SPEAKER:
You're listening to Everyday Evidence presented by the American Occupational Therapy Association, helping the occupational therapy practitioner apply evidence to practice. Here is your host, Matt Brandenburg.

MATT BRANDENBURG:
Today, we are joined by Mark Hardison. Thank you so much for sharing your time and being a guest on the show today, Mark.

MARK HARDISON:
Yeah. Super happy to be here.

MATT BRANDENBURG:
Yes, I'm very excited that you're on the show and we get this chance to learn from you and to catch up with you a little bit. You are an assistant professor at the University of New Mexico, and you've published a lot of research related to physical and psychological impacts of musculoskeletal disorders, mindfulness-based interventions, and quantitative outcomes of therapy. You are a jack of all trades in a sense. As today we will be discussing occupational therapy and eating disorders, you were part of a 2023 intervention research grant awarded by AOTF for assessing the feasibility of the Restorative Occupational Approaches for Disordered Eating, or ROADE program. Can you tell us a little bit about how you became interested in studying disordered eating, and then we'll kind of tie in the specifics of this program?

MARK HARDISON:
Sure thing. So, I think it's interesting that you kind of point out my expertise as being jack of all trades because I do think that that comes through in the type of stuff that I've worked on. And I think maybe the reason that that's the identity that I have is because I initially did my dissertation when I was in grad school on using mindfulness-based strategies in hand therapy, which to a lot of people is kind of a strange pairing because it's this more mental health focused intervention that's in this very biomechanical biomedical setting. I mean, from my perspective, that was a pretty intentional choice trying to merge the more body-focused interventions that we do in OT with the more mind-focused interventions. And I'm a huge proponent of holism within our practice, trying to kind of address all the components of a person's experience. And of course, when you're having a upper extremity injury, then you're also definitely having a mental health experience related to that injury.

And so, that kind of thinking has been the foundation of a lot of the work that I do. And that same kind of thinking factors into why I've designed the ROADE program the way that it is and how I feel about treatment for eating disorder. I guess how it came into treating eating disorder is, well, I guess... I mean, to be honest, it was an ongoing project that when I arrived at UNM was something that another faculty member was working on. So, Sophia Gregory is the original person who created the ROADE program and was running it and I kind of hopped on, coming with some mindfulness expertise and built it into a research project instead of kind of like this more like passion project, like kind of free clinic that was just kind of beginning. And so, I brought my expertise on mindfulness and paired that with Sophia's expertise and understanding of eating disorder and mental health treatment in occupational therapy. And that is what has become ROADE.

MATT BRANDENBURG:
That's awesome. And I love the perspective that you have and that it seems that is really evident within the program ROADE of the mind-body connection of treating an entire person of approaching therapy and interventions very holistically, which I fully agree with you is at the core of occupational therapy and best practice. Mark, how would you describe disordered eating for those of us who may not know much about the diagnosis and kind of difficulties that someone experiencing disordered eating may be going through?

MARK HARDISON:
Sure. So, disordered eating comes in a lot of different varieties. There a few diagnoses that are in this kind of umbrella terms of disordered eating. But I think one of the key characteristics that unites this branch of diagnosis is that there's a very dysfunctional relationship with food. And that can be something that has a strong impact on people's kind of everyday life in that there is just this kind of ongoing internal struggle all the time about eating, either eating too much or not at all or the texture related to food or the kind of societal expectations that are put on us about eating. And so, really, it's this internal battle that people are fighting, which can be very challenging and very isolating because there's a lot of shame involved with the diagnosis. And there's a lot of stigma for a lot of different mental health disorders. But without getting like overly DSM diagnostic, basically, people are having an intense kind of emotional reaction to eating in some way and using eating or not eating as somewhat of a dysfunctional coping strategy to manage other mental health things that are happening in their life.

I don't know if that's specific enough.

MATT BRANDENBURG:
I love it. And that's such a great point how these diagnoses do come with that extra component of societal stigma and of concerns and factors not related directly to the person, to societal expectations, to pressure from others. And it's such an important ADL. As all OTs will know, self-feeding and nutrition, and intake too, it impacts health in so many different ways, both physical and mental. It's definitely really important for OTs to be able to address. How would you kind of describe occupational therapy's role in working with this population?

MARK HARDISON:
Yeah. So, that's a really big question. It's as specific as what each individual is kind of going through or needs support with or help managing. A few large common areas that I think come up a lot are managing symptoms like managing intrusive thoughts or managing maybe feelings of fatigue or perhaps anxiety that comes with eating or not eating. So, it's working around those symptoms often to still be able to engage in meaningful things like school or work or even just socializing or taking care of yourself day to day. And so, I think there's the more like accommodating side of what we do in occupational therapy where we're trying to work around problems, work around symptoms. And in eating disorder because it's such a really long-standing diagnosis that it just takes a long time to resolve. It's not something that is going to very quickly go away. And so, one of our big focuses really is around harm reduction and around working around symptoms as a starting point to try to help people lead a meaningful life.

And then once we're working on that, we also do symptom management. So, building coping strategies and helping people reduce the actual symptoms themselves and then truly working on some of the things that are at the heart of the eating disorder itself. So, that's kind of the full range. But those are the broad strokes. I think something that people might be surprised by, at least from my perspective, is that even though it's called eating disorders, we don't often work on eating and feeding, although we do work maybe on meal planning if that's something that somebody is open to. But I think one of the mistakes that often is made within the medical model for the treatment of eating disorders really is this over focus on the food. And that's because, I mean, in certain settings, eating disorders are very serious and can be fatal, and so there's a physical safety component in many of these settings especially inpatient. And so, focus on food is necessary in those settings. And I kind of understand it.

But the ROADE program itself is an outpatient program, and so we work with people who are well enough to be living at home and leading their daily lives on their own. For those individuals, I think they perhaps have been in or out of inpatient treatment. They've read lots of things online. They've worked with providers to talk about eating and feeding. And I think there's almost this reactivity to the idea of working so specifically on feeding and food. And so, while it can be valuable if the person is open to it - like I said, of course, I would not work on that with somebody if they were open to it. But I think it's more important to be working with the person holistically and managing symptoms to improve daily life than it would be to specifically be a kind of monitoring or forcing food on people in certain way or feeling like you're controlling food. And that's specifically because a lot of people who have eating disorder, it's like the control of what they eat is like one of the ways they're trying to regain control in their life, in a life that perhaps doesn't have a lot of autonomy.

And so, it's like... One of the things you can't force somebody to do is eat or not eat. It's a personal choice that people get to make. And it's often - not all the time - but it is often a way that people are reclaiming their autonomy. And so, I'm very careful about addressing the specific food components with a person until they're really ready to do that if that makes sense.

MATT BRANDENBURG:
It absolutely does. I think every OT wants the people they work with to have autonomy and to feel like they're empowered to make decisions that benefit their own health. As I'm hearing you describe that, I'm visualizing an iceberg. And it sounds like in the typical medical model, if someone is presenting with an eating disorder, they're just seeing the food and the feeding that's above the water and this iceberg but not really addressing all those underlying factors that can include someone's mental health, that can include their background and really all those holistic components of who they are that lead to symptoms or manifestations of this difficult relationship and insecure relationship with food.

MARK HARDISON:
Yeah, absolutely. And it is a thing that takes time and that once the trust is kind of built and when you work with somebody for long enough. I mean, I am a really strong proponent of the organismic theory of humans where people really do know what's good for them and how to move forward in their life. And clients are the ones that know best about what's good for them and what they wanna do in their lives. And so, like with the right amount of support and the right attitude and the right kind of approach that's very autonomy supportive, people do come around to working on food, but it's often not the first thing that we do.

MATT BRANDENBURG:
Yeah, absolutely. And I'm excited to dive into the details of the ROADE program and kind of see the process of what the first thing you do is and how it progresses. Before we dive into that, I wanted to ask a question about a specialized care for eating disorders because I've read that it can be difficult to find, especially for people who aren't admitted to inpatient facilities. Can you kind of describe that situation for us?

MARK HARDISON:
Sure. And so, I guess I'll preface that by saying that I know more about within the state of New Mexico than I might know for the rest of the United States. My perspective is kind of informed by that. But basically, like at least within New Mexico, there is basically just one specialized treatment facility for eating disorder. There's one in the entire state. They have an inpatient program, they have a partial inpatient program, and then they have outpatient services. If you're not able to get to that location, you know what I mean? If you live in a different part of the state, if you your insurance doesn't work with them for some reason or whatever the case is, you're kind of out of luck. And unfortunately, there's just not that many providers that really specialize in eating disorder. It's even within the mental health world. And, I mean, we'll talk about the OT world as well. But like even within mental health where treatment of eating disorder most often happens, it's really a specialty topic.

And maybe some mental health counselors will know about it. But I think it's definitely a very specific type of counselor that is equipped to work with somebody that has that particular diagnosis. And so, it can be really challenging to find good mental health care and good mental health care that knows how to work with somebody who has disordered eating. And so, I think from the larger perspective, just in general, I think it's hard to find good treatment for eating disorder. But even more so, for people who are living in the community, like perhaps they are discharged from the partial inpatient program, their eating disorder still exists. It's something that doesn't go away that fast. Not in the course of months, even not in the course of years. And so, I think there's this big gap, basically. We let these people go back into the community, but there's very little real support that's qualified to help them kind of reintegrate with daily life and manage the ongoing issues that are obviously gonna come up.

I mean, it's a chronic thing that kind of can wax and wane in a situation where you're in a very controlled environment, in an inpatient or partial inpatient facility. Maybe you recover in a certain context, but then once you're back out in the community and there aren't those supports, those same kind of like all of the structure that's involved in those programs, I think it can be very challenging for people. And so, there's definitely a need for more outpatient services for individuals who have eating disorder because it's just like, what do you do if you have a big relapse? What do you do if you start to kind of spiral back into old ways of thinking or whatever the case is? And of course, there are gonna be life stressors that come up, there are gonna be the kind of ebb and flow of life, and eating disorder symptoms are gonna kind of maybe come back up. And so, I think in that context, ROADE is hopefully moving towards meeting that need.

MATT BRANDENBURG:
I love that. I think access to services is so important to carry over, follow through and improved outcomes over time after receiving specialized and holistic individualized care. Let's go ahead and discuss the ROADE program. You proposed it, as a potential solution, a program that can kind of fill that gap in terms of providing access to services that people really need. What is the Restorative Occupational Approaches for Disordered Eating program, Mark?

MARK HARDISON:
So, thank you for asking, Matt. Yeah. So, it's funny because in the granting world, you always have to have some kind of catchy acronym for your thing. That's just the way that it works. The ROADE program, I think, hopefully, we chose this name in a way that is a little bit meaningful because we really do see the recovery path as a road. It's a long road towards living your best life. And so, first of all, the ROADE program is still in its very early days. I mean, I would love for this to be a solution, one solution, one component of the solution maybe for this gap in services that I've identified. But we're still definitely at the piloting phase. As far as I'm aware, there's very little other research or even really philosophizing thinking in general on eating disorder treatment within occupational therapy. And I would love for this program to grow and blossom and become some kind of realized clinic or manualized intervention that you could get certified in or something like that. That's very far in the future at this point.

So, we're still working on it. So, to describe the ROADE, I mean, it does have a very specific sequence of different modalities that we use. But from like a large perspective, the idea is that we're trying to help people reconnect with their bodies is a major component of this because people who have eating disorder often are ignoring or have reduced access to the signals of hunger and satiation and just in general, kind of a dissociation with the body itself. And so, one big component is kind of like I mentioned at the beginning of our discussion, like trying to work holistically with people from a mental health perspective and a physical health perspective. A lot of the modalities themselves are ones that try to promote awareness and connection to the body. So, there are components of mindfulness and yoga and lymphatic massage that are involved in this. And the general sequence that we do so far is we do three sessions that are targeted around different types of meditative practices.

And I'm somebody that is experienced in giving meditation. Then there are five sessions that are dedicated to yoga. And the kind of contemplative practice within the yoga still continues. I mean, it's not just a physical practice. It's yoga that is pairing the physical movements with breathwork and awareness of the body. And then there are two sessions that are focused on self-massage using lymphatic massage principles at this point. And then sprinkled in there are components of education about self-management, about mental health, about food, about harm reduction, and about kind of crisis management or wellness recovery action planning basically. It's kind of this pairing of educational components with the more active meditative modalities and then working on kind of problem-solving through everyday life. And so, like each session itself is kind of split into like a check-in and talking through symptoms and how they're affecting daily life, doing any kind of creative problem solving like you might do in any other OT setting, kind of talking through issues as they come up.

And that's very individualized. So, it's kind of hard to describe to you exactly kind of what that might be. I mean, if that's working around trying to make sure that somebody has safe foods that they can eat so that they have enough kind of energy to be able to attend class and not lose focus or something like that. Or if that's working on setting up their living space in a way that doesn't trigger them into a binge or... And so, I mean, it's just kind of hard to describe all the different individual things that you might work on in that component, but basically, that's the check-in phase and the kind of creative problem-solving around daily life and symptoms. And then that leads into some learning about the contemplative practice, like the meditation or the yoga and kind of maybe some philosophy about that and how to use it and then actually leading the activity, whatever that is, which is usually about 20 minutes, 30 minutes, and then a debrief at the end where we try to integrate people's experiences and kind of bring out insights that people might have had about how their body is feeling, feelings of hunger or being too full or whatever the case is, whatever was going on for them during the meditation, during the yoga, during the massage, whatever the case was.

I think is a really, really important final step because it helps kind of bring everything together as far as helping people reconnect with how their body really is feeling so that they can make choices about their life that are better informed by insight to do with how they're feeling physically as far as interoception or even physical pain or fatigue and things like that. That's kind of the large overview.

MATT BRANDENBURG:
Yeah. No. Thank you. It's so nice to get a sneak peek into the process and really framework of the program. You mentioned it sounds just really well designed in that there is a framework and there are steps that provide guidance and kind of an outline, but there's that room for creative problem solving and for creative clinical reasoning from practitioners and from patients as well to work together to really individualize care and address factors and performance areas that are most impactful to the person.

MARK HARDISON:
For sure. Oh, and I forgot to mention. As you're talking this, this cued up in my brain that the program progressively provides more and more autonomy. Like it starts out more prescriptive, where we are providing kind of this palette of different coping strategies that people can kind of try out a little bit and we lead it and we talk to people about if they liked it or not and their experience. And then as the program goes on, eventually we are asking the clients themselves to identify what do you want to do today as far as meditation or yoga or massage. Like what worked best for you and what do you want more of, basically? Because we're hoping that that bridges into daily life because the program is only so long. I mean, it's two months and it's 16 sessions. It's twice a week, but eventually it ends. And so, we're hoping that people have identified coping strategies that work for them and that they can begin to build the skill to do independently on their own. And then once the program is over, that they would continue to use, hopefully.

MATT BRANDENBURG:
That's such a good point. And it makes me wonder, what if all medical intervention kind of had that same emphasis of starting prescriptive with the end goal being autonomy for the patient?

MARK HARDISON:
Oh my goodness! That would be a revolution for sure.

MATT BRANDENBURG:
Thank you for designing this program and explaining things because I think it really highlights some important principles on the macro and micro type scale. I wanted to ask if you could kind of speak to why these types of programs with this autonomous focus and a program designed to address the psychosocial symptoms and also self-management skills for people with people with eating disorders, why are programs like this so important to someone's overall health.

MARK HARDISON:
And I don't think this is a controversial take, but maybe it runs a little bit counter to the way a standard medical care works, which is that as a health care provider, I think we have to acknowledge and recognize and accept that we have no control over whether or not people heal or recover. In order for people to do that, it has to be something that comes from within because we're only in people's lives so much. I mean, in ROADE program, we really have the luxury of seeing people twice a week for an hour, two hours out of their week, which is a lot in comparison to a lot of settings. And we get to see them for two months which, again, is kind of a lot in comparison to the way other settings in OT work. Even within that, you're only in their lives for a very, very small amount of time. There are so many other things that happen in people's lives that affect their recovery process. And so, my perspective of being a therapist is really I need to be helping somebody figure out for themselves what it takes and what it means to be on a recovery journey because I can't lead them there by the nose.

Like it's something that if I even tried to do that, it would probably be harmful because that would be kind of like putting myself at the center of their recovery journey. I mean, there at the center of the recovery journey. But helping people learn that they are in the driver's seat, that they are in control of the narrative of their life. I mean, what that means and removing the stigma of me needing them to recover from my own kind of selfish reasons of wanting to feel like a good therapist or control them to get better so that my research outcomes look good or something like that, or whatever the case is. I think it's also counterproductive. So, I think when you can kind of let go of those ideas that we have a lot of control in people's lives and start to lean into the idea that it's really a lot of them, and as much as we can help them feel like they're driving their life and building really with narrative reasoning, and narrative reasoning is one of the components that we work on, really building the story of who were they before they came to therapy, who are they now while they're in therapy, and where are they headed?

What type of person are they? What type of person are they becoming? I think are all really, really important questions in therapy and help people feel like they're the ones that are driving their life, which I think is very, very important and one of the most important things really at the end of the day.

MATT BRANDENBURG:
We'll get back to our interview right after this quick message. You all know, we really try to make research more consumable and applicable on Everyday Evidence. But did you know that just one minute of your time could help us to improve the show, improve the resources the American Occupational Therapy Association provides for practitioners and improve the application of evidence to practice within our whole field? Please take our one-minute survey. It's only three questions, and you can find the link in this and every episode's description. And support the AOTA in continued efforts to improve our podcasts and to improve the translation of research to practice. Now, back to the interview. Absolutely. That empowerment that can come through therapy absolutely should be a main focus for interventionists and practitioners. You've mentioned some of the intervention strategies that you incorporate at ROADE to help patients feel that and experience that. Could you highlight some of the research or your own clinical observations and experiences related to the positive impacts of what you mentioned, including meditation, light yoga, breathwork, lymphatic massage?

How do those interventions really affect performance and health for people with eating disorders?

MARK HARDISON:
Sure. So, mindfulness research is kind of an interesting spot because it gets associated with kind of new-age practices a little bit. And so, I think it's misunderstood perhaps by people that are less familiar with mindfulness as an intervention. But I would say especially in the year 2024, we are at a place with mindfulness research where it is very uncontroversial to say that mindfulness helps with a few specific things. Like there are multiple systematic reviews outside of occupational therapy within the mental health world that say that mindfulness, when provided in a way that is accurate and good and in the correct dosage by a trained provider, that mindfulness improves people's anxiety, improves people's depression, and helps manage chronic pain. That's something that's been borne out over the research, especially the past decade, I would say. So, where does that leave occupational therapy? Well I mean, one of the issues is that there's very little research in general on mindfulness specific to our practice area.

So, it's something that gets given by psychologists, psychiatrists, medical doctors, perhaps. But there isn't a lot of research that identifies how OTs could or should use mindfulness-based practices as an intervention. And so, that's kind of where the research stands. I guess it's really hard to encapsulate this total literature body, but I'll just give very brief kind of talk on this, which is that the reason that mindfulness works, in my opinion, and this is backed up by research, is that it's kind of this layered effect in which there is just from breathing in a regulated way with no other kind of components of mindfulness, just regulated breathing itself has a physiologically positive response. It helps people relax. On top of that, you're getting the cognitive exercise of kind of building your sense of non-reactivity and open and awareness kind of curiosity about how you're feeling. And then that itself has an additional effect to the regulated breathing. And then like all interventions, of course, there is just the fact that you feel like you're getting some kind of positive benefit because you're doing an intervention.

So, it's all three components. There's a particular article... I don't know if this is something that you folks do. But there's a particular article by a researcher out of UC San Diego whose last name is Zeidan, and he did a randomized controlled trial about managing pain. And he had different conditions in this randomized controlled trial that kind of bore out each of these components. There was just a breathing arm to the intervention. There was a breathing and sham. So, breathing where they told people that it was a mindfulness activity, but it was not actually a mindfulness activity, so they're pretending. And then there was the real mindfulness activity. And so, you could see the difference in pain management for each of these interventions was kind of an additive effect. And the one that worked the best for pain management was, of course, the mindfulness meditation itself, building on all three components of the breathwork, the actual just effects of having something that's an intervention and then the true cognitive exercise of the mindfulness itself.

And I'd be happy to share that article or a link to that article if that's helpful.

MATT BRANDENBURG:
Please do. And we'll be sure to make it available in our episode description so all the listeners can check it out. That is so interesting. And hearing you describe kind of the positive effects of mindfulness meditation to really improve what sounds like interoception, self-acceptance, self-guided coping tool. Those are the types of things that it makes sense. Occupational therapy practitioners want their patients and the families and everyone they work with to gain those types of skills to really take on their own challenges as they come down the road when they're out of the program and really feeling empowered to take things on their own.

MARK HARDISON:
For sure.

MATT BRANDENBURG:
Could you take us through an example of how you would implement an intervention like this?

MARK HARDISON:
Ooh, that's so challenging. So, I think I don't know if you're gonna think this is deflecting, but here's what I'll do instead.

MATT BRANDENBURG:
No problem. Hey, (CROSSTALK) creative problem solving right now.

MARK HARDISON:
Yeah. Let me talk through some of the ways that I think occupational therapists can begin to integrate this type of thinking into their practice. Because it's a progressive thing that requires training, it's not something that I would recommend that you just go out and do, especially if you don't have your own personal practice of meditation, and especially if you have not been specifically trained to provide meditations. Now, the beautiful thing of our technological age is that you as a therapist don't have to be the one giving the intervention. You can outsource that to lots of free resources that are out there that I think are very reputable and wonderful. So, I guess let me talk you through the kind of progressively more intense ways in which you can incorporate meditation into your OT practice. Is that fair?

MATT BRANDENBURG:
I love that. Yeah, that sounds wonderful.

MARK HARDISON:
So, the first one is maybe overly self-evident. I think for many therapists, I hope this will be helpful, which is that just integrating the philosophy of meditative practice into your thinking can be helpful. And so, let me explain what I mean, which is that mindfulness itself is this open, curious, non-judgmental way of approaching your physical experience. And so, I think especially for our settings where clients are dealing with a lot of pain, engaging with how your physical body is feeling is very uncomfortable. And maybe doing certain exercises, stretches, strengthening activities, or occupations of daily life that involve using your physical body and interacting with your symptoms might cause a lot of physical pain. And so, I think building a attitude with yourself and encouraging this in your clients of openness to uncomfortable feelings. And so, again, I don't know if that's like overly self-evident, but the idea of sitting with your client and being like, yes, it is painful when you do this.

And of course, within the bounds of what's safe, let's engage with that. What does the pain feel like? When does it come on? How strong is it? Where in your body? Because there's this issue that is really common to the human experience, which is that the more we fight something, the harder and worse it is. Like the pain itself becomes this demon instead of just really what it is, this physical experience that's uncomfortable that we don't like. And so, encouraging this open and non-reactive relationship with pain or even with other uncomfortable sensations like anxiety, stress, worry. Those are all valuable human experiences and encouraging our clients to just non-judgmentally be aware of them. Just for a moment not try to change them, not try to avoid them, not try to make them go away. Just noticing them for everything that they are. That itself can help with acceptance and may even reduce the true physical experience of the uncomfortable feelings. And it's really the fight against the feelings themselves that causes some of the suffering.

So, that's my first kind of level. And I think that's very uncontroversial. You don't need a lot of training to do that. It's more just like an approach to how you work with people and how you understand and explain how to engage with uncomfortable sensations, feelings, experiences. So, that's level one. Level two is perhaps you can come up with a way to encourage people to use reputable mindfulness resources outside of therapy times. So, if that means having a set of headphones and some kind of MP3 player set up in your clinic that has a reputable meditation on them that clients can use before session, perhaps, as a way to help arrive at therapy. You know what I mean? Like, maybe people are getting out of work and rushing over and fighting traffic, and they're in pain and they're mad because, I don't know, it's just like challenging to deal with a medical condition when you're trying to live your life. So, helping people kind of come down from that anxiety and relax before they enter therapy can be really valuable.

And that doesn't require any training on your part. It might require purchasing some resources as far as the headphones and the MP3 player and maybe even purchasing a service to do with meditation or something like that that you can give to your clients. But that's not like a billable service. That's just something like in the waiting room, maybe you could have this. Or maybe you could have resources that you email to clients to help them fall asleep at night because we all know that if you're getting poor rest, that can interact with your healing process. So, getting better rest. And really, that is one thing that mindfulness at least in my personal clinical experience that my clients use the mindfulness for the most is to fall asleep because it helps them relax. So, those are ways outside of therapy where you could use the kind of mindfulness idea and that doesn't require any training, but it does require some resources. Level three is... And this one requires you to get training. So, here's the kind of the line.

And I wanna be very clear, in order to use mindfulness-based practices, you specifically need training to do so. You cannot just go out and do them. And there are... I think there right now I'm aware of at San Jose State, there is a certification that you can get in using mindfulness in OT. And I'm also aware of a occupational therapist out of Massachusetts who does sensory-enhanced yoga training that's like an online course. And I can kind of find those materials if that would be helpful. So, I'm not saying you necessarily need those and then there's not an endorsement of those specifically, but I'm just saying some kind of training specifically to do with implementing mindfulness is necessary for step three and step four. So, step three is maybe lightly including some mindfulness elements within your actual therapeutic activities. So, not just focusing on meditation, but maybe as we're doing this stretch, as we're doing this physical exercise, as we're doing this occupation of whatever the case is, engaging with it and leading it as the OT using mindfulness kind of cues for openness and curiosity and experiencing the kind of fullness of what it means to be doing that occupation.

And so, that's not like necessarily changing the type of intervention that you're doing. It's more changing how you're doing it if that makes sense. And then of course, step four would be actually using a guided mindfulness meditation as a therapeutic activity where you're training a coping strategy. And so, of course, you would need to relate that back to a particular symptom of a diagnosis that you've been referred from a doctor (UNKNOWN). So, if that's managing anxiety or managing chronic pain and teaching this self-management coping strategy that is specifically just a standalone mindfulness activity. So, those are kind of the four levels. Again, it's the attitudes themselves. It's providing outside resources. And those don't require training. What does require training is integrating the how you provide your typical OT services already with some mindfulness guiding along the side, or specifically doing a whole mindfulness activity itself that stands alone.

MATT BRANDENBURG:
I love that. And thank you for presenting that in levels. That's so beneficial to our listeners. Really, level one sounds like just using an empathetic approach to therapy that hopefully everyone is striving to do, but with that mindfulness focus. What have you seen as some of the outcomes of the ROADE program after implementing mindfulness and following the program? What positive effects have you seen in the lives of participants?

MARK HARDISON:
I don't want to pre-empt my research results. And so...

MATT BRANDENBURG:
And if not specifically related to the ROADE program, then maybe what positive outcomes have you seen by implementing mindfulness and other similar strategies in someone's overall health?

MARK HARDISON:
Sure. So, here's what I can share, which is... Again, I'm being a little bit careful because I don't want to provide a biased picture of the results of my study because we haven't fully completed things. And I can only really tell you anecdotally kind of my experiences. And of course, one of the outcomes of ROADE is actually a qualitative interview that I conduct that is open-ended. And so, people tell me how they're feeling and their experiences and things like this with all of that in mind. But in my experience of providing mindfulness meditation just in general across multiple projects, in my personal life, in my academic life with students where I've run groups, just in general, there seems to be kind of like a range of experiences that people get. And one of them is, ah, it didn't work for me. And that's completely fine. Like, I don't wanna stand here and tell you that mindfulness is gonna work for everybody because it's not. There needs to be a element of choice and kind of goodness of fit with the person and the way their mind works and where their mental health is at right now.

Also for people who are experiencing very strong mental health symptoms, like if you're having a panic attack right now, you should not be doing mindfulness. Or if you're having a strong uptick of anxiety, it can be very painful to do mindfulness because you're intentionally focusing on some of these things. And so, there are some situations where mindfulness is not indicated and some types of people and some types of brains that mindfulness does not work or it's not their preference. And that's completely fine. And so, if you're working with your clients on this, then you should definitely consider choice. Now, there are a much larger percentage of people who find mindfulness meditation to be very, very relaxing. And of course, that's not like the goal of the meditation. The goal of the meditation is just to become aware of how your body is feeling and that has a natural, relaxing effect for a lot of people. And so, sometimes people say, wow, this is the most relaxed that I've been in like this month after I give it to them for the first time, which... You know, that's a subjective experience and perhaps it's helpful.

And certainly, in the moment, it has changed their kind of interaction with the world. But in order to have a kind of a stronger effect, a more pervasive effect, it takes practice. It takes doing it multiple times, learning the practice on your own and kind of engaging with it as a habit. And then there's a third group of people which are like, oh man, I fell asleep and I love that as well, actually, because I'm like... And I don't want anybody to feel like they're doing meditation wrong because you're not. When you're doing meditation and you feel sleepy, what that's telling you is that perhaps that you are tired, which I think is a valuable insight to have and maybe will help you kind of make choices in your life that will facilitate more rest, hopefully. If you fall asleep during meditation, I think that's wonderful. And in fact, maybe you can use meditations to help you fall asleep if that's something that is troubling you. So, I think those are kind of in my experience, in total, those are the range of reactions.

Again, that's not specific to ROADE, and I just I'm too hesitant to say anything. I don't want to spoil the results of the study. And I certainly don't wanna preempt and try to make some kind of conclusion before all the data has been borne out. So, I apologize that I can't say more.

MATT BRANDENBURG:
No need to apologize. We appreciate and support unbiased and scientifically sound research on this show for sure. And I think that just means we're gonna have to have you on again to talk about how the program ended up going.

MARK HARDISON:
Sure. I would love to do that.

MATT BRANDENBURG:
You mentioned some considerations for practitioners, including someone's ability to live independently before implementing certain types of interventions for people with eating disorders. Are there other considerations or recommendations that you could give to practitioners who may work with people with eating disorders?

MARK HARDISON:
Oh, yes. That could be its own podcast like on its own. I think because there are not that many people who work specifically with people who have eating disorders who are OTs, kind of what you're saying is like eating disorder can often be comorbid with a lot of things that traditional settings of occupational therapy work on. So, something that comes to mind is like autism is sometimes comorbid with ARFID or avoidant restrictive food intake disorder, which is an eating disorder. Or perhaps even just our clients that come to us for another reason unrelated to anything to do with mental health that might happen to have bulimia or anorexia or something like this. I think it's very important to make sure that you are not unintentionally stigmatizing weight. I think developing an attitude within our clinical practice that is very body-positive, that talks about food and nourishment in a positive and healthy way, that does not endorse diet culture, that does not make comments about the way people's bodies look.

From an aesthetic standpoint, I think it's very easy to unintentionally be harmful because people who struggle with eating disorders is often - like you had kind of said - it's like an iceberg. It's very much under the surface. It's something that's done alone privately. And kind of in this cycle of shame often, I think it's very important to be gentle and to support people and make sure that we are not feeding into the societal stigma that is around weight and bodies. So, that's what I'll say.

MATT BRANDENBURG:
I love that. That's a wonderful recommendation. And like you mentioned earlier on, it's a process. Someone has a diagnosis like this, it's gonna be a journey. And I think that makes such clear sense that a practitioner should approach it knowing that it's going to be a journey and being gentle to really establish a positive relationship upon which someone can build and grow and become more autonomous. Like we've discussed, is really the end goal.

MARK HARDISON:
Absolutely.

MATT BRANDENBURG:
What additional resources would you recommend to our listeners who would like to learn more about the topics we've discussed today?

MARK HARDISON:
So, a resource that I like to use a lot is the - I believe it's the Mindfulness and Awareness Research Center out of UCLA. They have a fabulous website and they have free guided meditations. Again, I'm not sponsoring them. I'm not endorsed by anybody in particular. But this is just what I like and what I've used. There's also a KORU mindfulness, K-O-R-U mindfulness. Is a resource that is geared towards students, like college students. And I think they're pretty good. They have some free resources, but also it's something that you may have to pay for. If you're interested in kind of the interaction of mindfulness and occupational therapy, I wrote a scoping review in, I think, 2017 that was about that topic that was published in AJOT that I can provide resource for. I don't know. I mean, just there are so, so many mindfulness resources. I think if you're a therapist and you're looking for the kind of... What's it called? Brand name mindfulness intervention, the one that has the most research behind it, the one that I think is the most reputable is called Mindfulness-Based Stress Reduction, and it is originated by Jon Kabat-Zinn in the 80s.

And I think the intervention is wonderful. And you can buy the book called 'Full Catastrophe Living', which is by Jon Kabat-Zinn, which I think is a fabulous resource as a place to start. Of course, you would need more training and kind of more learning and experience. So, don't just read the book. But I think that's a good kind of step into the world of mindfulness meditation and healthcare.

MATT BRANDENBURG:
Absolutely. And, Mark, you've already shared so many wonderful nuggets of knowledge with us today. We conclude each show, however, with the Golden Nugget segment. And I wanna ask if you could share one piece of knowledge or one recommendation to practitioners. What would you say?

MARK HARDISON:
Ooh! I like this question. I would say the thing that will be the most helpful for all kinds of practitioners is to build your own practice for yourself as a starting place and kind of experiment with meditation or contemplative practices in general and make sure that you're just breathing before each encounter. Maybe just take a couple big deep breaths and reset, reorient to how your body is feeling, work on understanding, accepting the emotions that you're having within the clinical space, and then move in to do your treatments.

MATT BRANDENBURG:
I love that. That's such a wonderful nugget. Thank you again so much for your time today. I think our listeners are really gonna appreciate this. This is a profession that includes a lot of empathy. And I know a lot of us experience burnout and that last nugget to reset and to take time for yourself to breathe I think can be so impactful.

MARK HARDISON:
Absolutely.

MATT BRANDENBURG:
Awesome. Well, thank you again, Mark. It's been wonderful having you on, and hopefully, we can catch up again to discuss more of the outcomes from the ROADE program. If you would like additional information related to the ROADE program and Mark's ongoing research, feel free to send him an email at mhardison@salud.unm. That's M-H-A-R-D-I-S-O-N- @-S-A-L-U-D.unm.com.

MARK HARDISON:
Thanks, Matt. It's been a lot of fun.

SPEAKER:
Thanks for listening to Everyday Evidence. Tune in next time for more evidence-based practice, insights, and applications.