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Eating Disorders Institute of New Mexico

EATING DISORDERS QUARTERLY

www.EatingDisordersNM.com
505-884-5700

EDINM is Still 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

Between 23 and 32% of children in developed countries are over-weight or obese

CONTENTS

Lessons from the Grave

Most patients we work with recover and go on to live their lives. A few, though, do not. Over the years we have learned hard lessons from those we lost. For therapists new to the eating disorder (ED) field, it is often difficult to reconcile the idiosyncratic challenges of this field with the broader ethical and theoretical guidelines of our generalist training.

Perhaps the greatest divide between treating EDs and most other outpatient psychological problems is the question of patient autonomy. With the exception of suicidal or homicidal intent, we are trained to honor the individual's right to self-determination. The therapeutic relationship is central to treatment, we are taught, and its preservation a priority. True. However, when the patient is engaging in disordered eating that is wreaking havoc on his/her body — including the organ with which we do therapy, the brain — autonomy becomes an obstacle to saving the person's life.

In these cases, the therapist must make the decision to support establishment of a medical guardianship that compels feeding, and risk the therapeutic relationship. On those occasions that all of our clinical finesse cannot make a dent in the power exerted by the ED, the only ethical thing to do is wrest control away from the patient/ED and feed.

With ED, food is medicine. A malnourished brain cannot benefit from therapy and a malnourished body cannot heal. Whether that malnourishment comes from food restriction or purging or exercising, the bottom line is that the body cannibalizes itself, breaking down fat and muscle to fuel survival. Allowing this to go on too long results in a painful death.

Cont'd page 4 — Lessons

Primary care settings effectively promote pediatric weight management

There is ample evidence that behavioral lifestyle interventions result in positive outcomes for pediatric overweight and obesity as long parents adhere to the program. Part of the reason for high attrition rates is that most of these programs are conducted in academic settings or specialty clinics that are not optimally accessible to busy parents.

The pediatric primary care provider's (PCP) office is a relatively common landscape feature for most families with children. Hence, delivering lifestyle intervention in the PCP setting may make extended adherence easier for parents and result in stronger health outcomes.

To assess the impact of providing this intervention in a primary care setting, Mitchell et al conducted a meta-analysis of studies comparing primary care based pediatric weight programs with control conditions.

The researchers identified 18 studies that reported weight change among 3,358 otherwise healthy children ages 2–18 years whose pre-treatment BMI was above the 85th percentile. The included studies covered two or more of the four core healthy lifestyle components (i.e., diet, physical activity, sedentary lifestyle, disordered eating). None of the studies involved weight-relevant medication.

Of the 18 studies, one resulted in a weight gain. The remaining 17 studies all reported small but statistically significant decreases in participant weight compared to control groups.

Mitchell et al also found that the number of treatment contracts, number of treatment months, and number of visits with the pediatrician were associated with greater degrees of weight loss.

Mitchell et al conclude, "... primary care continues to be a suitable setting for pediatric overweight/obesity weight management interventions."

— TB Mitchell, CM Amaro, RG Steele (2016). Pediatric weight management interventions in primary care settings: A meta-analysis. Health Psychology, 35:7, 704–713.

2016 Conferences & Trainings

Oct 14 — Christian-based treatment of eating disorders: Reconciling self, life, and God. Renfrew Center, Dallas TX

Oct 26 — The Uniqueness of pregnancy for women of size & BED. Renfrew Center, Webinar.

Nov 11–13 — Feminist relational perspectives and beyond: Eating Disorders across the lifespan and in diverse populations. The 26th Annual Renfrew Center Foundation Conference for Professionals, Philadelphia PA

Dec 7 — The good, the bad, and the neutral: Navigating Nutrition with Eating Disordered Clients. Renfrew Center, Webinar.

Dec 9 — Complex treatment for the complex eating disorder client: Integrating ACT and experiential strategies. Renfrew Center, San Diego CA

Autonomous motivation predicts bigger treatment effects

Patients who voluntarily engage in treatment are autonomously, or internally, motivated. Those who are in treatment due to external forces are said to be there due to 'controlled motivation.' There is evidence in the clinical literature that autonomous motivation predicts better outcomes for a variety of problems (e.g., alcohol abuse, depression) but this construct has not been examined with an inpatient population suffering with Anorexia Nervosa.

Hypothesizing that "autonomous motivation would be a positive significant predictor of changes in eating and comorbid symptoms, while controlled motivation would be negatively related to changes in such symptoms," Thaler et al examined the motivation and treatment outcomes of inpatients with Anorexia Nervosa.

Eighty patients completed pre- and post-treatment assessments of eating disorder severity, depression and anxiety, and autonomous and controlled motivation. All participants completed a minimum of five weeks of inpatient treatment consisting of cognitive-behavioral therapy, specialist clinical support, and psychoeducation protocol.

Thaler et al found that higher levels of pre-treatment autonomous control predicted greater reductions in global eating disorder symptoms.

— L Thaler, M Israel, JM Antunes, S Sarin, DC Zuroff, H Steiger (2016). An examination of the role of autonomous versus controlled motivation in predicting inpatient treatment outcomes for Anorexia Nervosa. Intl J Eating Disorders, 49:6, 626–629.

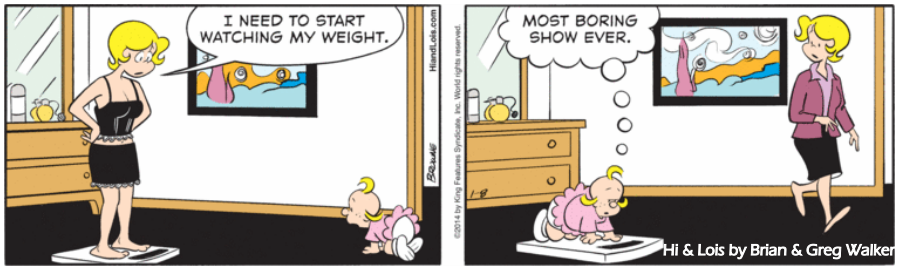
Help Children Develop Positive Body Image

Body image is one of the most interesting phenomena studied in labs and grappled with in clinics. It is the 'sense' of one's body — always present but rarely stable, emanating from the physical but not entirely physically-derived. Body image is a blending of the *picture* one holds of one's body (e.g., size, shape, coloring, etc.), and its *value* (e.g., attractiveness, abilities, importance, etc.). It is shaped by the interplay of our physical selves and our experiences. While most of us have a relatively stable sense of what our body is like, even the most psychologically sound individuals can have their body image bolstered or bashed by environmental events. For instance, short amounts of time spent looking at images of perfectly beautiful (i.e., photo-shopped) women can make well-adjusted women feel bad about their appearance. Negative comments from others about our appearance can shift us from confident to body image distressed.

For most of us, body image sometimes affects our confidence or mood or behavior — but it rarely pushes us to actions that seriously impair our functioning or risk our lives. For people with eating disorders (EDs), body image becomes the core of their psychopathology, taking on a central role in determining whether or not they feel worthy of love and being easily affected by mood or external events. As a result, these individuals go to pathological extremes (e.g., starvation, self-induced vomiting, exercise abuse, etc.) to try to control what their bodies look like — all the while being unable to perceive their physical appearance because their body images (i.e., perceptions) are so distorted.

Body image distress lies at the core of disordered eating and is an identified critical risk factor for the development of eating disorders. While science cannot yet tell us how to prevent EDs, we do know some of the things parents and providers can do to promote development of a healthy body image.

Parents



- Appreciate your own body. When you express dissatisfaction with your own body, you are teaching your children two things. One is that appearance is important, and the other is that the child's body is also in need of improving. Children identify with their parents. If you don't love your body, the message is that your child's body also needs improvement.
- Compliment children for who they are more often than for what they look like. Exclaim with joy over your children's' abilities, talents, and behaviors. This doesn't mean we should never compliment a child's appearance, simply that appearance should be the least frequent aspect of the child we get excited about.
- When you admire other people's appearance, do so without putting down your own looks. Model comfort with the fact that beauty comes in many flavors.

Cont'd on page 4 — Body Image

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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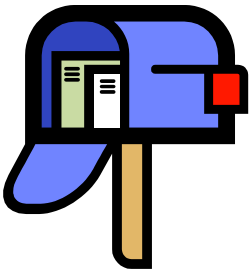

Body Image — Cont'd from page 3

- Speak up when you see media images and messages that promote unrealistic beauty ideals. Point out the power of photo-shop and the true motive of even the most tenderly-expressed advertisement. That motive is to make you feel bad about yourself by lying about what is possible and in so doing to take your money.
- Listen. When children make negative comments about their bodies, or start diet or exercise programs, ask about their lives. Listen carefully for what may be happening with friends, or their reactions to household dynamics. Often the body focus is a misdirected attempt to deal with, or avoid dealing with, bigger problems. Help your child identify what is really going on by listening well. Moreover, keep in mind that you often can guide children better by asking questions and listening than by directing.

Providers

- Be alert for dramatic changes in a child's growth and weight curves. If changes occur, ask the child whether s/he has changed anything about his/her food or exercise and, if so, why?
- Never encourage children or adolescents to diet. Dieting is a common precursor to disordered eating. If you are concerned about a patient's weight, encourage the family to eat together without the television (or other screen technology), talk about a "healthy intake" being one that includes a broad variety of foods and never makes anything off-limits.
- Be very clear with parents that three meals and, depending on idiosyncratic needs, a few snacks each day are healthy and promote long-term weight stability.
- Emphasize the importance of moderate exercise. Among student athletes, it is especially important to ensure that coaches' enthusiasm for 'practice and more practice' doesn't in the youngster's mind become 'more is always better and resting is lazy.'
- When working with student athletes, inquire about their food intake and listen carefully for over-emphasis on either caloric control or avoiding/emphasizing entire food groups. The toxic nonsense that becomes ingrained in the locker room easily results in seriously disordered eating.
- When talking to patients about their food, exercise, and/or body image concerns, always ask whether they ever "do anything to undo" it when they think they've overeaten. If they say they do (e.g., vomit, use laxatives or other drugs, over-exercise), take it seriously and make a mental health referral.

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Lessons — Cont'd from page 1

Once the legal piece is in place to compel feeding, our training again kicks in and we eagerly look for signs the patient is regaining rational thought so that autonomy can be returned as quickly as possible. Laudable and wrong.

Despite cries of 'treatment fatigue' and logical arguments against forced therapy, there is no 'too long' of maintaining restored weight. The powerful cognitive/perceptual distortions of ED take much longer to modify than does body weight. As long as the court can be persuaded, keeping the patient eating keeps his/her brain functioning and ultimately able to benefit from treatment. How long that takes is as long as it takes for the patient to stop caring that s/he is being required to eat.

There comes a point in starvation that the gastro-intestinal system simply stops and physical recovery is no longer possible. We do not know for any given individual where that point occurs. We only know that it is there, waiting, and life trumps autonomy.

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