporary Psychotherapy & Center for the Study of anorexia and Bulimia have posted their 2015 Webinar series.

ACUTE of Denver offers periodic, free, webinars for professionals who work with eating disorders. For their Winter/Spring schedule, contact Rachel Harriman.

(Lack of) Effect of alprazolam on eating behavior in anorexia nervosa

Individuals with anorexia nervosa (AN) experience food-related anxiety with pre-meal anxiety being associated with lower calorie intake. Steinglass et al assessed the impact of a short-acting benzodiazepine (anti-anxiety drug) administered before meals on patients' food intake.

Twenty inpatients with AN participated in a randomized, double-blind, placebo-controlled, cross-over study in which their food consumption was measured as a function of whether they received the anxiety medication or a placebo. All participants received 0.75mg of alprazolam at one test meal and a placebo packaged to look exactly like the alprazolam at a test meal on another day. Order of the medication versus placebo was counter-balanced.

The researches expected to see less anxiety and greater caloric intake at meals during which patients had received the active medication. They confirmed that the medication was actively working by finding appropriately increased sedation on medication days. However, the patients neither reported lowered anxiety levels, nor ate more relative to days they were given a placebo.

Steinglass et al concluded that despite the physiological impact of the medication, it appears that the entrenched food-related anxiety (and OCD-like rules) does not respond to benzodiazepines. Treatments that target the cognitive distortions behind the food anxiety remain our best option.

— JE Steinglass, SC Kaplan, Y Liu, Y Wang, BT Walsh (2014_. The (lack of) effect of alprazolam on eating behavior in anorexia nervosa: A preliminary report. Int'l J of Eating Disorders, 47: 901–904.

Whistle a Happy Tune — Sources of Self-efficacy

When Anna was asked by her young son how to manage their fear enroute from England to Siam where she was to become teacher to the king's children, she responded, "Whenever I feel afraid, I whistle a happy tune ... and the happiness in the tune convinces me that I'm not afraid" (The King and I, 1956). Anna's point was that her actions make her feel competent and as a result she is able to do that which at first flush seems not achievable.

As therapists, we know that until the patient believes s/he can do something, s/he is unlikely to make more than a half-hearted attempt, if that. Enhancing self-efficacy, the belief that one is *able*, is key to harnessing motivation to skills and turning it into action. Hence, it is helpful to consider from whence self-efficacy stems. Bandura outlines four primary sources of self-efficacy (Self-efficacy: The Exercise of Control. NY: Freeman, 1977) .

Mastery experience — Often considered the strongest source of self-efficacy, mastery is that sense of competence that comes from the experience of having successfully accomplished a task. As clinicians, we can foster mastery experience by carefully structuring treatment goals into "baby steps" that maximize the likelihood the patient will able to complete the assignment. For our more self-deprecating patients, however, it is important to also monitor the self-talk around these experiences to ensure they are attributing outcomes to their mastery rather than to the simplicity of the task or to our support.

Vicarious experience — Observing others execute a task can be instructive and consequently enhance self-efficacy with respect to the task. However, there is considerable variability in the direction and degree to which patients respond to social modeling. A positive impact on self-efficacy is more likely if the "model" shares important characteristics with the patient (i.e., the patient "relates"). A caveat is in order though — sometimes seeing a peer succeed at a task with which one struggles, reinforces that belief that one is inept. It is important to know your patient well and carefully monitor his/her responses if you are orchestrating social modeling of any nature.

Verbal persuasion — Attempting to convince someone of his/her competence offers a mixed-bag of outcomes. Depending on your persuasive skills, your patient's cognitive biases, and the task at hand, your efforts may as likely result in decreased as increased self-efficacy. Breaking verbal persuasion down into persuasion by others and self-persuasion (i.e., self-talk) offers a more promising outlook. Combining mastery experiences with positive self-talk is most likely to increase self-efficacy.

Physiological & affective states — The impact of physiological and affective states on self-efficacy is mediated by the individual's interpretation of those states. For instance, being in a good mood and having energy, when interpreted as evidence one is motivated and strong, contributes to self-efficacy. Conversely, interpreting positive affect as a potential distractor from focusing on a task may decrease self-efficacy. Similarly, interpreting sadness and fatigue as evidence that one is powerless will impair self-efficacy whereas self-efficacy may be enhanced if one interprets that same feeling as evidence that one is done with feeling bad and ready to make a change.

While bolstering patients' self-efficacy is helpful in treatment, it is clear that whatever steps we take must always be within the context of carefully monitoring patients' attributions for their outcomes. Reframing events and cognitive restructuring remain key to developing an enhanced sense of self and bolstering self-efficacy. And, as Anna so rightly pointed out, experiencing oneself whistling a happy tune can indeed convince oneself that one is not afraid to step out of the familiar comfort zone and make a change for the better.

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: EDQnews@gmail.com

Edition	Deadline	Edition	Deadline
April 2014	March 15	July 2014	June 15
October 2014	September 15	January 2015	December 15

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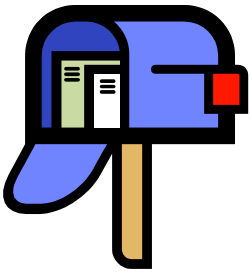

Criteria for Hospitalization

Treatment ambivalence is a mainstay of our population. 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	> 15%	> 10%
Minimal	> 10 days	> 5 days
Other	Low potassium, phosphorus, or magnesium	Substance abuse, incl. insulin, laxatives, or diuretics

In addition to RS risk, hospitalization for medical stabilization and monitoring is recommended as follows:

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

Help Wanted

Clinical Psychologist — The position will begin part-time and develop into full-time work. Requirements:

- Licensed in New Mexico and CBT experienced/adept
- Preferential consideration will be given to applicants who are credentialed with Presbyterian/Magellan, BCBS, and Optum/UH.
- Experience with eating disorders and obesity preferred but if you are interested and find journals and text-books a turn-on, we can train you.

Administrative Assistant — Beginning at 10 hrs/week and increasing as the individual's skillset increases and s/he is able to take on more of the day-to-day office management. Requirements:

- Excellent computer and Microsoft Office skills
- Excellent telephone skills
- Customer service experience

Please send resume and cover letter to blwolfe@swcp.com or fax to 505-884-5701.