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Eating Disorders Institute of New Mexico

EATING DISORDERS QUARTERLY

www.EatingDisordersNM.com
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Quick Fact

Reduction in ED symptoms leads to improvements in quality of life.

Linardon & Brennan, 2017; IJED 50(7): 715–730

Final Issue

After seven years of publishing the Eating Disorders Quarterly (EDQ), this will be our final issue. It has been great fun for me to pull together topical research studies and educational pieces about the challenges of treating eating disorders. Perhaps the most fun, though, has been correspondence with you, our readers. While it is unlikely that the number of emails I've received would make Anne Landers or Dear Abby jealous, I have enjoyed many interesting discussions piqued by the EDQ contents. Although the newsletter will no longer reach out to you, I remain willing and interested in discussing difficult cases with you, and generally talking about our clinical work. I am easily reached by email (below) and always try to return phone messages promptly.

The three most current years of EDQ remain on our website. You are welcome to browse at your leisure.

Best wishes,

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You Called Me Fat! Landmines in Communication

The thing that clinicians who are not immersed in the world of eating disorders (EDs) most frequently forget, is that EDs create a cognitive filter through which our well-intentioned words are often misconstrued—and that misconstrual never works in favor of recovery. For instance, the patient who is just returned from residential weight-restoration therapy and looks beautiful and healthy to us, hears, "You have gotten disgustingly fat" when we compliment the improvement in appearance. Similarly, the clinician who uses the results of the weight trajectory study (page 2 this issue) to reassure the patient with Anorexia Nervosa that "Most recovered patients achieve a healthy weight" hears, "But not all do and so you are going to become hideously huge." To say the path we walk with patients is rife with landmines is an understatement.

For Instance

You say	S/he hears
Awesome work this week!	I am failing at ED
You need X servings of ….	I am a pig if I eat all that
You're looking good	I'm fat
Do you prefer salmon or tuna?	I'm going to binge
You are too thin	They are trying to make me fat
We need to restart your period	They want me to be fat
Rest is as important as to exercise	I will be a worthless lazy slug

As you navigate this treacherous terrain, there are a few important and helpful things to keep in mind:

- EDs are egosyntonic. That is, they feel very much a part of the person. In fact, the afflicted individual believes their ED to be the most important and very best part of him-/herself. Thus, when you applaud progress combatting the ED, the patient is likely to hear that s/he is losing an important part of his/her identity.
- A core feature of the ED psychopathology is what

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Weight trajectory following recovery from eating disorders

Given the fact that eating disorders (EDs) almost invariably involve a desire to be thin, it is not surprising that one of the most difficult motivational barriers to engaging in treatment is the patient's irrational fear of weight gain; believing that any increase in weight will automatically lead to unrestrained weight gain and ultimately obesity. Despite clinicians' reassurances that weight restoration in Anorexia Nervosa and cessation of purging in Bulimia Nervosa is not obesogenic, there has been limited research on the weight trajectories of recovered ED patients.

Murray et al conducted a longitudinal study wherein they followed 225 recovered patients for ten years, and a subset of 175 for 22 years. The average age of their sample at intake was 24, and 46 years at 22-year follow-up. At intake, 53% of the sample was diagnosed with Anorexia Nervosa (either restricting or binge/purge type) and 47% with Bulimia Nervosa.

They found that despite early rapid weight gain during the first two years of the study (appropriate given over half the sample began severely underweight), the majority of participants maintained stable BMIs in the normal range 22 years later. Only about 20% of recovered individuals were in the overweight/obese range at 22 years, and approximately 8% of those with Anorexia Nervosa at intake (but recovered) remained underweight.

EDO Note: These findings may prove useful to educate patients and enhance their trust in recovery (and their treatment team). However, the clinician is cautioned to be judicious in its use keeping in mind the fact that many ED patients have great difficulty not distorting information with their ED-filter (see *You Called Me Fat!* on page 1). Know your patient well before quoting data!

—Murray HB, Tabri N, Thomas JJ, Herzog DB, Franko DL, Eddy KT (2017). Will I get fat? 22-year weight trajectories for individual with eating disorders. Int'l J Eating Disorders, 50: 739–747.

Lots of Facebook friends predicts lots of body dissatisfaction

Body dissatisfaction is a well-documented risk factor for eating disorders (ED) as well as a core symptom of a manifest ED. A century ago, young people built their body ideals on the basis of what the people with whom they interacted admired. Half a century ago (roughly), movies, magazine, and television took on greater weight in shaping the body ideals of the generations. Over the past few decades, social networking sites have multiplied dramatically and today Facebook boasts over 1.15 billion users worldwide.

Social networking sites differ from traditional mass media in many ways, not the least of which is in their promotion of personalized social comparison. Users post photos of themselves, compare them to photos of friends and celebrities, and spend an unprecedented amount of time looking at the screen.

Tiggemann & Salter conducted a prospective study of 438 young (mean age13.6 yrs) girls to track the impact of Facebook use on body image dissatisfaction. They measured Facebook use and body image concerns over a two-year period.

They found that girls with Facebook pages and more Facebook friends at Time1, showed much higher drives for thinness two years later at Time 2. Additionally, time spent on Facebook at Time 1 predicted excessive body focus and internalization of the ultra-thin body ideal at Time 2.

EDO Note: As a fulltime clinician treating EDs, these findings are not surprising. Over the past decade, the internet via social media has been an increasingly common presence in the clinical setting. We have had to expand our psychosocial intake strategy to assess for virtual friends as well as live ones, and question how much time patients spend on the internet "researching" ED -related questions and comparing their bodies to computerized images. Furthermore, the cognitive restructuring that is a critical component of effective ED treatment now must include particular focus on 'talking back' to pervasive, repetitive (and wrong) messages about what our patients 'should' look like.

— Tiggemann M, Salter A. (2017). Facebook and body image concern in adolescent girls: A prospective study. IJED, 50: 80-83.

2017 Conferences & Trainings

Oct 18th — Puberty, ovarian hormones & genetics: The basics of what you need to know. Presenter: Kelly Klump PHD. Renfrew Fall Webinar Series.

Dec 6th — Smoothing out the bumps: Transitional clients from higher levels of care. Presenter: Jancey Wickstrom, AM, LCSW. Renfrew Fall Webinar Series.

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Glen Waller has called a "broken cognition." It is a two-part cognitive distortion. One aspect is that even the smallest amount of food has the power to trigger dramatic weight gain. The other is that weight gain, once begun, will instantly surge out of control and result in extreme obesity. So, recognizing patient progress by reinforcing food intake or weight gain inherently risks triggering panic as s/he hears the "Good job, you gained a pound" to mean that there will be no end to gaining.

- Maintaining the severely restricted intake associated with Anorexia Nervosa and the non-binge-eating periods of Bulimia Nervosa is very difficult. Although it does indeed become easier for some patients not to eat (the hunger/satiety signaling system essentially becomes corrupted), the patient never truly loses the fear that if s/he succumbs to the urge to eat (or eat more), control will be quickly lost and binge-eating will result. Hence, when you encourage the patient to "add one more serving," her/his interpretation is that you are setting him/her up to binge and become obese.

- Early psychoanalytic thinking about Anorexia Nervosa often interpreted the disorder as a fear of adult sexuality. By staying very thin and avoiding menses, it was believed, the girl (low rates of males with Anorexia last century) served to retain her child status and avoid the complexity of adult sexuality. This may be true in some cases but most certainly is not a good across-the-board explanation for the disorder. What we do frequently hear in the clinic is that patients know that menses requires a certain degree of body fat. Thus, to the distorted ED mind, amenorrhea is a welcome sign of low body fat. As a result, even young women who profess a desire to one day have children and who can easily explain the biological necessity of a menstrual cycle to achieve that goal, are adamant that they must not resume menses.

- Exercise might well be one of the most difficult issues to negotiate with ED patients. Everybody with more than a 1st grade education knows that exercise is important to good health and that most Americans are dangerously sedentary. Thus, when we counsel our patients to reduce or cease their exercise routines, we are often received as though as we telling them to eat arsenic! Unfortunately, exercise is not always healthy. In fact, it is dangerous for the individual who exercises compulsively, ingests insufficient calories to match energy expenditure, or ingests adequate calories but purges them thereby upsetting his/her electrolyte balance. Despite the very real danger of cardiac events, seizures, and death, the patient we are thus counseling hears us telling him/her to (1) be unhealthy, and (2) get fat.

How not to call them fat

Traditionally, this would be the point in the article that the author tells you how to solve the problems outlined in preceding paragraphs. Unfortunately, neither decades of training and clinical experience, nor the bazillion (only a slight exaggeration) of scientific studies I have read has given me a clear set of instruction to pass along to you. With discouraging regularity, I step on one of these landmines and have to scramble to keep from losing a metaphorical limb of progress.

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When a Good Workout is Bad

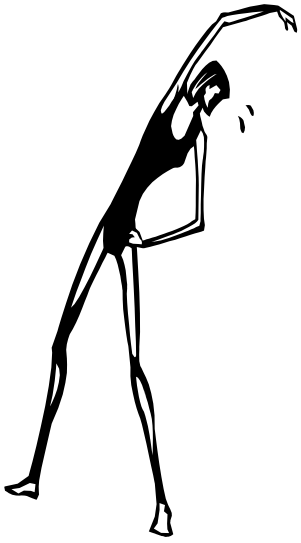
Everyone knows that exercise is healthy, but sometimes a good workout is just plain bad. For some ED patients, the same activity that is health-promoting for most of us becomes a toxic cog in the illness-maintaining mechanism. Distorted by the ED focus on body, and exacerbated by the obsessive-compulsive nature of that thought process, exercise becomes the price our patients believe they must pay for food, for sleep, and indeed for life itself. Hence, what may begin as a healthy habit can quickly become deadly.

Barring extreme malnourishment, figuring out when to prohibit a patient from exercise is not easy. The hurdles we must leap are tall. Not only do we stumble over defining exercise (are 10-mile runs and 10-minute walks both exercise?), but we trip over explaining why something "everyone" knows is healthy is unhealthy for this particular person. Were that not enough, there is the psychotherapeutic challenge of reassuring the patient whose identity is anchored in physical activity that exercise cessation will not leave her/him a big fat zero of a person (with the emphasis on fat).

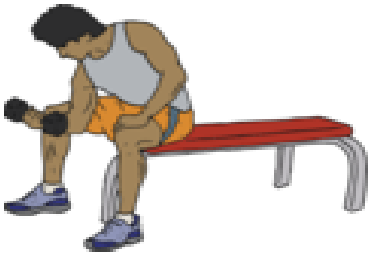
Identifying who can enjoy healthy exercise and who should be discouraged from exercising (we use the word "prohibit" but in truth we can, at best, discourage) rests on recognizing when the patient has crossed over from "like to exercise " to "need to exercise" territory. Without reliable objective measures, we are left with clinical judgment and the knowledge that it is our job to point out when a good workout is not good.

Compulsive Exercise Flag

If your patient endorses more than a few of the statements below, it is important to consider the possibility that she or he may be exercising compulsively.



- I am chronically tired and achy, get sick easily, and despite my efforts, my performance level is dropping.
- I exercise even if I don't feel well or my body hurts.
- I almost never exercise for fun.
- Every time I exercise, I go as fast or hard as I can.
- I experience stress and anxiety if I miss a workout.
- I miss family obligations because I have to exercise.
- I calculate how much to exercise based on how much I eat.



- I would rather exercise than get together with friends.
- I can't relax when I think I'm not burning calories.
- I worry that I'll gain weight if I skip exercising for one day.
- I crave the "high" feeling that I get from exercise.
- I stick to my workout no matter how nasty the weather.

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Minimizing the risk of limbs lost to ED landmines requires actively keeping in mind that what may be clear communication on your end is ED-distorted for your patient. There are a few general do's that may help. However, there is only one sure way of not leaving a session thinking it was a good step forward while your patient leaves formulating plans to increase his/her ED-focus—and that is to check for understanding. When you comment on the patient's behavior (e.g., "I can tell you worked really hard this week"), ask your patient, "What do you think I mean?" or "What did you just hear me say?" Then listen actively.

Do:

- Avoid talking numbers with your patient. Although there are certainly instances in which it is important to speak numbers (e.g., weight desensitization, nutritional requirements), keep in mind that the ED mind easily grabs onto the numbers and disregards all other input. On more than one occasion I have come to the end of a brilliant explanation for why I am recommending this or that and upon checking for understanding learned all my patient had heard was my positive reinforcement for "two weeks in a row" of menu compliance at the beginning of the session. Since then, she was consumed by fear that she was on a hell-bent spiral toward morbid obesity. So much for my brilliance.
- Focus on the results of treatment compliance rather than the actual behaviors themselves. Remember that ED patients are not anxious to lose their disorders; the ED is part of their identity. So rather than risk scaring the patient away, emphasize improvements in function (e.g., more energy for work/school, improved ability to focus) and feeling (e.g., lightening of depression).
- Maintain your sense of humor. EDs are among the most difficult of mental disorders to treat and you will have ample opportunity to cry. Your patients enter treatment feeling miserable and trapped and desperately want to *feel* better and are terrified of *getting* better—and you have to figure out how to disarm that landmine. Sometimes you can point out the oxymorons and have a good laugh together (good prognosis if the patient laughs!), and sometimes you just have to laugh by yourself. Laugh at the frustration, laugh at your mistakes, and laugh because you are lucky enough to have a profession in which you get a first-hand look at the complexities of the human mind, and an opportunity to restore a life.