

# MENTAL HEALTH NEWS™

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SUMMER 2013

FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

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☆☆ Next Issue: Mental Health News Becomes Behavioral Health News ☆☆

## Understanding and Treating Eating Disorders

By The National Institute  
of Mental Health (NIMH)

An eating disorder is an illness that causes serious disturbances to your everyday diet, such as eating extremely small amounts of food or severely overeating. A person with an eating disorder may have started out just eating smaller or larger amounts of food, but at some point, the urge to eat less or more spiraled out of control. Severe distress or concern about body weight or shape may also characterize an eating disorder.

Eating disorders frequently appear during the teen years or young adulthood but may also develop during childhood or later in life.<sup>1,2</sup> Common eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Eating disorders affect both men and women. For the latest statistics on eating disorders, see the NIMH website (<http://www.nimh.nih.gov/statistics/index.shtml>).

It is unknown how many adults and children suffer with other serious, significant eating disorders, including one category of eating disorders called eating disorders not otherwise specified (EDNOS).



EDNOS includes eating disorders that do not meet the criteria for anorexia or bulimia nervosa. Binge-eating disorder is a type of eating disorder called EDNOS.<sup>3</sup> EDNOS is the most common diagnosis among people who seek treatment.<sup>4</sup>

Eating disorders are real, treatable medical illnesses. They frequently coexist

with other illnesses such as depression, substance abuse, or anxiety disorders. Other symptoms, described in the next section can become life-threatening if a person does not receive treatment. People with anorexia nervosa are 18 times more likely to die early compared with people of similar age in the general population.<sup>5</sup>

### Different Types of Eating Disorders

**Anorexia Nervosa:** Anorexia nervosa is characterized by: (1) Extreme thinness (emaciation); (2) A relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight; (3) Intense fear of gaining weight; (4) Distorted body image, a self-esteem that is heavily influenced by perceptions of body weight and shape, or a denial of the seriousness of low body weight; (5) Lack of menstruation among girls and women; and (6) Extremely restricted eating.

Many people with anorexia nervosa see themselves as overweight, even when they are clearly underweight. Eating, food, and weight control become obsessions. People with anorexia nervosa typically weigh themselves repeatedly, portion food carefully, and eat very small quantities of only certain foods. Some people with anorexia nervosa may also engage in binge-eating followed by extreme dieting, excessive exercise, self-induced vomiting, and/or misuse of laxatives, diuretics, or enemas.

Some who have anorexia nervosa recover with treatment after only one episode.

*see Eating Disorders on page 24*

## Eating Disorders: Early Warning Signs and Assessment

By Rachel W. Bush, PhD, Assistant  
Professor of Psychiatry and Behavioral  
Sciences, New York Medical College

For over two decades, people have been coming to my office to change. My job is to ask important and meaningful questions and to try and understand the answers that I receive. I have needed to know how to closely look for unknown truths never confessed that lead to growth and hope. Livingston (2012) argues that one of the greatest risks in life is to be honest with ourselves. Secrecy is frequently at the core of all eating disorders.

Early assessment of the warning signs of anorexia nervosa, bulimia nervosa, binge eating-disorder (BED) and eating disorder not otherwise specified (EDNOS) is essential in preventing the downward spiral of lethality. We know that timing is

everything. The earlier we intervene, the greater the clinical success and prevention of a runaway train of self-destruction. Eating disorders are extremely serious and when untreated can be deadly. We know that anorexia has the highest mortality rate of any mental illness. The prevalence of eating disorders is significant. Currently in the United States we know that 20 million women and 10 million men will suffer from an eating disorder at some time in life. Clinicians need to first rule out organic causes of multiple medical conditions that may be misdiagnosed as eating disorders (Lyme, Addison's Disease etc.). In addition there is a risk of complications from coexisting conditions like anxiety, depression, attention deficit disorder, addictions, trauma and personality disorders, which can interfere with a practitioners thorough eating disorders assessment. If you don't look closely and thoroughly to investigate relevant clinical

symptomatology, it is easy to miss the complex interaction of genetic, biological, psychological, family, social and environmental factors. Every treatment needs to be individually tailored to be most effective.

### Anorexia Nervosa

No psychotherapy is consistently an effective treatment for adults with anorexia and there is a need for further research on predictors of treatment acceptance and completion. (Halmi). Clinicians need to look closely and find out about recent weight loss and dramatic changes in eating habits. Self-imposed starvation and extreme dieting is the most common eating disorder. Anorexia is more prevalent in over-achievers, outstanding athletes and individuals with perfectionistic features. The mirror is an enemy reflecting an individual who is always "too fat." Even when dangerously under weight,

there is still a wish to lose more. There is an individual trying to hide in baggy clothing, a cycle of self-hatred, the wish for control, caloric restriction, over exercise, self-induced vomiting, laxatives, diuretics, enemas, diet pills, zero calorie beverages, secretive or ritualistic eating patterns, and an avoidance of social gatherings when food is served. When asked "How would you feel if you lost or gained 15 pounds?" the answer is linked to self-esteem and self-worth, shame, humiliation, and urges to self harm (cutting, burning etc.). Ask about the relationship to the scale. How often do you weigh yourself? It might be never, for fear of a bad number, multiple times a day, recorded by a nutritionist, nurse or doctor when they are standing on the scale backwards and determined that the weight not be stated. Does the individual sit down for meals or

*see Early Warning Signs on page 18*

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# From the Publisher

## Behavioral Health News: The Bright New Future of Mental Health News

By Ira Minot, LMSW  
Founder and Executive Director  
Mental Health News

It was 15 years ago that we first launched *Mental Health News*. We have published 60 exciting issues over these years and covered many important topics in each issue. Thanks to so many of you, we have been honored with articles from some of the best minds in the field of mental health treatment, advocacy, and policy making. Our readers cross many levels: from consumers, to family members, to treatment professionals, and providers of vital services. Under the banner of our mission to provide essential community mental health education, all of our readers and supporters have rallied together into what I like to call the *Mental Health News Family*.

Now, in our upcoming Fall 2013 issue, we will transform *Mental Health News* into *Behavioral Health News*. As times are changing, healthcare reform and service integration are pointing us in a new direction and *Behavioral Health News* will respond to this need. We are working with leaders from the mental health and substance use communities to bring you the very latest news, clinical best practices, advocacy, and resources in the tradition of our award-winning format. In ad-



Ira Minot, LMSW

dition to behavioral health, we will cover key issues in the integration of primary care and behavioral health services.

Some of the data that confirmed the need for us to become a behavioral health publication were that: over 93% of the heaviest Medicaid users in New York

City have either a mental health or substance use diagnosis; of these, 65% have a co-occurring mental health and substance use diagnosis; and that the hospital readmission rate for mental health consumers is higher for medical rather than psychiatric reasons.

The creation of Health Homes highlight the challenge and promise of integrated mental health, substance use, and primary healthcare. As the healthcare system moves toward integrated managed care, these issues will need to be addressed on a regular basis. In each issue of *Behavioral Health News*, these and other practice and policy issues will be addressed by leaders from the field. *Behavioral Health News* will keep all stakeholders informed and prepared for the upcoming January 1, 2014 rollout of integrated managed care in New York State and beyond.

According to Dr. Peter Beitchman, Chairman of the *Mental Health News* Board of Directors, "For the past 18 months, the Board has been closely monitoring the vision and roll-out of Federal and State healthcare reforms. One of the striking aspects of this current reform is that it has propelled both policy-makers and providers to adopt a new view of mental health and substance use services as integrated behavioral health services. While consumers, families and providers

have advocated for years for more and better integration of mental health and substance use services, the healthcare reforms underway will make such integration a reality. Given the changing healthcare landscape, the Board has moved to expand the scope and purview of *Mental Health News* to include the full spectrum of behavioral health services. We are enormously excited about the upcoming premier of *Behavioral Health News* this fall. It is a new phase in our publication's history which we hope all consumers, families, providers and advocates from both the mental health and substance use communities will welcome, and will join us in supporting this new effort."

In the coming months we will be reaching out to the entire substance use community in New York State and beyond. As we have done in the past, we will strive to create a roadmap to vital substance use services in every community. This will be a huge undertaking that will require new resources, but we are ready to meet the challenge. We will need more sponsors, advertisers, and good writers from both the mental health and substance use communities to make our dream a reality. We know that with your help and support we will succeed!! As always, please call me at (570) 629-5960 or email me at [iraminot@mhnews.org](mailto:iraminot@mhnews.org)

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Reframing treatment around recovery and resiliency offers new hope and a bright future for those who live with mental illness. While everyone must follow their own path to recovery, and every local community offers a unique set of supports, a few key principles can help ensure success:

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- Building on the strengths and abilities of each individual
- Cultural competence
- Techniques, tools, and technology to empower people to live purposeful lives
- Peer support from others who have been there
- Flexibility and innovation at every step
- Inspiring hope to drive recovery

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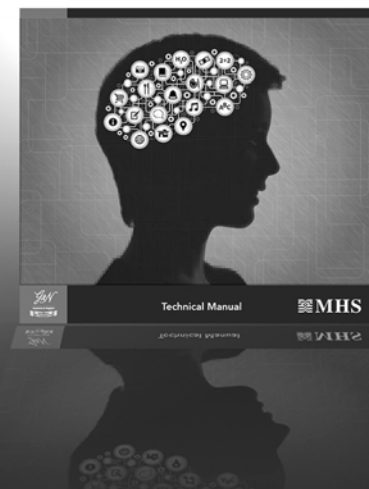
1. **Take bread out**
2. **Place bread on counter**
3. **Open fridge**
4. **Look for cheese**
5. **Can't find cheese**
6. **Look for cheese**
7. **Can't find cold cuts**
8. **Find cold cuts**
9. **Close fridge**
10. **Forgot cheese**
11. **Place toppings on counter**
12. **Open fridge again**
13. **Grab mayo**
14. **Forget to close fridge**
15. **Place mayo on counter**
16. **Forgot cheese**
17. **Look in fridge again**
18. **Find cheese**
19. **Place cheese on bread**
20. **Place cold cuts on bread**
21. **Add mayo**
22. **Close sandwich**
23. **Eat sandwich**

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ASSESSMENTS

# The Role of Inpatient Treatment In the Management of Individuals With Eating Disorders

**By Evelyn Attia, MD**  
**Director, Center for Eating Disorders**  
**New York-Presbyterian Hospital**

Eating Disorders, including anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) are serious disorders affecting 2-5% of the population, and are associated with high rates of medical as well as psychiatric morbidity. Notably, suicide is responsible for one in five deaths among individuals who die with AN (Smink 2012).

Treatments for eating disorders are complex, and often include a team of multi-disciplinary clinicians such as pediatricians or internists, psychiatrists, psychologists or other mental health professionals, and nutritionists. Effective treatments emphasize improved eating behaviors, and, for AN, include nutritional rehabilitation and weight restoration. Treatments may occur both in an inpatient and outpatient setting depending on the clinical presentation and illness severity.

Patients and clinicians alike are understandably interested in identifying effective treatments that use the least restrictive settings. Nevertheless, higher levels of care, including inpatient treatment, are sometimes necessary for the management of the serious medical and psychiatric manifestations of these complicated illnesses. Inpatient treatment is appropriate for more severely affected individuals with eating disorders, especially those in need of medical or nutritional stabilization or those who present with significant psychiatric co-morbidity. Hospital settings are used for individuals with eating disorders who require 24-hour attention for medical, psychiatric and behavioral disturbances associated with their illnesses. Most commonly, seriously underweight individuals with AN who demonstrate the medical features of starvation, including significant bradycardia, hypotension, or the metabolic disarray that may result from disordered eating behaviors are treated in a hospital. Most patients with BN and BED receive intensive treatment in less restrictive settings. However, when severe concurrent medical or psychiatric problems persist or patients fail to respond to outpatient treatment, even individuals with BN or BED may need inpatient care.

When practitioners consider whether inpatient treatment is indicated, a variety of factors should be taken into account, such as the patient's weight, rate of recent weight loss, cardiac function, metabolic status, eating disorder behaviors, psychiatric co-morbidities, available social supports, and response to previous treatments. Should a patient require inpatient care, the hospital program should be expected to include the following elements: a multi-disciplinary team to offer close supervision; consistently applied policies and procedures aimed to manage eating and associated behaviors; careful medical monitoring; nutritional planning and re-feeding; individual, group and family treatment components; and post-hospitalization planning to help patients



**Evelyn Attia, MD**

move significantly toward recovery. By having a full array of services and support, the program will be able to address the patient multi-faceted needs.

## A Clinical Example

The Outlook at New York-Presbyterian Hospital/Westchester Division, part of The Center for Eating Disorders at Weill Cornell Medical College and Columbia University Medical Center, is a psychiatric inpatient unit specializing in eating disorders treatment. The program illustrates the elements of behavioral management that may be used to assist individuals with eating disorders. When first arriving at The Outlook, patients receive information about unit expectations and unit policies. Patients are asked to consume 100% of prescribed foods and supplements and, if diagnosed with AN, fully normalize weight. For individuals with binge eating or purging behaviors, goals for normal eating and post-eating practices are reviewed. Weight recommendations are discussed with patients. The unit is highly structured, with supervised meals and snacks, group-based therapeutic activities, and individual and family psychotherapy sessions.

Upon admission to The Outlook, patients receive a comprehensive medical and psychiatric evaluation. The patient's height and weight are measured at the time of admission, and patients are weighed daily in order to observe trends in weight. Medical stabilization includes addressing any acute medical complications that may result from either the eating disorder itself (e.g. hypokalemia from vomiting) or from the initiation of treatment (i.e. re-feeding syndrome). Every day, the patient's medical status is assessed, initially multiple times a day, until the patient's status stabilizes.

The treatment for AN includes medical stabilization, weight gain and weight maintenance. The hospital setting is commonly used for the first of these phases and as much of the second phase as can be

arranged. Ever shortening hospital stays have made it less common for patients to complete weight restoration on an inpatient unit. Weight maintenance and treatments focusing on preventing relapse following successful weight restoration are essential for ultimate treatment success but are generally conducted using outpatient settings.

The treatment for BN and BED includes structuring patients' meal-time eating and interrupting patterns of vomiting and other compensatory behaviors. Patients with BN and BED whose illnesses are serious enough to require inpatient treatment may require medical stabilization for fluid or electrolyte imbalance, or may need medication adjustment, either for their significant eating disorder symptoms or for the mood and anxiety symptoms that commonly co-occur with BN and BED.

## Caloric Intake

Patients with AN are initially provided with a daily diet of food in the form of three meals and one snack totaling 1800 kcal. All patients are supervised during and for one hour following each meal and snack. In addition, all patients are prescribed a multivitamin with therapeutic minerals, thiamine, and folic acid as a preventive measure given their malnourished state. Once patients are tolerating their initial diet without developing re-feeding syndrome, the diet is advanced in a step-wise fashion. Daily caloric prescription is increased by approximately 400 kcal/day every 48-72 hours using food to a maximum of 3000 kcal/day and nutritional supplement, generally to the level of 800 kcal/day, although additional increases may be necessary to achieve adequate weight gain. Patients with BN or BED are generally provided with a regular diet, as the unit's nutritional plan targets normal eating, not weight change. All patients are expected to eat and drink 100% of the food and nutritional supplement prescribed. Meal and post-meal times are highly structured and supervised. Thirty minutes are allotted for each meal, and prescribed foods may not be saved or exchanged.

During the weight gain phase for individuals with AN, patients are expected to increase 1-2 kg/week. If the rate of weight gain is not adequate, additional doses of nutritional supplement may be added or the duration of close observation may be increased. In addition, unit privileges and activity level may be also adjusted if weight does not increase expectedly.

Therapeutic activities are informed by principles of cognitive behavioral therapy (CBT) and emphasize the expectation that additional treatment will be necessary following the hospital stay. For patients with anorexia nervosa, post-hospitalization treatments will likely include additional weight gain and weight maintenance goals. For patients with bulimia nervosa and binge eating disorder, post-hospitalization treatments will aim to maintain and enhance behavioral changes achieved during the hospital stay such as eating three meals daily and cessation of purging.

The unit's behaviorally focused protocol provides structure and guidance to aid patients and providers through the challenges associated with achieving significant behavioral change for individuals with eating disorders, leading to improved eating, weight and general emotional health. The treatment relies on reinforcement of healthy changes and interruption of patterns of illness. (Attia 2009) Patients with eating disorders are commonly ambivalent about treatment and benefit from the support and clarity that accompany structured treatment programs. While not always possible, it is optimal to review the behavioral program with patients prior to admission, but even in the setting of prior review and agreement, patients may experience the plan as harsh or punitive and staff must be well versed in approaching questions and confrontations about program principles in a compassionate and clear manner. Finally, it is essential for staff to be mindful that clinical protocols are imperfect and may require adjustment in practice. Clinical treatment teams will need to decide together whether and how a protocol adjustment may be important for a particular patient.

In addition to the behavioral treatment and nutritional rehabilitation described above, individual and family psychoeducation and support are part of an intensive comprehensive treatment plan.

## Clinical Challenges

Several clinical challenges are commonly encountered in the delivery of inpatient treatment for eating disorders. Ambivalence regarding treatment goals and, relatedly, the management of persistent eating disordered behaviors, including restriction of dietary intake and post-meal purging may be difficult for staff to negotiate. Therapeutic sessions should include discussion of motivations for behavioral change with particular focus on the factors that contributed to decision to seek treatment. Clinical programs generally have policies and procedures to help patients resist engaging in behaviors of illness. For example, supervision during and following meals aims to support and redirect patients around urges to engage in symptoms. Peer supervision and frank clinical discussions with all team members may be helpful to maintain consistency and avoid undue rigidity around clinical management decisions.

Patients with particularly limited insight into their illness may require involuntary commitment for some or all of their eating disorders treatment. Physician-certified or court-ordered treatment poses challenges for patients and for specialized staff. Staff may find it useful to consider the medical urgency of the clinical presentation and the life-sustaining elements of the treatment in their treatment planning. Sometimes, patients describe a sense of relief or acceptance that accompanies intensive treatment because of the perception that they "have to" eat or "have no choice" about the treatment components. Further, a study of hospitalized patients

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# Current Trends and Controversies in the Treatment of Eating Disorders

By Douglas Bunnell, PhD, FAED, CEDS  
Chief Clinical Officer, Carolyn Costin,  
Executive Director, and Kenneth W. Wil-  
lis, MD, Medical Director,  
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Eating Disorders (ED) such as anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED) are complicated medical and psychiatric illnesses. Patients, families, and clinicians face enormous challenges in their attempts to pursue and support full and lasting recovery. Yet, in spite of the many clinical, societal, and financial challenges, there has been real progress over the past several years in our understanding of these illnesses and in the development of robust, evidence based treatments. At the same time, regional, national and parent advocacy groups have raised public awareness of ED and have developed important support resources for patients and their families. In many ways we can be optimistic about these trends and hopeful that people with ED can avoid the potential long term, chronic, and often tragic, including deadly consequences of these illnesses. This article will briefly summarize new trends and point out some of the remaining areas of controversy and barriers to comprehensive treatment and recovery.

Over the past several years, the American Psychiatric Association, Society for Adolescent Health and Medicine and the



**Douglas Bunnell, PhD**

National Institute of Clinical Excellence (UK) have published practice guidelines for ED. Clinicians, insurers, patients and their families can use these resources to familiarize themselves with the current state of the field and to help structure and evaluate treatment options. It is well beyond the scope of this article, but medical monitoring, psychopharmacological treatments and nutritional therapy are all essential components of any multidisciplinary



**Carolyn Costin**

nary approach to the treatment of ED. The focus in this article will be on where things stand in terms of the best psychotherapeutic approaches.

While there is some considerable variation in the recommendations, there is a consensus about a number of first line treatments for ED. For adults and adolescents with BN, Cognitive Behavioral Therapy (CBT) has the strongest research base. CBT helps patients interrupt their



**Kenneth W. Willis, MD**

ED symptoms and behaviors and focuses on a quick normalization of eating. Stabilization of eating then yields to a focus on the thoughts, beliefs, and behaviors that perpetuate the ED cycle. Interpersonal Psychotherapy (IPT) has also been shown to be effective with BN, over the longer term. IPT, in contrast to CBT, focuses almost exclusively on the role of relationships

*see Trends and Controversies on page 22*

## How Do I Prevent My Child from Developing an Eating Disorder?

By Elissa K. Zelman, PsyD, CEDS  
Licensed Psychologist

For most people, eating disorders are mysterious, confusing and frightening disorders. In our society, we are now bombarded with articles and television movies about eating disorders. While the key to prevention is educating the public about how eating disorders develop, these media resources often fuel anxiety and provide little to better understand these mystifying disorders.

So, what does cause eating disorders? Is it the media? Is it someone needing to be “in control”? Is it a “perfectionistic personality”? These are questions I am asked all the time. In truth, any one thing does not cause eating disorders. While an incident may trigger the beginning of an eating disorder (i.e. a diet, or comment about one’s body), they are complex and fueled by multiple factors. The good news is that while eating disorders are becoming increasingly common amongst children, teenagers and adults, many people do not develop eating disorders.

Some common risk factors influencing the development of an eating disorder include people who are perfectionistic and show rigid thinking patterns (“if I do not get 100%, then I have failed”); are highly influenced by other people; have difficulty experiencing and expressing their feel-



**Elissa K. Zelman, PsyD, CEDS**

ings (say “I’m fine” when they’re not); have experienced emotional, physical or sexual trauma; and who come from dysfunctional families or those where success is strongly judged by external assets (i.e. appearance, achievement). If you recognize some of these elements in yourself or

your family, it does not automatically mean your family is at risk. However, it is helpful to examine how these factors have influenced you, and subsequently your children, and how you can make changes to enhance the health of your family.

Here are some measures you can take to help fight eating disorders:

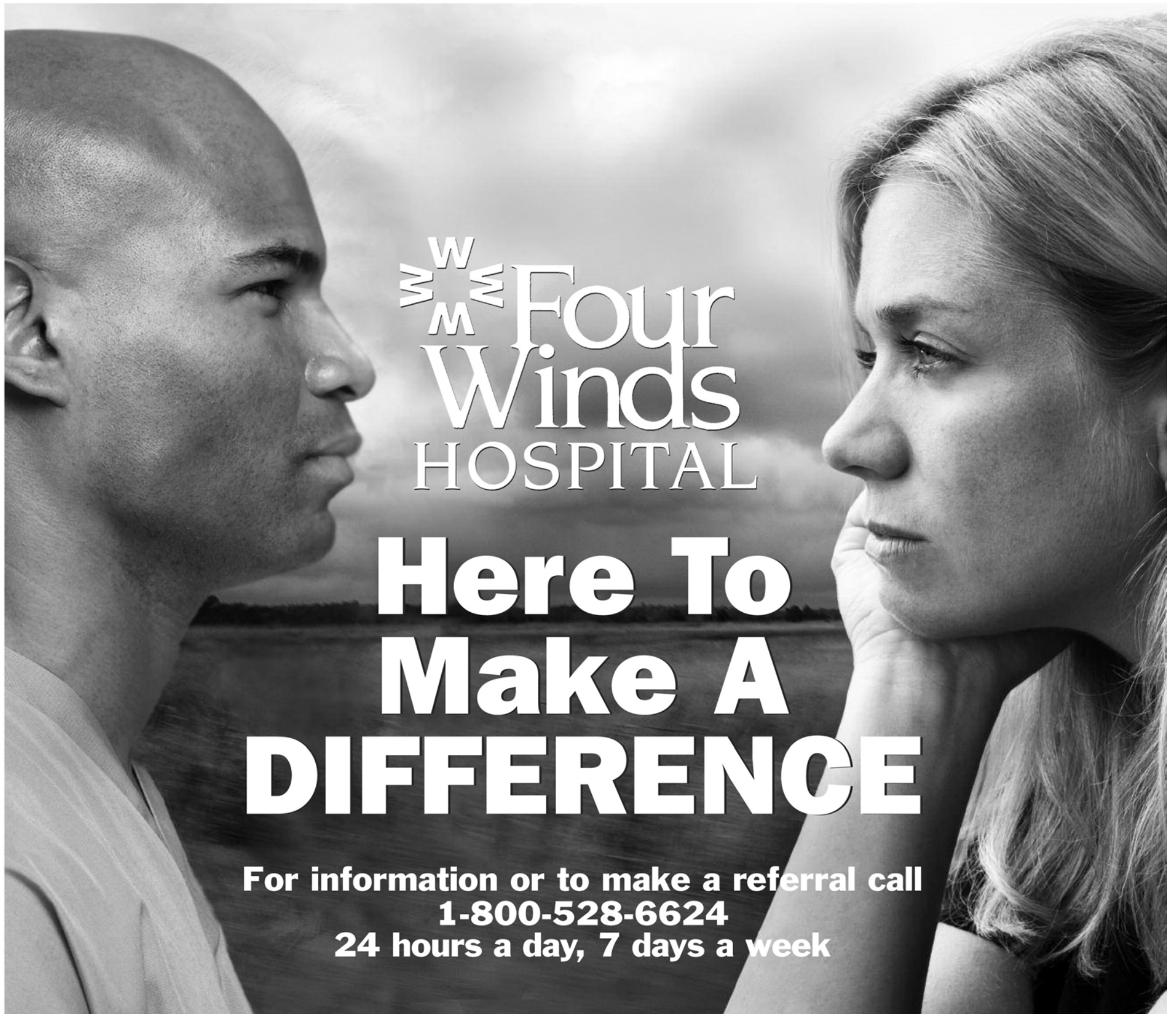
1. Look at your own attitudes about weight, appearance and aging. What do you model for your children in terms of self-acceptance? Are you accepting of the fact that people naturally come in various shapes and sizes? For example, if you lined up 10 people who are all 5’6”, would they all have the same shape and weigh the same thing? Of course not! If you have difficulty with this concept and think there’s a “right” way that you, or your child should look based on their sex, age etc., challenge your thinking. Think about what you are teaching your children in terms of accepting themselves.

2. Weight Health! Healthy people come in all shapes and sizes! Unfortunately, we are taught in our culture that fat = lazy and unhealthy, while skinny = disciplined and successful. The reality is people are genetically shaped in a certain way and have about as much control over it as their height! Also, we know nothing about how healthy someone is by looking at them. We see people every day, of all sizes, who

look “terrific” and are medically unstable. If we all try to be more accepting of size diversity, maybe we won’t try so hard to attain an unrealistic body image.

3. Research shows that the most important factor influencing health and longevity is exercise (<http://www.ncbi.nlm.nih.gov/pubmed/23139642>). Being active and eating a healthy, moderate diet will allow you to stay at the weight you are meant to be. This does not mean that you should demand your child exercises every day “or else.” If you are concerned about your child’s weight, try to develop fun, family-oriented activities. It increases positive interactions, decreased a sense of shame for your child, and is healthy for everyone!

Especially for the parents of girls, but also of boys, help them remember that what’s important is who they are, not how they look. There’s an old slogan from Eating Disorders Awareness Week in 1994 that goes “Don’t Weight Your Self-Esteem, it’s What’s Inside That Counts.” Emphasize what kind of person they are, what makes them unique, their talents and passions etc. Starting very early and becoming more apparent around junior high, girls, in particular, become all too consumed with their appearance and forget that they are a whole person. Let’s help remind them!



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# The Structure of a Revolution in Obesity Treatment

By Michael J. Cameron, PhD

Although Katherine used to enjoy hiking and skiing, if given a choice between elevators or stairs she now selects elevators. Katherine is 81 pounds overweight, has prescriptions for gastro-esophageal reflux and high blood pressure, and has avoided her primary care physician for 2 years. Katherine is 41 years old and struggling. She recently lost 11 pounds but then gained 13 in a month while completing a stressful work project. Every day her post-it note confronts her with the phone number for lap band surgery. She plans to call the clinic tomorrow.

Community prevalence data indicate men, women, and children have progressively lost personal control of their body weight over the last decade. Currently, more than two thirds of adults are considered overweight or obese in the United States. Additionally, more than one in six children and adolescents has a BMI indicative of obesity.

The notable effects of excess body weight include cardiovascular disease, Type II diabetes, cancer, osteoarthritis, liver and kidney disease, work disability, breathing difficulties, and depression. The healthcare costs for overweight people have doubled over the last decade. Specifically, treatment of excess body



weight and related health problems costs approximately \$93 billion annually (CDC). Accordingly, there is a keen interest in preventing excess body weight and identifying effective interventions.

## Our Prescriptive Culture

Management strategies for excess weight vary depending on the physical condition and age of an individual, but fall along a continuum from non-intrusive to physically invasive. Treatment protocols include hypo-caloric diets, generic lifestyle changes, surgical

procedures, and pharmacological treatments. Our culture embraces institutional-level interventions that are all-purpose, pre-designed, impersonal, and based on one-way transactions (i.e., the experts provide care). Commonly prescribed interventions do not emphasize self-determination, self-control, self-efficacy, or dynamic assessment and data-based decision making. Currently, people struggling with their body weight are prescribed interventions that are generically arranged, automated, or surgical. These interventions differ markedly from a strength-based and

person-centered educational model. Accordingly, it is time for a revolution in how the professional community supports people with excess body weight.

## Why a Strength-Based and Person-Centered Approach Matters

In contrast to generically arranged strategies for addressing weight control, contemporary ingestive behavior researchers study food and liquid intake systematically and emphasize individualized treatment plans. A strength-based and person-centered approach differs from the aforementioned methods in that it integrates practices focused on a person's established strengths; personal preferences and choices; valued outcomes; participant and family collaboration; dynamic assessment; data collection on key health behaviors; and design and implementation of evidence-based interventions driven by knowledge of patients' triggering variables, and motivations.

The approach guides development of a rich repertoire of essential health-promoting behaviors that will produce valued results and lasting health behavior change. We believe that obesity treatment requires a systematic, paced, and collaborative approach to produce permanent

*see Revolution on page 23*

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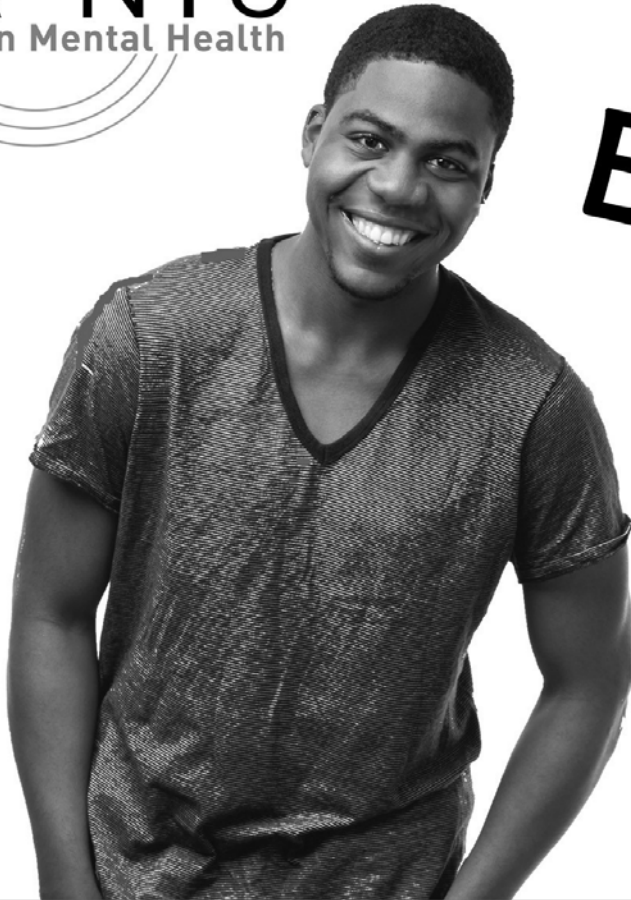
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## Spotlight on Eating Disorders

**By Thomas R. Insel, MD, Director  
The National Institute of Mental Health  
February 2012 Director's Blog**

**W**hat is the most fatal mental disorder? The answer, which may surprise you, is anorexia nervosa. It has an estimated mortality rate of around 10 percent.<sup>1</sup> What is the cause of this high rate of mortality? The answer is complicated. While many young women and men with this disorder die from starvation and metabolic collapse, others die of suicide, which is much more common in women with anorexia than most other mental disorders.

The last week of February is National Eating Disorders Awareness Week. Eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder. We often hear about the epidemic of obesity and the health consequences of over-eating, but the perils of anorexia and bulimia are less recognized. Here are some little known facts about eating disorders, all gleaned from NIMH-funded research.

First, the demographics of eating disorders may be changing. The National Comorbidity Study-Replication, an NIMH-funded population-based epidemiologic study from a decade ago, struggled with estimating the prevalence of eating disorders because the researchers found that many respondents were reluctant to admit to these syndromes during a structured



**Thomas R. Insel, MD**

interview. Nevertheless, the study reported that these disorders are more common in women. The lifetime rate for anorexia nervosa among women was estimated at 0.9 percent compared to 0.3 percent among men. The lifetime rate among women for bulimia nervosa was 0.5 percent compared to 0.1 percent among men. And the lifetime rate among women for binge eating disorder was 3.5 compared to 2 percent among men.<sup>2</sup> Almost certainly, these numbers are under-estimates. We have seen hospitalization rates for eating disorders continue to rise, increasing 18

percent between 1999 and 2006.<sup>3</sup> In addition, contrary to the traditional stereotype that eating disorders mostly affect white upper middle class females, the ethnic makeup of those contending with eating disorders may be changing. On a recent trip to China, when I asked mental health officials about their number one concern, in both Beijing and Shanghai, I heard about anorexia nervosa.

Second, the treatments for eating disorders are changing. Traditionally, anorexia in adolescents has been viewed as a “family systems” problem requiring a “parentectomy” — exclusion of the parents or caregivers from the teen’s treatment plan. But research at the Maudsley Hospital in London, which was replicated in the United States by Le Grange and Lock, has shown that outcomes appear much better if parents are empowered and included, rather than excluded, from the treatment.<sup>4</sup> In fact, a carefully controlled trial evaluating the effectiveness of a family-based treatment approach found 50 percent of participants continued to experience full remission one year after the end of therapy.<sup>5</sup> Whether this same approach will work for older patients is not clear, but research is currently underway that incorporates families in the treatment of adults with anorexia. The proof of principle is important: family involvement can be critical for recovery.

While it is encouraging to have new and effective treatments, we continue to hear from families with a teenager who has received insurance coverage for inten-

sive care for a metabolic crisis, but could not get coverage for the underlying eating disorder. There may be no other area of mental health care with such an obvious injustice. Imagine a teenager with leukemia receiving antibiotics for an infection but not receiving treatment for the cancer. While the dynamic duo of mental health parity and health reform may lead to a solution, coverage of treatment for eating disorders will ultimately differ by state. That is all the more reason to remember — at least one week of the year — that eating disorders are serious, sometimes fatal, disorders.

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**See Page 27 For Details**

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# The NYSPA Report

## The Safe Act: A New Reporting Requirement for Mental Health Professionals

By Rachel A. Fernbach, Esq.  
New York State Psychiatric Association

The Secure Ammunition and Firearms Security (SAFE) Act, signed into law by Governor Cuomo on January 15, 2013, is a gun control statute that substantially strengthens rules governing access to firearms and ammunition. The law also imposes a new mandatory reporting requirement on health care professionals that went into effect on March 16, 2013 and applies to physicians, psychologists, registered nurses and licensed clinical social workers. This column will provide a brief overview of the new reporting requirement, and discuss NYSPA's concerns about the law as currently drafted, including the statute's failure to mandate notification to potential victims or local law enforcement as well as failure to require that any potential threat be of both a serious and imminent nature.

### Summary of the Reporting Requirement

The SAFE Act amends the Mental Hygiene Law by adding a new §9.46, which imposes a mandatory reporting requirement upon health care professionals if they conclude, using reasonable professional judgment, that a patient is likely to engage in conduct that would result in serious harm to self or others. Under the statute, reports must be made to the local director of community services who will then forward the subject's name and non-clinical identifying information to the NYS Division of Criminal Justice Services (DCJS). This information will be utilized by DCJS to determine whether an existing firearm's license should be suspended or revoked or whether a person will be ineligible to obtain a firearm's license. In this situation, law enforcement authorities are also authorized to forcibly remove licensed guns or firearms from an individual's possession. A separate section of the SAFE Act requires that all patients admitted to an inpatient unit on an involuntary basis be automatically reported to the National Instant Criminal Background Check System (NICS-100) using a state portal.

### Patient Confidentiality

One of NYSPA's overriding concerns about MHL §9.46 in general is that it may adversely impact the willingness of individuals to seek out or continue with mental health treatment. As many readers are aware, the duty of confidentiality between a doctor and patient is one of the core guiding principals of the practice of medicine and is even more critical in the context of the treatment of mental illness. Psychotherapy is unique among medical specialties in that patients' disclosure of their inner thoughts and feelings is often essential to the treatment of mental illness. If patients do not feel secure that the information they provide to a health care professional will be kept confidential, they may be dissuaded from pursuing necessary care and treatment.



Rachel A. Fernbach, Esq.

At the same time, however, organized psychiatry recognizes that the duty of confidentiality may yield to public health and safety concerns if a mental health professional concludes that a patient presents a serious and imminent risk of harm to self or others and that a breach of confidentiality might prevent injury or possible death. Other state law and generally accepted psychiatric practice dictates that such a breach would be justified only when a disclosure is made to a potential victim or to law enforcement. In this case, disclosure may prevent possible harm or injury either by notifying appropriate individuals or law enforcement authorities who are able to take immediate action, including bringing the patient to a psychiatric emergency department for evaluation. Without this element - disclosure to prevent imminent harm or injury - the breach of confidentiality would not be warranted.

### Proposed Bill Rewrite

To address its concerns, NYSPA suggested revisions to the bill to ensure that the duty to report is triggered *only* when the treating professional concludes there is a *serious and imminent* danger to the patient or others and that notification is also made to a potential target or law enforcement. NYSPA's proposed language closely tracks the standards already in place in MHL §33.13, which authorizes, but does not mandate, treating psychiatrists and psychologists working in OMH or OPWDD licensed or operated facilities to warn possible victims or law enforcement when they believe that a patient presents a serious and imminent risk of harm to self or others. NYSPA's proposed bill rewrite was shared with Governor Cuomo's office and many members of the Legislature, but unfortunately, it was not included in the recent state budget amendments and we await further action at the state level.

### Interaction with HIPAA

NYSPA is also concerned that the SAFE Act reporting requirement conflicts with the Health Insurance Portability and Accountability Act, a federal law governing the use and disclosure of personal health information (HIPAA). We believe that the SAFE Act conflicts with the HIPAA rule permitting the disclosure of health information to mitigate a threat to health or safety. Under HIPAA, such a disclosure may be made only if the threat is both serious and imminent and is made to law enforcement or to a potential target. To express its concerns, NYSPA filed a complaint with the Office of Civil Rights, a division of the U.S. Department of Health and Human Services which is charged with investigating possible HIPAA violations. As NYSPA pointed out in its complaint, which is currently under review, permitting MHL §9.46 to stand as written would place providers in New York in a situation where compliance with the state statute might constitute a violation of the federal statute.

### OMH Implementation

OMH has announced that all mandatory reports will be made using a web-based submission form available on the OMH website. The online form requires specific information about the provider as well as the individual in question and the reason the provider believes the person is likely to engage in conduct that would result in serious harm to self or others. It appears that OMH is not seeking a detailed medical or psychiatric history of the individual, but rather a straightforward declarative statement regarding the threat posed. A

sample completed report provided by OMH includes the following entry: "Sam has threatened to kill his wife and children by tomorrow." This statement provides sufficient information to indicate the nature of the potential threat and clearly indicates a level of imminence because the threatened activity is expected to occur "by tomorrow." Here, OMH has, in practice, inserted an element of imminence into the reporting criteria – in keeping with NYSPA's suggestions.

### Conclusion

NYSPA will continue to pursue changes to the new law to secure greater confidentiality protections in connection with the treatment of mental illness. With respect to the version of the statute currently in force, we are recommending to our members that they use reasonable professional judgment to determine when a report is mandated, keeping in mind that patients already admitted to an inpatient unit are unlikely to represent an imminent risk of harm to self or others. NYSPA's ultimate goal is to narrow the reporting requirement so that health care professionals are provided with clear and unambiguous guidance on when such a report is mandated. We believe that explicitly amending the statute to add imminence as well as notification to law enforcement and a potential target will enhance society's ability to protect public health and safety while balancing the need for privacy in the context of mental health treatment.

*Ms. Fernbach is a Staff Attorney at the New York State Psychiatric Association.*

*References: OMH (NYS Office of Mental Health); OPWDD (NYS Office for People with Developmental Disabilities).*



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## Web-Based Virtual Humans For Supporting Healthcare and Medical Needs

**By Joseph M. Brennan, Jr.**  
Chief Engineer, Institute of Creative Technologies Contract, U.S. Army Research Laboratory, Human Research and Engineering Division, Simulation and Training Technology Center

The rapid pace of Virtual Reality (VR) and interactive computer games advancements are producing significant opportunities for the health and medical communities. The Department of Defense (DoD) is capitalizing on these advancements through research centers such as the Institute for Creative Technologies (ICT); a University Affiliated Research Center (UARC) associated with the University of Southern California (USC) and being managed by the U.S. Army Research Laboratory's Simulation and Training Technology Center. Innovations being developed by this research center represent the start of a rapidly growing field. The SimCoach project is one of the efforts pioneering this growth.

The SimCoach project employs VR-based virtual humans for use in a web-based application which has the potential to revolutionize the internet. SimCoach characters act as virtual coaches offering expert advice, healthcare information, and support to the military community in mul-



**Joseph M. Brennan, Jr.**

tiples arenas to include depression, stress, brain injury, relationship counseling, substance abuse, suicide, rehabilitation, reintegration and other relevant specialties. The use of VR-based virtual humans to effectively serve as a virtual coaches, mentors, and trainers are well documented. There is a growing field of research that applies virtual human characters to training and assessment of bioethics, patient communication, interactive conver-

sations, history taking, coaching and mentoring, and clinical assessments.

The SimCoach project was developed to address current issues with the DoD and Veteran's Administration (VA) healthcare systems. Numerous blue ribbon panels of experts have attempted to assess the current DoD and VA healthcare delivery system and provide recommendations for improvement. These reports identified a need for enhancing the healthcare dissemination/delivery system for military personnel and their families in a fashion that provides better awareness and access to care while reducing the stigma for persons seeking healthcare assistance.

For example, the American Psychological Association (APA) Presidential Task Force on Military Deployment Services for Youth, Families and Service Members report stated that they were, "...not able to find any evidence of a well-coordinated or well-disseminated approach to providing behavioral health care to service members and their families." The APA report also went on to describe three primary barriers faced by the military community for behavioral healthcare: availability, acceptability and accessibility. Specifically the APA report indicated that: (1) Well-trained mental health specialists are not adequately available, (2) The military culture needs to be modified so that mental health services are more accepted and

less stigmatized, and (3) Behavioral health services are often not readily accessible due to a variety of factors such as long waiting lists, limited clinic hours, a poor referral process, and inaccessible geographic locations. The SimCoach application addresses these kinds of challenges.

Virtual SimCoach characters interact with users, in an anonymous fashion, to determine what their specific interests, concerns, and needs are. The SimCoach application then uses this information to guide users step-by-step towards getting the assistance they need. Based on the information obtained through these user interactions the SimCoach application gathers and provides relevant material such as articles, multimedia content, video testimonials of people having similar experiences, social networks and support groups, videos and information regarding various treatment options, and referral lists of live providers. The SimCoach application also provides assistance with scheduling appointments, the ability for users to perform simple neurocognitive and psychometric tests to inform self-awareness or aid in making decisions on initial referral options, and the capability to print out summaries of the computerized sessions so that users can bring these

*see Virtual Humans on page 26*

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**Early Warning Signs from page 1**

is the role of host or hostess being played with the goal of meal avoidance. When at the table, is food cut into a variety of small pieces, moved around the plate, flattened or smashed, but not eaten. We see that identity is not defined by achievements, interests, accomplishments and relationships. Instead the primary focus is on appearance, weight, make-up, and jewelry. Distorted body image is a constant with a rigid conviction of being fat with no change in self-perception through reality testing from clinicians, friends and family. We might see aversions to favorite foods or avoidance of foods high in fat, calories, oils or significant dietary changes like meat lovers transforming into vegetarians over night or a new pattern of eating food that is not liked or keeping old rotted food to create nausea or the loss of hunger. Reports of severe constipation, thinning hair dizziness/fainting, brittle nails, irregular periods or amenorrhea, complains of constant coldness with a drop in internal body temperature, baby fine hair covering the face or body (lanugo). Is pregnancy avoided due to fear of weight gain? Is breast feeding refused solely because of the need to immediately return to pre-pregnancy weight. Is there a family history of eating disorders or significant psychiatric illness. Do adults want or need to buy clothing in the children's department? Are only certain sizes of clothing acceptable for purchase? Are size tags quickly removed from garments? Is summer dreaded due to wearing shorts, bathing suits, sleeveless blouses or dresses? Do we see that salad dressing or sauces are ordered on the side and food secretly being thrown away or fed to pets. Are lunches, protein bars or shakes forgotten at home or quickly ditched?

**Rachel W. Bush, PhD****Bulimia Nervosa**

Clinicians find that there are periodic episodes of binge eating with compensatory food restriction or purging. It can be easy to miss the signs given that weight is normal or even over the desired weight range. There can be hoarding of food in rooms, gastrointestinal problems, severe dehydration, electrolyte imbalance, discoloration of teeth or poor enamel due to exposure to stomach acids. Swollen salivary glands (chipmunk cheeks), complaints of sore throats, mouth sores, or long periods of alone time sought to allow for episodes of bingeing or purging with complaints of low energy or chronic fatigue. It is not uncommon for dental check ups being avoided so that the signs and symptoms of illness are not revealed.

Is there a new use of candles, air freshener or fresh flowers in order to hide the smell of vomit? Is there a quick escape to the bathroom after meals with doors locked and loud running of water or radio use to prevent outsiders hearing vomiting. Is there a feeling of being invisible or unnoticed except when in the hospital? Is there a feeling of disconnection and out of body experiences associated with periods of binge eating or purging? Do we see recurring patterns of mood instability, impulsivity, addiction and feelings of numbness.

**Binge Eating-Disorder**

Recent reports from the Mayo Clinic indicate that BED affects almost as many males as females. Do we see individuals desperately seeking periods of free alone time to purchase high caloric junk food to ingest quickly. Is there evidence of weight gain or obesity. Do feelings of shame, doubt, embarrassment, avoidance of hobbies, not sharing meals with family or friends and ongoing patterns of social withdrawal. The challenges of recovery are greater given the length of time that the individual is symptomatic. There is a need for physical, spiritual, emotional, social reconstruction. Given longstanding obesity, high blood pressure and the development of cardiovascular problems is not uncommon.

**Eating Disorder NOS**

EDNOS is the most common diagnosis. However, it is frequently missed given individual variation in symptomatology. Chronicity is on the rise given difficulties in creating a routine of balanced healthy meals and the shift in focus on weight and appearance to relationships and emotional feeling states. Eating of non-food items is not uncommon. These

disorders are often overlooked medical illnesses due to co-morbidity. The complexity of chief complaints and differences in presentation can leave a clinician feeling de-skilled. There is a sense that nothing is routine or predictable given that important pieces of the clinical picture are missing.



**Future Treatment Planning**

By tuning into the warning signs of eating disorders earlier, we increase our ability to effectively prevent and treat eating disorders with psychotherapy (individual, family and group), nutritional consultation, pharmacotherapy, medical and dental follow-up care is no longer avoided when healthy weight is achieved and maintained. We can prevent relapse by extending periods of stability and the development of positive feelings associated with food, meal sharing, regular exercise, health and wellness. Ideally we will see greater productivity at work, relational connectedness and the true ability to fully care and love others and self. During my work in clinical practice I have been continuously filled with hope and impressed by my patients capacity for positive change.

For further information, visit The National Eating Disorders Association website at [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org). NEDA is the leading non-profit organization in the United States advocating on behalf of and supporting individuals and families affected by eating disorders. The mission of NEDA is prevention, improved access to quality treatment, and eating disorders research.

*Rachel W. Bush, PhD, is a licensed clinical psychologist with a private practice in Pound Ridge, New York. She can be reached by phone at (914) 764-1440 and by email at [Rbushphd@yahoo.com](mailto:Rbushphd@yahoo.com).*

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# Suffering from Mental Illness in the Orthodox Jewish Community

By Linda N. Baron-Katz

After being diagnosed with bipolar disorder, I had a tough time being accepted, especially in the Orthodox Jewish community. You see, I am an Orthodox woman – I keep my head covered, dress modestly, keep kosher, observe the Sabbath and Jewish holidays, and am readily identified as an observant Jewish woman. Community has always been very important to me, both as a Jewish woman, and as a woman in recovery.

Sadly, mental illness carries a lot of stigma in my community, primarily because of a lack of education and understanding. While the Orthodox Community is loving, nurturing and tight-knit, people with mental illness are sometimes treated as outsiders. Because of this bias, many Orthodox Jewish men and women are reluctant to “come out” as people living with mental illness, assuming that keeping quiet will keep them safe. But, choosing not to disclose makes many of us feel more isolated and alone within our very own communities.

For quite some time, I struggled to feel accepted within my own Orthodox community. I lived in a Jewish neighborhood, and was active in my synagogue. I wanted to marry someone from my same background – like most women in my community, it was extremely important to me to



**Linda N. Baron-Katz (L)  
Receives Award for Her Book  
“Surviving Mental Illness”**

get married and start a family. But when I first started dating, I found that Orthodox men ran away from me the moment I told them I had bipolar disorder. They would ask questions like, “Do you think you could handle having children?” “Would you be able to discipline a child?” or “Would you be able to keep a job?” I felt as if I was on trial for having a disability, and the questions became overwhelm-

ing. It might have been the way they were asked, but I had to wonder if they would use the same tone, or seem as concerned if I had said I had cancer.

While these questions might seem inappropriate to someone just starting to date, they are key values and concerns within my community. And as I heard the same questions over and over, I soon realized that I needed to find support from people who knew about mental illness and would not penalize me for it, people who would help me get serious about my life in recovery, including finding a life partner, making friends, and getting a job. I wanted the same things other women in my community wanted, and I was determined to get them, even if I was “different.”

I decided that if I couldn’t find community within my own community, then I would go elsewhere. First, I joined NAMI and got involved with the Friendship Network. Through this network, I dated a few Jewish men with mental illnesses. But although these men were Jewish, they were not Orthodox and I was unlikely to find a life partner among them. Having faith in Hashem (G-d) and Orthodox Judaism were still important to me, despite the challenges I faced in my community. So I decided to take matters into my own hands.

I realized that the first step would be to educate my own community. Through Havurat Yisrael, an Orthodox synagogue, I organized an awareness event entitled

“Stigma towards the Mentally Ill.” I invited three speakers from Community Access, a mental health organization in NYC, to participate in a panel discussion. The editor of Jewish Week helped by assigning a reporter and photographer to the event, to make sure the word got out. It was time for me – and others with mental illness in my community – to start talking about this topic openly.

Becoming an advocate in my community gave me the confidence I needed to have a fulfilling romantic relationship. I finally met someone I liked who also had a mental illness. Our mental health issues were not the only thing we shared. He had a similar religious upbringing and family values. More importantly, he was compassionate, and we understood one another in ways that I did not feel were possible with other men I had met. After a courtship, we married. Today, my husband continues to support me, no matter what I decide to do with my life.

But marriage wasn’t my only goal and community is bigger than a single relationship. With the help of the Women’s League at my synagogue in Kew Gardens Hills, I worked to put together more Jewish events focused on mental illness. Then I realized that other Jews in my community felt the same as me, so I formed a Peer Support Group called “Jewish Adults with Mental Health Issues.”

*see Orthodox Community on page 26*



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## A Word or Two on Setting Boundaries

**By Akavar Dylutra, Volunteer  
In Our Own Voice Program  
NAMI of Mercer County New Jersey**

**A**s I have worked my way through my recovery I have had to learn a few things about setting boundaries. Learning to set boundaries has become a very important part of getting myself a few steps closer to being healthier and happier.

I was absolutely clueless when the concept of setting boundaries first came up in therapy. It was probably group therapy in either inpatient or intense partial outpatient. I started hearing about how important it was to set boundaries. The idea that I needed to do such a thing absolutely horrified me. I could not imagine standing up to someone and saying: "This is what I need."

The thought of insisting on what I needed gave me an uneasy churning feeling in the pit of my stomach. This was a very familiar feeling – I had experienced this all of my life whenever I needed to stand up and assert myself. Up until four years ago I would drink, drug, or slide into another unhealthy behavior until the need to assert myself had passed. Consequently, I never learned any healthy ways to set boundaries.

I gradually started to learn to set boundaries. I had gone through all my savings and maxed out all my credit



**Akavar Dylutra**

cards. I was coming out of my impatient stay and had to go to the local social services office to apply for benefits. I needed to assert myself to continue to live. So I did.

I did not recognize it at the time, but I was starting to learn to set boundaries in a healthy way. I was very nice, but insistent. I quickly learned that I needed to quietly but firmly keep asking "What oth-

er benefits do I qualify for?" And always with a smile on my face. It was about the fifth time I asked the case worker this question that they finally volunteered that they could help with my rent. What a relief that was – until then I had no idea where I was going to live the next month.

So I could set boundaries and assert myself when I needed to do so. But I did not yet believe that I could. Nor could I do it on a regular basis. The thought of asserting myself still churned my stomach.

I tend to think about things and solve them logically in my head. Then it takes some time for me to understand them emotionally. I started to understand the logical need to set boundaries as I worked my way through therapy. I gradually started to set more and more boundaries, but that did not stop the churning of the stomach. But at least I was pushing myself to occasionally be assertive.

A quick aside on the difference between assertive and aggressive. For me, being assertive comes from a calm internal self-confidence. Aggression comes from fear.

One day I had an insight into my emotional issues regarding setting boundaries. I had never learned to set boundaries as a child. I came from a family with authoritarian parents who did not understand how to encourage a child to set healthy boundaries. I had learned that setting certain boundaries would get my parents angry at me. So I did not set those and

other boundaries – this made life in my family of origin much easier.

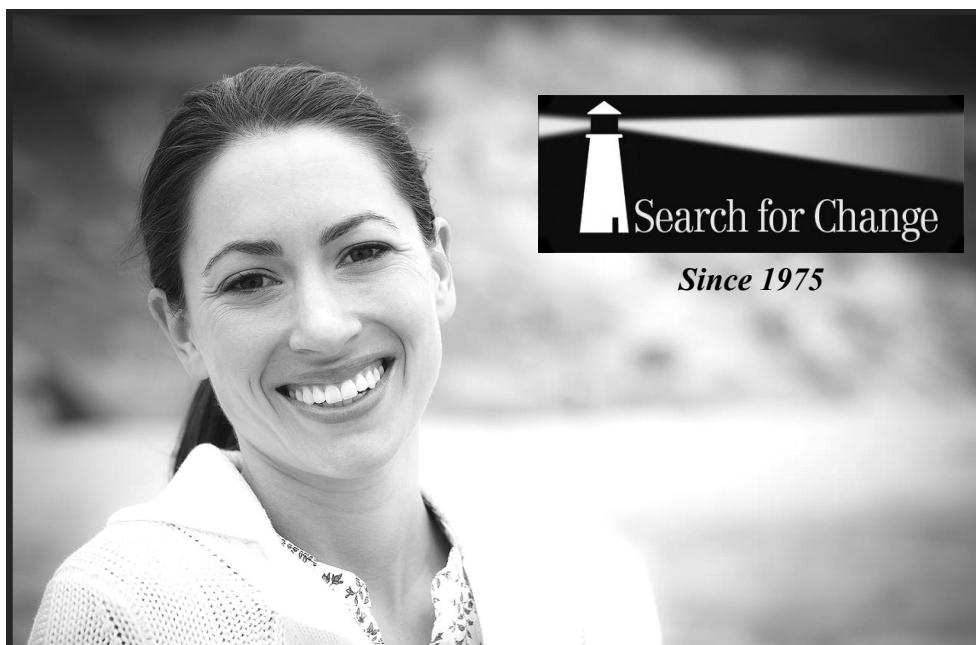
During my insight I realized that the idea of asserting myself had caused the lifelong churning of my stomach when I needed to set a boundary. Setting boundaries had caused such unpleasantness for me as a child that I continued to avoid doing so as an adult. The churning in my stomach was my emotional reaction to the frustration of not setting a boundary.

I started to realize that I fled the scene whenever the need to set a boundary came up. Then, I would get upset about not setting the boundary and lapse into unhealthy behaviors to cope with the unpleasant emotions.

The next step in my realization was that at times I would need to stand up and set a boundary. Since I did not know how to set boundaries in a healthy manner I would tend to be very unpleasant as I tried to set a boundary. As a child I would throw a tantrum or become physically violent in an attempt to set a boundary.

There are many unpleasant words to describe an adult who attempts to set a boundary and does not know how to do so in a healthy manner without "acting out." I was aggressive when I had to set boundaries. I was afraid that I would not be able to set the boundary so I felt I had

*see Setting Boundaries on page 26*



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**Trends and Controversies from page 8**

and relational disruptions in the etiology and maintenance of the ED.

For children and adolescents, with AN, Family Based Treatment (FBT) is now commonly regarded as a highly effective treatment approach. FBT, formerly known as the Maudsley approach, has long been in use in the UK but has only gained widespread application in the US over the past 5 years. FBT puts families in charge of their child's eating and nutritional stabilization and provides skills and support around ED, emotional regulation, and adolescent development. While it is a somewhat counterintuitive treatment for many clinicians, FBT has demonstrated effectiveness for approximately fifty percent of adolescents with AN. Indirectly, FBT has also had an impact on the ways in which we understand the families' role in the etiology of ED. More than any other factor, the development of FBT has cemented our recognition that many of the clinical features of families with a child with an ED may actually be a consequence of the burden of caring for a seriously ill child. In past years, even not very long ago, many clinicians still viewed these clinical features as etiological factors; parents, particularly moms, who were anxious and overly activated were automatically seen as "enmeshed" with their child, rather than appropriately anxious about a real threat. This has been a sea change in our understanding of AN in kids and teens, and represents perhaps, one of the most important positive changes in our approach and understanding of ED. However, as with all treatment modalities

appropriate case selection and continuing support from clinicians is very important in order for FBT to be successful.

There are a number of other treatment approaches that are developing a strong research base. Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), and a variety of experiential, mindfulness based approaches all have roles in the comprehensive treatment of ED.

#### Gaps in Our Understanding and Treatment

The good news is that we have increasingly diverse and well supported evidence based treatments for ED. But there are still substantial barriers to effective and accessible treatments.

**Complexity, Acuity and Comorbidity:** Many patients with eating disorders have associated medical and psychiatric comorbidity. Our best practices treatment guidelines are not specific enough to guide comprehensive treatment planning for patients with ED combined with other conditions such as primary depression and other mood disorders OCD and anxiety spectrum disorders, trauma histories and PTSD, substance abuse, or, for instance, diabetes. Clinicians must adapt these guidelines to fit the needs of individual patients, addressing not only the ED per se but also the patient's level of acuity and need for therapeutic structure or higher levels of care. Advances in genetics and neuroscience are directing our attention to some of the basic underpinnings of ED. These include both impulsive and dysregulated temperaments, especially in

patients with BN and BED and, for patients with AN, temperaments characterized by inhibition, harm avoidance and perfectionism. We also know that ED can cause or exacerbate relational and family difficulties and deciphering, articulating and addressing the relational impact of an ED on a family or vice versa, can be extraordinarily difficult.

Effective treatment requires clinicians to embrace conceptual complexity. We must adapt our treatments to address differences in temperament and learning, as noted above, but also to address things as basic as gender and age. Male patients, a fast growing subset of patients with ED, have some important differences in clinical presentation and treatment focus. Similarly, older women with ED, those above 30 years old for instance, are facing very different developmental and social demands than adolescent women.

**Treatment Acceptability:** Even our most effective treatments, FBT and CBT for example, help only about half of patients achieve full symptom remission. Many patients find these front line treatments helpful, but many others actually drop out of treatment early. Whether this is due to a negative response to the actual treatment or a reflection of the ambivalence they might feel about recovery, we, as a field, still lack treatments that most patients find acceptable. This is particularly true for adults with AN, for whom there is no current evidence based treatment. However there is a strong consensus that full restoration of healthy weight is essential for recovery.

**Training and Dissemination of EBT:** The dissemination of evidence based

treatments (EBT) is a common dilemma in health care and it remains a significant issue within the ED field. While training in treatments such as CBT, DBT and FBT are increasingly available, the vast majority of clinicians may not have access to specialized applications for ED. Just recently, there is an emerging focus on the actual study of best practices for dissemination; essentially a search for evidence based training for evidence based treatments. One of the less obvious issues is clinician attitudes towards evidence based manuals and guidelines. There is a significant debate about the pros and cons of specific guidelines; many clinicians feel that clinical researchers lack an appreciation for the complexity of front line treatment realities. Researchers, to caricature a bit, are prone to seeing clinicians as anti-science artisans who overvalue clinical intuition. The ongoing challenge for many will be weaving evidence based treatments into a clinical framework which takes maximum advantage of both relevant research and the beneficial nature of the clinician-patient relationship. ED professional organizations such as the Academy for Eating Disorders (AED) and the International Association of Eating Disorder Professionals (IAEDP) have both developed task forces to help address this ongoing and fundamental debate.

**Treatment Accessibility:** This is an underappreciated factor in our current treatment models. Most patients and families will struggle to identify, access and afford high quality treatment. Clinical recommendations for treatment intensity

see Trends and Controversies on page 25



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**Steve Vernon,**  
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## Revolution from page 10

health transformation.

### Ten Stages for Health Reclamation

Our program is built upon theory-based and evidence-based interventions typically applied to health promotion and disease prevention. The stages of the model are outlined below; the unique features of the program include one year commitments to help participants acclimate to new lifestyles; ongoing assessment, data collection, and data-driven decision making; a step-by-step syllabus outlining objectives; goals; knowledge, skills, and abilities to be acquired; and directed readings for discussion; weekly one-hour cohort meetings (five or six “matched” participants and a facilitator). Participation occurs exclusively via communications technology; and objective daily data reporting via: (a) Wi-Fi body scale (e.g., Smart Body Analyzer by Withings) that sends key measures (body weight, body fat percentage) to a secure account immediately available to program facilitators and co-participants, and (b) wireless devices to collect fitness and exercise adherence data online (e.g., Nike FuelBand). Uniform progress across key health indicators (body weight, body fat, cardiorespiratory health, muscle strength, flexibility) is emphasized. Interdisciplinary team support is given by various health professionals (nutritionists, MDs, psychologists, exercise physiologists) providing consultation to community members. The team is established to facilitate continuity of care, collaboration

among key providers, and to address every human need centered on weight control. Creation of a complete record of participants’ comprehensive progress is delivered (with consent) to physicians monitoring their health.

These features of our model are the foundation for guiding participants through the 10-stage program. This program is technology-driven; every stage is coordinated through the internet.

**Stage 1: Baseline.** The initial baseline stage includes a thorough assessment of personal eating patterns and contextual factors (e.g., restaurants) contributing to food choices and overall ingestive behavior. The program is designed for far-reaching quality of life changes; therefore, data are gathered on key physical health and fitness indicators and lifestyle status. Self-monitoring begins after this stage is completed.

**Stage 2: Self-Monitoring.** Researchers found that self-monitoring food intake yields 64% more weight loss. Consequently, program participants log information (e.g., caloric intake, nutritional balance, exercise adherence) daily. Self-monitoring systems may involve “high” or “low” technology based on personal preferences. The data from personal “learning logs” are summarized, graphed, reviewed, and analyzed weekly. Understanding personal eating and movement patterns is emphasized.

**Stage 3: The Motivational Interview.** Motivational interviewing is non-judgmental. The approach attempts to increase participants’ awareness of the potential problems caused, consequences experienced, and risks faced as a result of suboptimal health choices. The moti-

vational interview is a pivotal feature of the program scheduled after the requirements of the previous two stages are fulfilled. This is a participatory process whereby program members co-discover their own ingestive patterns and voice reasons for change. Participants also identify personal strengths, previous health-related successes, and personal preferences centered on food and physical movement.

**Stage 4: Planning for Health.** Planning is essential. The success of any health promotion program is related to the development of executive functioning skills, including planning, strategizing, organizing, setting goals, and attending to details that support healthy eating and exercise adherence. During this stage, participants schedule time for preparing grocery lists, shopping for a nutritionally balanced diet, preparing snacks and meals, and identifying a personal schedule for paced eating, exercise, and physical movement. Participants also set specific, measurable, attainable, relevant, and time-bound goals. Finally, participants write personal health mission statements to document their diverse and valued outcomes.

**Stage 5: Telehealth Community and Virtual Guidance.** Members join a telehealth community of five or six people working toward a common goal. The community meets weekly for one-hour teleconferences. Within the context of a community meeting, participants: (a) systematically advance through the information outlined in the syllabus, (b) review their personal data, (c) identify their areas of success and challenges, and (d) with their facilitator, troubleshoot and adjust

their individualized programs. Participants also develop a Personal Information Management system wherein they document all strategies and adjustments that produce positive health changes.

**Stage 6: The Easing Process.** All participants are “eased” into changes centered on: (a) nutritional balance (i.e., consuming the right amounts of calories, water, macronutrients, micronutrients, and high satiety foods); (b) the frequency, duration, and intensity of movement and exercise; and (c) the development of a health network. All decisions regarding the easing schedule are based on individuals’ data.

**Stage 7: Trigger Analysis.** Participants must begin formally studying their responses to: stress, social circumstances, restaurants, dehydration, long durations between snacks and meals, high glycemic foods, nicotine usage, alcohol consumption, weekend schedules, vacations, and sleep deprivation. A trigger analysis reveals correlations every participant must understand and ultimately manage.

**Stage 8: Exercise Intensity Adjustment.** Recommendations from the CDC regarding exercise intensity are reviewed. The interdisciplinary team guides the optimization of exercise based on participants’ physical, medical, and orthotic conditions; pharmacological regimens; and ages. Emphasis is placed on exercise diversity; perceived enjoyableness; developing healthy networks; plans for home, workplace, and vacation sites; and episodic illness.

**Stage 9: Relapse Prevention.** Recent estimates indicate that only 5 to 10% of people successfully keep weight off long-term.

see Revolution on page 26

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## Eating Disorders from page 1

Others get well but have relapses. Still others have a more chronic, or long-lasting, form of anorexia nervosa, in which their health declines as they battle the illness.

Other symptoms may develop over time, including:<sup>6,7</sup> (1) Thinning of the bones (osteopenia or osteoporosis); (2) Brittle hair and nails; (3) Dry and yellowish skin; (4) Growth of fine hair all over the body (lanugo); (6) Mild anemia and muscle wasting and weakness; (7) Severe constipation; (8) Low blood pressure, slowed breathing and pulse; (9) Damage to the structure and function of the heart; (10) Brain damage; (11) Multiorgan failure; (12) Drop in internal body temperature, causing a person to feel cold all the time; (13) Lethargy, sluggishness, or feeling tired all the time; and (14) Infertility.

**Bulimia Nervosa:** Bulimia nervosa is characterized by recurrent and frequent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes. This binge-eating is followed by behavior that compensates for the overeating such as forced vomiting, excessive use of laxatives or diuretics, fasting, excessive exercise, or a combination of these behaviors.

Unlike anorexia nervosa, people with bulimia nervosa usually maintain what is considered a healthy or normal weight, while some are slightly overweight. But like people with anorexia nervosa, they often fear gaining weight, want desperately to lose weight, and are intensely unhappy with their body size and shape. Usually, bulimic behavior is done secretly because it is often accompanied by feelings of disgust or shame. The binge-eating and purging cycle happens anywhere from several times a week to many times a day. Other symptoms include:<sup>7,8</sup> (1) Chronically inflamed and sore throat; (2) Swollen salivary glands in the neck and jaw area; (3) Worn tooth enamel, increasingly sensitive and decaying teeth as a result of exposure to stomach acid; (4) Acid reflux disorder and other gastrointestinal problems; (5) Intestinal distress and irritation from laxative abuse; (6) Severe dehydration from purging of fluids; and (7) Electrolyte imbalance (too low or too high levels of sodium, calcium, potassium and other minerals) which can lead to heart attack.

**Binge-Eating Disorder:** With binge-eating disorder a person loses control over his or her eating. Unlike bulimia nervosa, periods of binge-eating are not followed by purging, excessive exercise, or fasting. As a result, people with binge-eating disorder often are overweight or obese. People with binge-eating disorder who are obese are at higher risk for developing cardiovascular disease and high blood pressure.<sup>9</sup> They also experience guilt, shame, and distress about their binge-eating, which can lead to more binge-eating.

### Treating Eating Disorders

Adequate nutrition, reducing excessive exercise, and stop-ping purging behaviors are the foundations of treatment. Specific forms of psychotherapy, or talk therapy, and medication are effective for many eating disorders. However, in more chronic cases, specific treatments have not yet been identified. Treatment plans often are tailored to individual needs and may include one or more of the following:<sup>(1)</sup>

Individual, group, and/or family psychotherapy; (2) Medical care and monitoring; (3) Nutritional counseling; and (4) Medications.

Some patients may also need to be hospitalized to treat problems caused by mal-nutrition or to ensure they eat enough if they are very underweight.

**Treating Anorexia Nervosa:** Treating anorexia nervosa involves three components: (1) Restoring the person to a healthy weight; (2) Treating the psychological issues related to the eating disorder; and (3) Reducing or eliminating behaviors or thoughts that lead to insufficient eating and preventing relapse.

Some research suggests that the use of medications, such as antidepressants, antipsychotics, or mood stabilizers, may be modestly effective in treating patients with anorexia nervosa. These medications may help resolve mood and anxiety symptoms that often occur along with anorexia nervosa. It is not clear whether antidepressants can prevent some weight-restored patients with anorexia nervosa from relapsing.<sup>10</sup> Although research is still ongoing, no medication yet has shown to be effective in helping someone gain weight to reach a normal level.<sup>11</sup>

Different forms of psychotherapy, including individual, group, and family-based, can help address the psychological reasons for the illness. In a therapy called the "Maudsley" approach, parents of adolescents with anorexia nervosa assume responsibility for feeding their child. This approach appears to be very effective in helping people gain weight and improve eating habits and moods.<sup>12,13</sup> Shown to be effective in case studies and clinical trials,<sup>14</sup> the Maudsley approach is discussed in some guidelines and studies for treating eating disorders in younger, nonchronic patients.<sup>11,12,15-18</sup>

Other research has found that a combined approach of medical attention and supportive psychotherapy designed specifically for anorexia nervosa patients is more effective than psychotherapy alone.<sup>19</sup> The effectiveness of a treatment depends on the person involved and his or her situation. Unfortunately, no specific psychotherapy appears to be consistently effective for treating adults with anorexia nervosa.<sup>20</sup> However, research into new treatment and prevention approaches is showing some promise. One study suggests that an online intervention program may prevent some at-risk women from developing an eating disorder.<sup>21</sup> Also, specialized treatment of anorexia nervosa may help reduce the risk of death.<sup>22</sup>

**Treating Bulimia Nervosa:** As with anorexia nervosa, treatment for bulimia nervosa often involves a combination of options and depends upon the needs of the individual. To reduce or eliminate binge-eating and purging behaviors, a patient may undergo nutritional counseling and psychotherapy, especially cognitive behavioral therapy (CBT), or be prescribed medication. CBT helps a person focus on his or her current problems and how to solve them. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognize, and change inaccurate beliefs, relate to others in more positive ways, and change behaviors accordingly.

CBT that is tailored to treat bulimia nervosa is effective in changing binge-eating and purging behaviors and eating attitudes.<sup>23</sup> Therapy may be individual or group-based.

Some antidepressants, such as fluoxetine (Prozac), which is the only medication approved by the U.S. Food and Drug Administration (FDA) for treating bulimia nervosa, may help patients who also have depression or anxiety. Fluoxetine also appears to help reduce binge-eating and purging behaviors, reduce the chance of relapse, and improve eating attitudes.<sup>24</sup>

**Treating Binge-Eating Disorder:** Treatment options for binge-eating disorder are similar to those used to treat bulimia nervosa. Psychotherapy, especially CBT that is tailored to the individual, has been shown to be effective.<sup>23</sup> Again, this type of therapy can be offered in an individual or group environment.

Fluoxetine and other antidepressants may reduce binge-eating episodes and help lessen depression in some patients.<sup>25</sup>

### How Are Males Affected

Like females who have eating disorders, males also have a distorted sense of body image. For some, their symptoms are similar to those seen in females. Others may have muscle dysmorphia, a type of disorder that is characterized by an extreme concern with becoming more muscular.<sup>26</sup> Unlike girls with eating disorders, who mostly want to lose weight, some boys with muscle dysmorphia see themselves as smaller than they really are and want to gain weight or bulk up. Men and boys are more likely to use steroids or other dangerous drugs to increase muscle mass.<sup>26</sup>

Although males with eating disorders exhibit the same signs and symptoms as females, they are less likely to be diagnosed with what is often considered a female disorder.<sup>27</sup> More research is needed to understand the unique features of these disorders among males.

### The Hope of Research

Researchers are finding that eating disorders are caused by a complex interaction of genetic, biological, behavioral, psychological, and social factors. But many questions still need answers. Researchers are using the latest in technology and science to better understand eating disorders.

One approach involves the study of human genes. Researchers are studying various combinations of genes to determine if any DNA variations are linked to the risk of developing eating disorders.

Neuroimaging studies are also providing a better understanding of eating disorders and possible treatments. One study showed different patterns of brain activity between women with bulimia nervosa and healthy women. Using functional magnetic resonance imaging (fMRI), researchers were able to see the differences in brain activity while the women performed a task that involved self-regulation (a task that requires overcoming an automatic or impulsive response).<sup>28</sup>

Psychotherapy interventions are also being studied. One such study of adolescents found that more adolescents with bulimia nervosa recovered after receiving Maudsley model family-based treatment than those receiving supportive psychotherapy, that did not specifically address the eating disorder.<sup>29</sup>

Researchers are studying questions about behavior, genetics, and brain function to better understand risk factors, iden-

tify biological markers, and develop specific psychotherapies and medications that can target areas in the brain that control eating behavior. Neuroimaging and genetic studies may provide clues for how each person may respond to specific treatments for these medical illnesses.

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### *Inpatient Treatment from page 6*

with eating disorders found at 2-week follow up, that 41% of patients with AN and 50% of patients with BN who did not endorse the need for hospitalization at the time of their admission converted to believing they did need admission (Guarda 2007). The challenge to staff includes helping patients connect with their motivations for improvement, however limited they may be.

Intensive treatment for eating disorders is a potentially useful program of care for individuals struggling with weight and eating disorder behaviors who need more structured treatment than what traditional outpatient interventions provide. Offered across a range of settings, intensive treatment may be an effective way to manage the serious psychiatric and medical features that may be associated with AN, BN or BED.

### *Trends and Controversies from page 22*

and level of care can, and in fact often do, exceed the treatment authorized by insurers. This is not a simple issue; patients and families want the best treatment possible but insurers find it difficult to assess whether the treatment being provided is appropriate or effective. The burden falls, at least in part, on the clinical research community to develop better and more efficient therapies for ED as well as documenting the treatment strategies and programs that are effective.

*Definitions of Recovery:* How do we know when our patients are truly recovered from their ED? The answer to this question has important implications for treatment, the patient's quality of life, research, and insurance coverage. While some may see symptom remission, weight restoration and cessation of overt ED behaviors, as the threshold for recovery, many clinicians and researchers point to the importance of addressing key maintaining factors that can leave even symptom free patients highly vulnerable to relapse. These may include psychiatric and medical co morbidities, issues around emotional regulation, cognitive and learning factors, a number of personality and temperamental factors, and one's living and work environment. In our opinion, a full and lasting recovery from an ED requires more than simple symptom remission, at least for the ma-

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majority of patients, and our treatment models and conceptualizations of these disorders must be complex enough to cover these numerous bases.

### Summary

It is an exciting time in the ED field. Advances in our understanding of these complex disorders have generated optimism about improving treatment and treatment outcomes. There is a growing awareness of the role of evidence based treatments and, hopefully, increasing ability for patient and families to access specialized care. At the same time, we have to continue to embrace complexity and avoid the false security of reductionistic models of formulation, treatment and recovery. We need to address issues of age, gender, culture and ethnicity. In our opinion treatments must shift their focus from a search for etiological factors to a focus on the factors that perpetuate and maintain the disorders. New research is investigating the common underlying maintaining factors across multiple general psychiatric disorders, and this work may help us better address common transdiagnostic factors like emotional and experiential avoidance, temperament and mood dysregulation. Clinicians, researchers, patients and families all have a role in developing, studying, disseminating and advocating for high quality treatments for patients with ED.

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**Virtual Humans from page 16**

with them when seeking treatment.

Due to the success of the SimCoach project to date and the desire to expand the selection of virtual characters available in support of a wider range of other applications the United States Army Telemedicine and Advanced Technology Research Center (TATRC) funded additional development efforts to include a web-based authoring platform to allow the creation of new virtual characters and additional capabilities by non-technical users. The authoring tool, currently being referred to as Roundtable, is built upon a broad set of virtual human component technologies developed by the ICT to include computer graphics, animation, and natural language processing. Once created the newly developed virtual characters can then be deployed to standards-based web application servers and content-delivery networks for testing and use by potential users on the web. The Roundtable authoring system has been used for various other efforts including a regional veteran support initiative called BraveHeart, sponsored by the Atlanta Braves and Emory University, as well as a virtual guide for the U.S. Army Medical Department (AMEDD) in support of an Army Surgeon General-mandated annual

**Sample SimCoach Virtual Characters and Personalities**

professional quality of life scale questionnaire (ProQOL) for healthcare providers in response to increases in provider fatigue and burnout.

In the future, the Simcoach application is planned to be extended further by providing capabilities to create web-based virtual standardized patients (VSPs) which will be made available for use for training novice health and medical practitioners in the field in areas such as interviewing techniques, interpersonal communications skills, rapport building and performing assessment and diagnosis. Educators will be able to generate various types of VSPs quickly and easily to supplement existing curriculums which use

human standardized patients. Another extension to the Simcoach application which is planned in the future involves the development of virtual librarians to support user interactions with complex databases like MedLine.

In summary, the SimCoach application offers a new, exciting, and engaging means by which to empower the military population with the capability to gather healthcare information, understand their situations better, obtain advice, explore available options, obtain assistance with decision making regarding treatment options and referrals, access resources, monitor healthcare, and initiate treatment when needed. The technology is continu-

ally being repurposed and used for a variety of commercial and DoD applications.

**Conclusion**

Significant technological advancements in VR and interactive computer games have generated novel opportunities for the health and medical communities. Technical innovations, such as those being developed by the ICT, will continue to advance the health and medical fields and represent the start of a rapidly growing field. Additional information regarding these and other technological innovations being developed by the ICT is available at <http://ict.usc.edu>.

References used in the development of this article are available from the author upon request.

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**Setting Boundaries from page 21**

to be aggressive so that everyone knew I “meant business” on this one. My mentor used to tell me that I pulled out a buzz saw and ran everyone over. I guess I did.

Gradually I connected emotionally to the need to set boundaries. I started to learn to set boundaries without my stomach churning. I also learned how to set them without throwing the adult version of a tantrum.

Eventually I started to see that many other people did not know how to set boundaries in a healthy manner. Like me, they either did not set the boundary and became emotionally frustrated, or they set the boundary using their buzz saw as their aggressive force.

From this insight I started to see that many times when people are upset and in my face it is because they are attempting to set a boundary. Rather than react to

their upset, I attempt to understand the boundary they are trying to set. Usually this boundary is inconsequential to me and I am able to diffuse the situation by acceding to their boundary. I am not always able to get myself to that point, nor does the other person always calm down. But it is a start – these understandings do tend to help most of the situations I encounter.

At one point I started to look at my personal relationships through this lens of my inability to set boundaries in a healthy manner:

Suppose that Ignatz and Minerva wind up in a relationship and neither of them have ever learned to set healthy boundaries in a healthy manner. Suppose that Ignatz is always giving in when he feels the need to set a boundary. Ignatz is going to have pent up frustration from not setting boundaries when necessary.

One day Ignatz sets a boundary with Minerva, but in an aggressive manner –

remember, he knows no other way. This probably comes as a total surprise to Minerva. Minerva has probably never realized Ignatz’s need to set boundaries because Ignatz never stood up for himself before. Now Ignatz has stood up – but with a very aggressive stance.

Minerva has never understood how to set boundaries either. So she does not understand that Ignatz is just attempting to set a boundary. All Minerva sees is the aggressiveness of the boundary and she feels the need to set a boundary in self-defense and with equal aggressiveness.

This little example helped me to understand how deeply this inability to set boundaries affects our relationships. I use Ignatz and Minerva for convenience. This example can be extended to any relationship between individuals – relationships at work, parents and their adult children, even siblings. It helped me to understand why so many relationships

devolve into constant arguing and, unfortunately, physical violence. Most of the time, all people are trying to do is set boundaries. This inability to set healthy boundaries in a healthy manner on both sides causes a perpetual turmoil in many relationships.

I hope that these insights into setting healthy boundaries in a healthy manner helps you as much as they have helped me. Are all my boundary issues solved? Of course not. However, I have learned to take responsibility for my side. Other than to protect myself, I cannot do anything about another person who insists on aggressively setting boundaries.

At last my emotional understanding of setting boundaries is catching up to my intellectual understanding of the need to do so. With continual work I know that I will get them more closely aligned. Will I ever get “there”? I doubt it. After all... It’s a journey, not a destination.

**Revolution from page 23**

Participants must understand long-term weight maintenance, particularly calculating calories and balancing calorie intake and output (e.g., through exercise) and, more specifically, metabolism, the digestive system, and transitioning to a weight-maintenance lifestyle.

*Stage 10: Personal Relapse Recovery.* A recovery plan must be established before such a plan is required (e.g., 5-pound gain or exercise non-adherence). This stage of the program helps participants discover and understand their personal relapse triggers and high-risk situations that cause relapses despite their commitment to healthy living.

*The Person-Centered Revolution.* Katherine’s story is not uncommon. Many people, like Katherine, need step-

by-step guidance involving identification of personal strengths and preferences; knowledge of their personal patterns; interdisciplinary teams (nutritionists, physicians, psychologists); emphasis on self-control and self-efficacy within natural living conditions; telehealth, informatics, and a virtual community; skill building, nutrition and exercise planning; and a healthy network including family and friends.

We submit that the most compassionate treatment model involves a strength-based and person-centered approach. It is time for a revolution and paradigm shift through which individuals are the architects and co-creators of their own success and healthy lifestyles.

You can reach Dr. Cameron by email at: [behavioralhealth.cameron@gmail.com](mailto:behavioralhealth.cameron@gmail.com) or by phone at (818) 606-8229.

**Orthodox Community from page 20**

The group allows Orthodox Jews with mental illness to form a community of mutual support, and to learn together what it means to live a life in recovery.

Through all my endeavors, I have been able to not only raise awareness within the Orthodox community, but also help end the suffering of people who have

been isolated because of their mental illness. At the same time, having a sense of purpose and knowing I have played a role in reducing stigma in my community has helped with my own recovery. My vision continues, and I know I will continue to fight for what I believe in.

To learn more about my life with mental illness I invite you to visit my website: [www.surviving-mental-illness.com](http://www.surviving-mental-illness.com).

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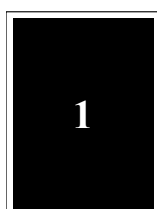
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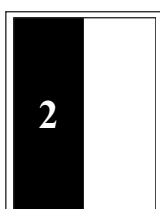
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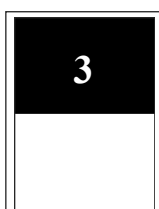
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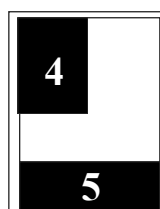
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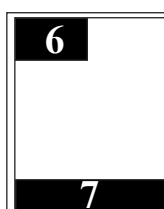
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