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Eating Disorders Institute of New Mexico

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EATING DISORDERS QUARTERLY

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Happy New Year!

I hope 2016 is off to a good start for you. Here at EDINM we are looking forward to another satisfying year — working with patients, their families, and our wonderful colleagues. So we begin the year by thanking you for your work with us in 2015. Here's to a terrific 2016!



As continuing education coordinator the NM Psychological Association, I have the

pleasure of inviting excellent speakers to present at our Friday seminars. Although not ED-related, some of the upcoming talks may be of interest to you. Each one carries four CE units. Click [here](#) to go the website for more information as well as other continuing education opportunities.

3/4/16 — *Psychologists Role in Disability Determinations*, Cathy Simutus, PhD.

3/8/16 — *Sleep Disorders* — Two speakers:

(1) *Insomnia and Sleep Apnea: The Strangest of Bedfellows*, Barry Krakow, MD.

(2) *Overview of Cognitive Behavioral Therapy for Insomnia: Research Findings and Clinical Application*, Aaron Joyce, Ph.D.

4/8/16 — *Bariatric Surgery and the Psychologist*, Kamila Cass, Ph.D.



Quick Fact

Between 10% and 40% of people with Type 2 Diabetes have an eating disorder

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Motivation Reality Check

In our work with patients and their families, we run up against two commonly-held misperceptions: (1) motivation is something one “gets” and once gotten, it sticks, and (2) motivation is a singular thing (e.g., motivation to recover).

In fact, motivation is a fluctuating willingness to act and the factors that affect it include everything from tangible events to subtle nuances such as weather, hormones, sleep quality, etc. Hence, it is unrealistic to expect motivation to remain constant over time and across circumstances. Failing to appreciate the fluidity of motivation sets patients up for the same problem associated with other dichotomous thinking which is concluding one has relapsed when motivation flags, and consequently giving up (which does lead to relapse). Appreciating the fluidity of the feeling, on the other hand, helps one experience fluctuations without drawing catastrophic conclusions about them. Accepting the fact that

at this moment or in this circumstance one is feeling less motivated, while remembering that at an earlier moment or in another circumstance one felt charged to keep working makes it easier to allow the moment to pass without acting on it.

The second common misperception about motivation, especially when talking about big abstractions like “recovery,” is that motivation is for the whole thing – Recovery. What people forget is that “recovery” emerges from multiple behaviors that come together to produce the life envisioned when one says, “I want recovery.” Thus, it is important for patients to recognize the many life domains that are affected by their eating disorder and that stand to benefit from behavioral change. The more detailed their articulation of the impact of the disorder and the benefits of change, the more likely they will be able to reframe triggering situations into opportunities to assert her/his recovery desires.

Risk of Type 2 Diabetes Elevated with Binge Eating

Roughly 10–40% of individuals with Type 2 Diabetes (T2D) meet criteria for an eating disorders, most commonly binge eating disorder. There is also evidence that binge eating is an independent risk factor for T2D. Raevuori et al undertook a large-scale study to examine the prevalence, incidence, and risk of T2D among patients treated for eating disorders between 1995 and 2010.

Raevuori et al identified all patients treated at the Eating Disorders Unit at Helsinki University Central Hospital during the 15-year time frame of the study. For each of the 2,342 patients identified, the scientists included four controls (n = 9,368) matched for age, sex, and place of residence.

Of the patient group, 54% met criteria for Bulimia Nervosa (BN), 39% for Anorexia Nervosa (AN), and 7% for Binge Eating Disorder (BED).

No relationship between T2D and AN was found. However, BN and BED, both characterized by binge eating behavior, conferred greater risk for T2D.

Prior to entering treatment, patients had a substantially higher risk of T2D than did controls (BED 15.2% v 2.2%; BN 1.5% v .3%). Over the lifetime of the study, patients continued to have considerably higher rates of T2D than their matched controls (5.2% v 1.7%).

The scientists also found a significant difference for males and females in that male patients had an overall higher incidence and prevalence of T2D across the 15 years of the study. The higher risk of T2D for men is consistent with general epidemiological data.

Raevuori et al conclude by reminding providers who treat patients with eating disorders to keep in mind the impact of binge eating on glucose metabolism.

— A Raevuori, J Soukas, J Haukka, M Gissler, M Linna, M Grainger, J Suvisaari (2015). Highly increased risk of Type 2 diabetes in patients with Binge Eating Disorder and Bulimia Nervosa. *Int'l J Eating Disorders*, 48: 555–562.

2016 Conferences & Trainings

Feb 18-21: Annual Conference, [International Assn of Eating Disorders Professionals](#), Amelia Island, FL

Feb 26: Choosing the Path of Acceptance: The Power of Emotional Awareness in Eating Disorder Recovery, Jancey Wickstrom AM LCSW, [Renfrew](#), Chicago, IL

Feb 27–28, Family Based Treatment for Adolescents with Anorexia Nervosa, Kara Firzpatrick PHD & James Lock MD, [Training Institute for Child & Adolescent Eating Disorders](#), Palo Alto, CA

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.

Impact of Stigmatization of People with Eating Disorders

In a multi-national survey, Griffiths et al examined the stigmatization reported by people with eating disorders (EDs). In particular, they were interested in the nature of stigmatization experienced, its impact on individuals' well-being, and whether stigma differs among ED subtypes or between genders.

Study participants included 317 individuals with ED diagnoses. Of the 317, 52.1% had Anorexia Nervosa (AN), 27.1% had ED Not Otherwise Specified (EDNOS), and .8% reported Bulimia Nervosa (BN). Only 13 of the 317 were male. Sample age ranged from 14 to 54 years.

Participants reported two stigmatizing beliefs to be most common and particularly damaging to their well-being: "I should be able to just pull myself together," and "I am personally responsible for my condition."

When reported stigmatization was broken down by diagnostic category, participants with BN were more frequently stigmatized as "having no self control" than were those with AN or EDNOS. Consistent with past research, there appears to be a particularly negative perception of BN.

Male participants reported more frequent criticism for being "less of a man" because of their disorder than females reported being "less of a woman." With the small male sample, however, this result is at best tentative.

Given the difficulty people have admitting an ED and seeking treatment, public education to minimize stigmatization is clearly important. Based on these findings, focus on the fact that EDs are mental disorders and not lifestyle choices is a good place to start.

— S Griffiths, JM Mond, SB Murray, S Touyz (2015). The Prevalence and adverse associations of stigmatization in people with eating disorders. *Int'l J Eating Disorders*, 48: 767–774.

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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 or under close medical supervision

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Effective Weight Management

For those who are obese, losing weight is a healthy goal. However, alongside the dangers of excess weight is the reality that diets seldom result in lasting weight reduction. Decades of research has taught us that working with the determinants of weight is the most effective way to achieve the healthier lifestyle that results in lasting weight management.

Determinants of Weight

Three reciprocally-operating forces determine weight: biology, psychology, and environment. This complexity means one-dimensional treatments (e.g., diet, psychotherapy) cannot affect weight over the long run. Managing weight requires a strategy that concurrently addresses all three forces.

Biologically, we have an inherited potential size range. Additionally, humans are best-suited for our ancestral environment where the food supply was often unpredictable. Hence, we evolved to be thrifty with our energy expenditure. When food was plentiful, we stored energy for times of scarcity and, while seeking food we ignored hunger signals to remain focused on the hunt. We are also wired to ignore fullness if good-tasting food is present. (If food is hard to come by, it makes sense to eat as much as you can when it is available!) Until the last century, this worked pretty well.

Today, it is the rare American who exerts much energy to get food — our environment has changed. For most, hunting and gathering means driving and ordering. In addition, much of today's food contains more calories than it did 100 years ago. Thus, our ability to store energy and eat past fullness now means we store more energy than we need to fuel our daily physical activity.

Entwined with the biological and environmental influences is that powerful force that sets us apart from the rest of the animal kingdom — our psychology. Influenced by biology and environment, and influencing both of them, our mind attaches meaning and expectations to food and eating. Food is not only essential to our survival, but is an essential part of our social and emotional life. Attempting to limit food often means placing limits on our life.

Weight Management

Most programs and products fail to address the full complexity of weight. Like a three-legged stool with a missing leg, failing to concurrently focus on all three forces results in collapse. Lasting weight management requires attention to the individual's biological givens, his or her psychological status, and the environment in which she or he functions.

Biological strategies begin with acceptance of the potential weight range dictated by inheritance. The individual who comes from a long line of large people will be unable to sustain a very small physique for any length of time. Setting biologically realistic goals from the outset is the first essential step. From there, efforts to shape diet and exercise are more easily sustainable.

Environmental management was the primary target of the first generation behavioral weight loss programs. Based on the data from learning studies, stimulus control strategies such as modifying exposure to eating cues are effective in minimizing our natural tendency to eat reflexively, rather than intentionally.

Psychological aspects of food and exercise are the most difficult to address as they tend to be most idiosyncratic. The complex meanings attached to what, how much, where, when, and with whom we eat and move must be harnessed to support the individual's efforts to modify biology and environment. Integrating the psychological profile with biological and environmental changes provides a firm foundation on which to build a healthier lifestyle.



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

Support and education for families



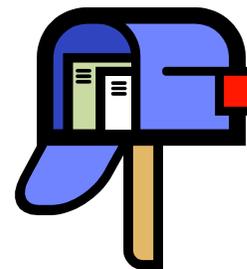
Notices

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

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

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



The Role of Childhood Feeding Practices in Adult Obesity

Or why it is a really bad idea to put children on diets

Emily J. Wolfe, MA – Department of Anthropology, Ohio State University

The study of obesity from an anthropological perspective focuses on population-wide forces, seeking to understand how human traits emerge and disappear over time. In studying obesity, anthropologists consider human evolutionary history, as well as current cross-cultural variation. They seek to understand why obesity is so prevalent in modern affluent societies and how our susceptibility to it may have been shaped by our long history as hunter-gatherers, as well as why there is a variation in obesity prevalence within different societies, social classes, and ethnic groups.

One of the earliest anthropological theories explaining human obesity, the “thrifty genotype” theory, was proposed in the 60s and is still in favor today. The thrifty genotype hypothesizes that during humans’ long history as hunter-gatherers, our bodies adapted to that feast-or-famine lifestyle by increasing fat retention during times of feast. In doing so, our ancestors were able to survive famines and thus we are still here. As a result of this positive adaptation, however, our current genetic makeup is such that when we experience insufficient energy intake, our bodies are genetically primed to increase fat retention to ensure survival. This trait paradoxically increases the morbidity and mortality risks associated with obesity by making us more likely to gain weight in the long-term when we try to lose weight by dieting.

Anthropological studies in different areas of the world have identified infant and childhood undernourishment as an independent risk factor of adult obesity. For instance, women who were exposed to the 1959-1961 China Famine as infants experienced a higher average body weight and were more likely to be obese than their counterparts who were not exposed to the famine as infants. Similarly, Guatemalan children who had experienced malnutrition prior to the age of three years had significantly greater adult abdominal fat than their adequately-nourished counterparts. In addition, malnourishment in Brazilian children was an independent risk factor for adult overweight and a higher waist-to-hip ratio; Brazilian children who were not malnourished had lower rates of obesity. Across continents and across decades, there is ample evidence to suggest that childhood malnourishment creates a vulnerability to adult obesity.

Western ‘dieting’ practices mimic famines. To battle obesity, we calculate how many calories are required to support our bodies in their daily routines and we eat less than what is required. In essence, we create a biological famine. There are few chronic dieters who can report that following each diet they did not regain more weight than they lost — they are the successful surviving progeny of their hunter-gatherer ancestors. Malnourishment triggers both fat retention and over-eating once food is again available.

Well-intentioned parents concerned their plump children may become obese adults limit the children's caloric intake and paradoxically increase the likelihood that those children will grow up with a pronounced biological vulnerability to obesity. In addition to the genetic priming of fat retention observed in malnourished children, making food (quantity or type) off-limits increases its desirability. As a result, genetically vulnerable adults who are finally free of parental dietary control are especially prone to obesity.

Anthropologists are not necessarily parenting experts. Our branch of science provides a big-picture glimpse of human development and, in the case of obesity, that picture makes a strong argument against childhood dieting. As for adult dieting, we do not have anthropological data supporting the obesogenic impact of dieting. However, ask any dieter about his or her repeat dieting weight trajectory and a similar picture to that we have for childhood malnutrition will likely emerge.



Food! Yum!