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Eating Disorders Institute of New Mexico

EATING DISORDERS QUARTERLY

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Quick Fact

40% of Americans either have had or know someone who has had an eating disorder.

In this issue ...

You will notice a change to our *Research Corner*. Over the years, readers have asked me to comment on the studies we summarize. I have resisted doing so for fear that my biases (and intellectual shortcomings) would distort the content. However, the request has come frequently enough that I have added a brief "EDQ Note" to each summary. I would love to hear whether this is useful, or whether I have simply annoyed you.

Our clinic has grown as big as we would like at this point which means two things have changed. One is that we are no longer hiring clinicians. The other is that we have an empty office for rent. The description is on page 4. If you or any clinicians you know are looking for office space, please send them our way.

Elsewhere in this issue, you will find articles on the 'look' of people with ED (see below) and the etiological strands of obesity (page 4).

Happy Spring!
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What do people with EDs look like?

If daytime television is to be believed, people with eating disorders (EDs) are either skeletally thin or circus-side-show obese; and they are almost all white females, especially the skinny ones. That is probably the most common stereotype, however, it is not the only one. So, what are the visible differences between people that might help us know for which patients we need to be on alert for EDs?

Can we rely on size? — The smallest percentage of people with EDs are extremely thin or extremely obese. People with EDs cannot be identified by appearance alone. Even folk who are extremely thin do not necessarily have an ED—poverty, illness, ideological extremism, any number of things might result in emaciation. Extreme obesity also has multiple causes and does not necessarily signal an ED.

Is gender a red flag? — Although generally more prevalent among females, 25% of Anorexia and Bulimia cases are male as are more than a third of Binge Eating Disorder cases. Moreover, several studies have suggested that EDs have a higher mortality risk for males. Not missing this diagnoses is pretty important to the estimated 10 million American men who struggle with EDs.

How about sexual orientation or gender identity? — Historically, we believed that EDs were the exclusive domain of straight women and, to a lesser degree, gay men. However, science has trumped belief. Over recent decades, the freeing of LGBT individuals to 'come out' has allowed scientists to better study this population. What we now know is that EDs occur among gay and straight males, straight and lesbian women, bisexual people, and transgendered people. In other words, one's sexuality does not flag one's likelihood of having an ED, nor does it protect one from this deadly disorder.

Can race or ethnicity clue us in to an ED? — No. Growing up in places other than the Northern/Western hemisphere no longer means you are unlikely to have an ED. Those of us who study and treat these disorders have job security regardless of where on the planet we work. Whether in small-town Asia, New York City, urban Italy, or rural Argentina, we find people who struggle with body image and disordered eating. In the US, studies have documented concerning rates of EDs among African-Americans, Asian-Americans, Hispanics, Native Americans, and Euro-Americans.

How about profession? — Professions that emphasize body appearance or function are risk factors for EDs (e.g., dance, wrestling,

EDs Look — cont'd page 4

Three-year follow-up of eating behavior and experience in bariatric surgery patients

Bariatric surgery has grown in popularity over the past several decades (> 250,000 procedures/yr in US), and it is well-documented that the persistence of uncontrolled eating after surgery is a negative predictor for weight loss. Also known is that there are high rates of eating pathology among bariatric surgery patients. Yet, the association of eating pathology other than binge-eating has not been extensively studied.

Devlin et al followed 183 bariatric surgery patients for three years post-surgery to examine the relationship of eating pathology and eating experience with weight loss. They studied patterns of objective and subject binge frequency, loss of control eating, overeating, grazing, inappropriate compensatory behaviors (e.g., self-induced vomiting). They also examined eating experience (i.e., hunger, cravings, and food enjoyment).

The scientists found that overall rates of pathological eating dramatically reduced after surgery. However, reductions were not evenly distributed across behaviors and did not occur for all experiences.

Significant reductions occurred for objective binge episodes, but loss of control eating, although reduced, remained a problem for many. There was no discernable change in rate of subjective binge eating. With respect to hunger and enjoyment of food, both decreased after surgery.

Post-surgery variables that predicted poor weight outcomes were high preoccupation with dieting and weight/shape (i.e., ED thinking), hunger, and ≥ monthly loss of control eating.

EDO Note: Although not the main focus of this study, it is interesting to note that ED-thinking has the power to even interfere with the impact of physically rearranging one's digestive system. Cognitive restructuring is imperative.

— MJ Devlin, WC King, MA Kalarchian, GE White, MD Marcus, L Garcia, SZ Yanovski, JE Mitchell (2016). Eating pathology and experience and weight loss in a prospective study of bariatric surgery patients: 3-year follow-up. Int'l J of Eating Disorders, 49(12):1058–1067

2017 Conferences & Trainings

Apr 5 — Deception of the Screen: Adolescents, Eating Disorders, & Social Media. Renfrew Center Foundation. Webinar. Presenter: Hannah Beaver LCSW

May 7 — Treatment with Clients of Size: Exploring Weight, Body Image and Counter-Transference Issues, Webinar. Presenter: Paula Gayfield LPCS, CEDS

On demand webinar — Psychotherapy for adults and adolescents with eating disorders, RiverMend Health Institute.

On demand webinar — Dangerous dieting, RiverMend Health Institute.

Weight discrimination a key factor in obesity-linked depression

Studies have shown that obesity is often linked to depression, and that the more obese an individual is, the more likely s/he is to suffer from depression. Robinson, Sutin, and Daly undertook a large-scale, three-cohort prospective project to identify the mechanism that drives that weight-obesity link. Specifically, they examined weight status, perceived weight-based discrimination, and depression among 20,286 adults from the United Kingdom (n = 15,908) and the United States (n = 4,378).

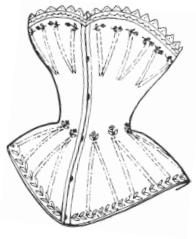
All three studies from which Robinson et al drew their data spanned several years, and included face-to-face data-collection. The samples were comprised of people across the weight spectrum, including obese. This allowed the scientists to assess the impact of weight-based discrimination on subsequent development of depression among people not overweight, overweight, and at various levels of obesity.

Robinson et al found that individuals who suffered with Class II and Class III obesity were more likely than their thinner counterparts to experience weight-based discrimination and were also more likely to experience increases in depression over time. Overall, perceived weight-discrimination explained over 31% of the total effect of obesity on depression. In simpler words, roughly 1/3 of the cause of obesity among these people was attributable to weight-based discrimination.

EDO Note: As clinicians, we may moderate the depressive power of discrimination by asking patients about their experiences, expressing our indignation at it, and coaching patients in reframing discrimination as the reflection of others' ignorance rather than the reflection of the patient's worth.

— E Robinson, A Sutin, M Daly (2017). Perceived weight discrimination mediates the prospective relation between obesity and depressive symptoms in US and UK Adults. Health Psychology, 36:2, 112–121.

Unraveling the Obesity Braid



The past century has seen a cornucopia of weight loss products to tempt the overweight consumer. In 1912 we bought the *Improved Reducing Corset* to compress our waistline and extract our juices. Since then, we have binged on a vast assortment of diets and pills promising to shrink our bodies—but ultimately shrinking only our wallets. Billions of dollars lighter, we are now physically at our heaviest. Why? Why are we fatter than ever when we have an infinite variety of low-calorie foods and "scientifically designed" weight loss plans? The answer is simple. We consume more energy (food) than we spend. What determines how much we eat is the Obesity Braid.

In spite of commercial claims to the contrary, overeating is not the result of one particular problem. There is no single gene or metabolite, neither one allergy nor psychological state that causes us to become fat. Rather, there are three broad categories of circumstance that intertwine to determine body size. There is our physical reality, our psychological life, and the world in which we live. These forces twist together like a braid to influence what, when, why, where, and how much we eat.

The Physical Strand

Each of us is born with a genetic link to our parents and ancestors across the millennia. They bequeathed us the perfect design needed to thrive as hunter-gatherers, working hard for an unpredictable, often nutritiously insufficient food supply. The ancestors who survived to pass down their genes were the ones who took full advantage of food when it was available. One might say they were the founders of the Clean Plate Club—never sure when their next meal might be, they ate as much as they could of whatever was available. Doing so ensured they had enough fuel on board to keep them alive until they found their next meal. Today, we call this pattern "binge eating" and it is no longer adaptive because food is no longer scarce. Hence, keeping our weight healthy in today's world requires that we behave somewhat contrary to design. We must turn away from tantalizing tastes and smells when we have eaten amounts we "know" to be sufficient, even though our brain seems hard-wired to "want" more as long as it is available.

Our physical hard-wiring not only pushes us to eat whenever food is available, it also triggers us to eat in response to stress. Our ancestral environment included two important classes of stressor: we were either being attacked, in which case we fought or fled, or there was a food shortage, in which case food-seeking was adaptive. This aspect of the physical strand of obesity gets particularly tangled up with the psychological strand.

The Psychological Strand

The psychological strand of the Braid encompasses everything experience has taught us—from early lessons that delicious flavors soothe skinned knees and hurt feelings, to current stressors and pressures that drive us to seek comfort. Each time we take solace in a delicious mouthful, we are responding to our physical (mind/body) hard-wiring and reinforcing the mental connection between pain-relief and food. Over a lifetime of learning , reaching for food when we experience discomfort becomes automatic. We often find ourselves eating without having made the conscious decision to do so.

The Environmental Strand

How much we ultimately eat is influenced, last but not least, by our environment. Our forefathers who walked long distances to find naturally-occurring food ate without concern about calorie intake. However, we live in a time and place during which food is more

Braid—cont'd page 4

Evening Intensive Outpatient Program

Our IOP provides 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 seamlessly and effectively.

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.
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: 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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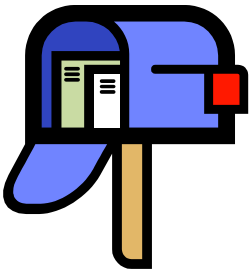
EDQnews@gmail. com



Mental Health Office for Rent

- Fully furnished office in mental health suite. Your private office includes access to a shared waiting room, staff kitchen/bathroom, patient bathrooms, group room, and group kitchen – all ADA compliant.
- Included in the rent: utilities (gas, electric, water, waste), fax, wireless internet, monitored security system, and janitorial services.
- Furnishings include desk, chair, locking file cabinet, small sofa, sofa-chair, book-cases, wall art.
- Located in Rio Rancho just up the hill from Cottonwood Mall and across the street from Intel and Haynes Park, we are accessible by public transit. The office complex of which we are part is primarily medical.

Call Brenda Wolfe at 505-884-5700, extension 101 or email: blwolfe@swcp.com

Obesity Braid — Cont'd from page 3

abundant and calorically-dense than ever in our history. Added ingredients that pack flavor and calories into our foods, combined with their easy accessibility, makes the world a landmine for our physical and psychological eating triggers.

Unraveling the Braid

The three strands of the Braid are tightly interwoven. Even if a pill could change our genetic heritage, we would still face psychological pressures that drive learned behavior and the environmental minefields of available high-calorie food. Psychotherapy to change our basic psychology (were such therapy available, which it is not), would still leave us with physical vulnerability to environmental pressures to overeat. Unraveling the Braid means learning to manage our natural physical and psychological tendencies, and structure our environment to play to our strengths rather than vulnerabilities. As a starting point in the journey away from obesity, here are three changes your patients can begin today:

Accept that the body will not always provide the best signal for when one has had enough to eat. While it is not a good idea to leave oneself hungry at the end of a meal, it is important to differentiate physical hunger from automatic eating. Educate the patient about healthy portion sizes and encourage eating slowly enough to recognize subsiding hunger as those amounts are consumed.

Explore different ways to soothe emotional distress. While eating is a primary source of pleasure, there are many other things one can do to feel good. Any activity that releases tension, distracts from distressing thoughts, and/or just plain feels good is a healthy alternative to emotional eating.

While there may not be much one can do to eradicate junk food from our communities, plenty can be done to improve personal environments. Rid the car and work-place of food to weaken the link between eating and driving, etc. Establish a Designated Eating Place such as the kitchen or cafeteria — that is where food should be stored and eaten. Clean living spaces of high-risk foods so that when one does start rummaging for a bite, the choices are health-enhancing.

EDs Look — Cont'd from page 1

gymnastics, skating). However, EDs show up anywhere people are, so doing something relatively sedentary like teaching or lawyering is not necessarily protective. In fact, a recent large-scale study of law students found that 27% had EDs yet only 3% had been diagnosed. So don't let the letters after someone's name prevent you from screening for EDs in your practice.

So, what do EDs look like?! — They look like people. Always keep that in mind as you work with patients. Failing to do so risks missing the opportunity to prevent tragedy. One more thing—do not believe daytime television!

