

Message from the President

Stephen Wonderlich, Ph.D.

I hope this note finds each of you well and that the ending and beginning of the millennia have gone smoothly. I am pleased to tell you about several changes that are occurring in the Academy that I think will benefit all of our members and the entire field. As most of you know, the Academy is growing dramatically, both in terms of membership and opportunities to pursue our basic mission: to promote excellence in research, treatment, and prevention of eating disorders. In order to keep up with our growth and plan for the future, the Board of Directors, along with our Central Office, Education and Training Director, and all of our Past Presidents met for a strategic planning meeting on October 10 & 11, 1999 in Toronto, Ontario. The two days were packed with brainstorming sessions, problem solving, and developing action plans for the Academy. We were joined by Carolyn Pizzuto, of Cleveland, a professional facilitator, to help us push the limits of our creativity and also to keep us on task. I wish each member could have been present to see the enthusiasm of the group as we addressed the future. We candidly considered and discussed our perceptions of the Academy's strengths and weaknesses, as well as obstacles which could hinder our development in the next decade. Collectively, the group envisioned the Academy as becoming the premiere resource for training and education, research, prevention, and advocacy in the field of eating disorders.

We spent considerable time developing the following five specific goals that the Academy will pursue over the next few years. First, we will grow and involve a balanced and multidisciplinary membership. Specifically, we seek to have 1,000 members by the end of the year 2000, expand Special Interest Groups, and develop criteria for Fellowship status in the Academy.

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The American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorder (Revision)

Joel Yager, M.D.

After several years of development, the revised American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorder was published as a supplement to the American Journal of Psychiatry in January 2000 (volume 157 #1). This document represents considerable work and substantial updating, and reflects major input by many members of the Academy for Eating Disorders. The core work group consisted of Drs. Arnold Andersen, Michael Devlin, Helen Egger, David Herzog, James Mitchell, Pauline Powers, Alayne Yates, Kathryn Zerbe and myself, virtually all people who have had a serious long term relationship with the field. The various drafts drew several hundred pages of helpful and instructive comments and suggestions from literally dozens of consultants and commentators well known in the eating disorders community and from a large number of professional and advocacy organizations. All these comments were taken into account in putting together the final draft. Although the guideline is purportedly written for psychiatrists, in fact the document is broadly written so that it should be useful for clinicians of all backgrounds and persuasions. The input and influence of psychologists, adolescent medicine specialists, other primary care physicians, registered dietitians, social workers and other caregivers has been significant.

Since the document fills 30 wordy two-columned journal pages, has seven instructional tables, and contains 356 references (coded by the nature of the supporting evidence), I can only touch on some of the more important highlights. Members of the Academy are certain to want copies of the revised guideline for study and for files.

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Two Newsletter Issues on "Standards of Care"

David M. Garner, Ph.D.

This issue as well as the next issue of the Newsletter will be devoted to the topic of "Standards of Care for Eating Disorders". Pressures from consumers, managed care companies and credentialing institutions have led to increasing concern about establishing standards of care or practice guidelines in the treatment of eating disorders. The Academy has been acutely aware of this issue and its members were major contributors to the recent American Psychiatric Association revision of the Practice Guidelines for the Treatment of Patients with Eating Disorders. The aim of the next two issues is to continue the discussion of standards of care with articles that address specific topics of interest in the management of eating disorders. In the first featured article, Dr. Joel Yager will summarize the recent APA practice guidelines for the treatment of eating disorders. In the second featured article, Dr. Pauline Powers outlines psychopharmacological approaches to eating disorders. In the third article in this issue of the Newsletter, Dr. Debra Boardley provides suggestions to dietitians for the treatment of eating disorders. The next issue of the Newsletter will feature three more articles that address standards of care. Dr. Pauline Powers will discuss standard laboratory values for eating disorders. Dr. Craig Johnson will discuss the use of former or recovered patients in the treatment of eating disorders and Dr. Peter Beumont will address the Australian experience with standards of care.

It is important to emphasize that these articles do not in any way represent the official position of the Academy on Standards of care. The articles are intended to stimulate discussion by the Academy members regarding standards of care.

Reactions to these articles are welcome; we will possibly publish comments in a subsequent issue of the Newsletter.

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SIG/Division Workgroup Report

Pat Fallon, Ph.D. and Marsha D. Marcus, Ph.D.

During the last couple of years as the membership in the Academy has grown, the Board has been involved in ongoing discussions about maximizing membership participation in areas of interest in the field. We are also concerned that our members feel that they have both a home base and a way to communicate across disciplines. Initially, Academy Divisions were created to provide a way for members of our organization to identify with their respective professional groups. However, as we have evolved and grown, we have recognized significant limitations inherent in this approach. First, we heard from some members that they did not feel that they had an appropriate division with which to affiliate (e.g. marriage and family therapists or university counseling center folks). Second, the way that the divisions were structured actually seemed to work against the Academy's mission, which is to promote interdisciplinary interaction between professionals. And finally, several of the Divisions reported a lack of member interest in attending Division meetings and no clear mandate for Division initiatives (e.g. at the San Diego meeting the Psychiatry Division actually decided to disband).

After extensive debate and discussion, the Board had decided that in order to further the collaborative, interdisciplinary mandate of the Bylaws, it will be more effective to subsume divisions under the umbrella of Special Interest Groups (known affectionately as SIGs). We feel that this is the best way to facilitate interaction among people with common interests in a way that allows cross-fertilization between disciplines and encourages the enrichment of the Academy by providing ideas from diverse fields. To this end, it was decided that initially each division will become a SIG and we will then see if there is enough interest in maintaining individual SIGs at future meetings. Additionally, we want to encourage the development of other topically oriented SIGs (e.g. eating disorders in males, psychodynamic psychotherapy). We also want to facilitate the ability of members to belong to more than one SIG by providing a variety of SIG meeting times at conferences so Academy members can attend more than one meeting.

We have drafted the Policy and Procedure for the creation and governance of SIGs and have named Eric van Furth, Ph.D. as SIG coordinator to facilitate the work of the numerous groups. We would welcome your input in the ongoing process of helping the Academy meet the challenging needs of members as we grow.

Psychopharmacological Approaches to Eating Disorders

Pauline S. Powers, M.D.

Introduction

At present, psychopharmacologic treatment is not the first line of treatment for any of the eating disorders. For bulimia nervosa patients, cognitive behavioral therapy (CBT) is more effective than medication¹ and for anorexia nervosa patients, the first goal of treatment is weight gain. Nonetheless, medication can be very helpful for many patients at various stages during treatment. In the following discussion, the evidence-based psychopharmacologic treatments for bulimia nervosa (BN), anorexia nervosa (AN) and binge eating disorder (BED) will be presented. Precautions in the use of psychotropic medications will then be outlined.

Bulimia Nervosa

Several antidepressants have been shown to be effective in reducing episodes of binge-eating and purging including the tricyclic antidepressants, the monoamine oxidase inhibitors (MAOIs), and the selective serotonin re-uptake inhibitors (SSRIs). Although the antidepressants are effective in reducing symptoms, few patients have a complete cessation of binge eating and purging. The tricyclic antidepressants may worsen arrhythmias secondary to electrolyte disturbances and the anticholinergic effects may decrease saliva and increase the likelihood of dental erosions. The dietary restrictions required for use of the MAOIs may be difficult to follow for patients who binge impulsively and may pose a serious risk of a hypertensive crisis. The SSRIs have the fewest side effects.

Fluoxetine

Fluoxetine, an SSRI, is the only drug currently approved by the Federal Drug Administration (FDA) for eating disorders and has been evaluated in two large multi-site studies of bulimia nervosa^{2,3}. The dosage of fluoxetine that resulted in the greatest reduction of binge-eating and purging episodes was 60 mg. per day. Typically, patients can be started on 20 mg. per day and the dose increased over the course of a week to 60 mg per day.

Common side effects include headache, nausea, and insomnia. The headache and nausea usually abate within a few days and insomnia can be avoided by taking the medication in the morning. Perhaps a third of patients develop sexual side effects with fluoxetine, particularly delayed orgasm. Although a number of remedies for the sexual side effects have been proposed, none has yet been demonstrated to be effective in clinical trials. The most promising are serotonin blocking agents; for example,

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The Treatment of Eating Disorders: Role of the Dietitian

Debra Boardley, Ph.D., RD/LD

Dietitians can play an important role in providing nutrition intervention to patients with eating disorders. Although eating disorders are mental disorders and must be treated as such, they do result in the disruption and eventually the complete breakdown of normal eating. Additionally, patients often suffer malnutrition. While the psychological intervention is not within the treatment domain of the dietitian, as the nutrition expert, the dietitian can be an integral member of the interdisciplinary treatment team. The eating disordered patient needs more than nutrients and nutrition information and the dietitian involved in the treatment should be aware of the unique challenges in this population.

Perhaps the most important step in providing nutrition care to eating disordered patients is to realize the potential pitfalls. Many patients with eating disorders have a wealth of nutrition "facts". For example, they may know calorie and fat gram counts of many foods items, they may limit cholesterol and saturated fat intake for heart health, they may eat fruits and vegetables for vitamins and minerals. But healthful diets are more than nutrition facts. Eating disordered patients have been known to rigidly follow the food guide pyramid for menu planning. If food is carefully chosen and measured, it is possible to eat according to the food guide pyramid and still have less than 1,000 kcals each day. The dietitian must be aware that giving more nutrition facts may actually reinforce the restrictive food choices. For example, the patient may question whether or not saturated fat is the "bad fat". An affirmative reply may validate the patient's perceptions and might lead to even more fat restriction. Another example is that a patient may ask if eating carbohydrates causes insulin level to rise. Although this is true, the patient may use this information to omit carbohydrates from the diet because they have read high protein diet guidelines and now believe that insulin is responsible for making fat.

Dietitians may give information that is technically correct, but need to be careful and consider the possible applications of the information and how it can be used out of context. The goal of successful treatment of the eating disorder is the return to normal eating. Desired outcomes include: an energy intake that allows weight maintenance within a healthy weight range, resolution of food restriction and food rituals, and inclusion of a variety of foods in the daily diet. Although the treatment of eating disorders is sometimes a very slow process, the structure of normal eating patterns should be a part of the process from the beginning of treat-

ment. It is extremely important to remember that many of the behaviors that characterize eating disorders, are both a symptom of and at the same time, a result of the eating disorder.

The preoccupation with food, the binge eating, and even many of the emotional, personality, social, cognitive and physical changes that are commonly seen in eating disordered patients are characteristic of the documented response of humans to starvation (Keys et. al, (1950; see Garner, 1997). Therefore, it is absolutely essential that early in treatment sufficient calories be consumed and that weight be returned to a healthy range as soon as possible. This will resolve the negative psychological manifestations that are due to starvation so that treatment can be targeted at the remaining issues.

In addition to emphasizing calorie intake and body weight, the dietitian can be involved in the process of restoring regular eating patterns. Restoring regular eating involves meal planning, mechanical eating, spacing meals, and specifying the quantity and quality of food (Garner, 1997). This approach to eating establishes structure that allows the patient to move away from the chaotic eating patterns that characterize eating disorders. It is especially helpful in avoiding under-eating and over-eating and allows patients to add "fear foods" in a controlled amount. The number of calories that a patient needs depends upon their current weight, metabolic conditions, eating patterns, and their ability to tolerate feedings. Weight should be closely monitored and calorie intake should be adjusted to allow gradual and steady weight gain of about 1 to 2 pounds per week.

A frequent criticism of this structured eating approach is that it is not 'healthy' to make people eat in such a prescriptive manner. However, this is considered a treatment. Putting a cast on a healthy leg has negative effects in that it will lead to loss of muscle strength and flexibility. The same cast can be vital to the repair of a broken leg. These eating "crutches" can be discarded when normalized eating becomes intrinsic.

The psychoeducational approach to treating eating disorders is based on the assumption that these patients have misconceptions about the factors that cause and then maintain their disorder. Treatment involves correcting these false perceptions. (For a more discussion of psychoeducational principles in treatment, see Garner, 1997). Helping patients combat food myths often requires specialized nutrition knowledge. The dietitian is uniquely qualified to provide scientific nutrition education within this context. Considering the plethora of media messages about nutrition, foods, and diets, all eating disorder patients will have different myths that have played a role in the development of the disorder. The following is a brief discussion of some of the most common issues.

The eating disorder patient must be made aware of the fact that the first and foremost need of the body is for energy. The body must have a regular and sufficient source of energy. Many patients take vitamins or minerals but they need to understand that the body can not properly use other nutrients when calories are restricted.

A common characteristic of eating disordered patients is that they tend to divide foods into "good" food and "bad" food categories. Frequently, these are extreme interpretations of healthful dietary guidelines. For example, if sugar is "bad", a diet that does not have sugar is "good". Patients need to understand that there is no "good" food nor "bad" food, as all food contributes some nutrients (i.e., chocolate contains magnesium and copper). Nutrition education should include discussions about the six classes of nutrients and that all are needed in adequate amounts. Emphasize that essential nutrients are chemicals that are found in food and need to be obtained in food sources.

Patients often worry about the healthfulness of their diet. They are often uncomfortable adding fat to their diet because they think it contributes to heart disease. However, the truth is that eating disorder patients usually have very low cholesterol levels and are more likely to die of heart conditions related to their disorder (low potassium, catabolism of heart tissue) than they are of coronary artery disease. Patients need frank discussions about the negative health consequences of a restrictive diet.

Patients need to understand the complexity of nutrition. Too often, decisions about food are based solely on number of calories or grams of fat. The dietitian can be instrumental in providing scientifically sound information. Fat is not bad, it is an essential nutrient. Sugar is needed for the brain to function. Calcium supplements can not prevent osteoporosis. Weight loss is not always healthy, it is possible to be too thin. Variety and moderation should be emphasized as key concepts to healthful nutrition practices.

The most important approach is to work as a treatment team. Nutrition therapy is a necessary but not sufficient for the treatment of eating disorders. The dietitian should work with a qualified mental health provider in a multidisciplinary approach.

References:

- Keys A., Brozek J., Henschel A., Mickelsen O., & Taylor HL. (1950). *The Biology of Human Starvation* (2 volumes). Minneapolis: University of Minnesota Press.
- Garner, D. M. (1997). In Garner DM & Garfinkel PE (Eds.). (1997). *Handbook of Treatment for Eating Disorders*. New York: Guilford Press

9TH INTERNATIONAL CONFERENCE ON EATING DISORDERS

EVALUATING THE PAST AND ENVISIONING THE FUTURE

MAY 4 - 7, 2000 NEW YORK HILTON AND TOWERS

Thursday, May 4

8:30am - 11:30am

Clinical Teaching Day Workshops

(separate registration is required)

- A. *Family Therapy for Anorexia Nervosa*
Christopher Dare, MD & Ivan Eisler, PhD
- B. *Comorbidity and Eating Disorders*
Tim Brewerton, MD & Amy Baker Dennis, PhD
- C. *The Assessment and Treatment of Childhood Obesity*
Denise Wilfley, PhD & Len Epstein, PhD
- D. *Medical Management and Pharmacotherapy of Eating Disorders*
James E. Mitchell, MD
- E. *Nutritional Management of Eating Disorders: What Treatment Providers Need to Know*
Eileen Stelfox, MPH, RD & Cheryl Rock, PhD, RD, FADA
- F. *Cognitive Behavioral Treatment of Bulimia Nervosa*
Christopher Fairburn, MD

5:00pm - 7:00pm Opening Reception

6:00pm - 7:30pm Discussion Panels

- 1. *Therapist Issues in the Treatment of Eating Disorders*
- 2. *Maximizing Access to Care and Insurance Coverage for Patients with Eating Disorders*
- 3. *The Use of Technology in the Treatment of Eating Disorders*

Friday, May 5

8:30am - 8:45am Welcome and Conference Goals

Stephen Wonderlich, PhD, President
Michael J. Devlin, MD, Co-Chair, Program Committee
Kathleen M. Pike, PhD, Co-Chair, Program Committee

8:45am - 10:45am Plenary Session I: **New Developments in Diagnosis and Treatment**

Eating Disorders 2000: Beyond Cultural Stereotypes
Ruth Striegel-Moore, PhD

Early Influences on Disordered Eating
W. Stewart Agras, MD

Innovations in Obesity Treatment
Susan Z. Yanovski, MD

Evolution of Eating Disorder Treatment

Programs: Looking Back and Looking Ahead
Beatrice Bauer

10:45am - 11:15am Break

11:15am - 12:45pm Workshop Session I

12:45pm - 2:30pm Luncheon Break

1:30pm - 2:30pm Poster Session I and Exhibit Viewing

2:30pm - 3:30pm Debate Resolved: **Significant Funds Should be Allocated for Primary Prevention of Eating Disorders**

Moderator

Niva Piran, PhD

Affirmative

Runi Børresen, M.Phil. and C. Barr Taylor, MD

Negative

B. Timothy Walsh, MD and Christopher Fairburn, DM

3:30pm - 4:00pm Break

4:00pm - 5:30pm Workshop Session II

5:45pm - 6:45pm Academy for Eating Disorders Annual Membership Meeting

6:45pm - 8:15pm Dinner on your own

8:15pm - 9:30pm Videotape and Discussion: **Follow-up of the Minnesota Semistarvation Study Participants**

Scott Crow, MD and Elke D. Eckert, MD

Saturday, May 6

7:00am - 8:00am Special Interest Groups

8:00am - 9:00am Presentation of Lifetime Achievement Award

Approaching Eating Disorders in the New Millennium

Paul Garfinkel, MD, Professor and Chair, Department of Psychiatry, University of Toronto and President and CEO, Centre for Addiction and Mental Health, Toronto, Canada

9:00am - 9:15am Academy President
Stephen Wonderlich, PhD

9:30am - 12:30pm Scientific Session I

12:30pm - 2:00pm Conference Luncheon and Awards

2:00pm - 3:30pm Workshop Session III

3:30pm - 4:00pm Break

4:00pm - 6:15pm Plenary Session II: **New Clinical Trials**

Motivational Pre-Treatment Interventions: Can We Make Our Individual or Group Treatment More Effective
Melanie Katzman, PhD

How Do Treatments Work and for Whom?: Mechanisms and Predictors of Response
G. Terence Wilson, PhD

How Do We Keep Patients Well: Issues of Relapse Prevention
Kathleen M. Pike, PhD

Long-term Prognosis in Anorexia Nervosa: Lessons from a 21-year Follow-up Study
Wolfgang Herzog, MD

Commentary

Aila Rissanen, MD, PhD

6:30pm - 7:30pm Poster Session II and Exhibit Viewing

Sunday, May 7

8:00am - 10:00am Scientific Session II

10:00am - 10:30am Break

10:30am - 12:45pm Plenary Session III: **Genetic and Environmental Risk Factors**

Genetic Epidemiology: A Report from the Front Line
Kenneth Kendler, MD

Twin Studies of Eating Disorders
Cynthia M. Bulik, PhD

Search for Anorexia Nervosa Susceptibility Loci
Wade Berrettini, MD, PhD

Family Studies
Michael Strober, PhD

Commentary
Stephen Wonderlich, PhD

12:45pm - 1:00 PM Conference Summary and Closing

Michael J. Devlin, MD, Program Co-Chair
Kathleen M. Pike, PhD, Program Co-Chair

President's Message, from page 1

Our discussion about membership emphasized the strength of our multidisciplinary organization and the importance of increasing the involvement of all members in the activities of the Academy. Our second goal is to develop and implement a comprehensive education and training program using state of the art technology. New technology, including telemedicine and CD Rom, are revolutionizing education and training in health care delivery. Future annual meetings and teaching days may be delivered through such technology to a much broader range of professionals, which ultimately benefits a larger number of eating disordered individuals. A third goal is to create and endow a foundation which will provide financial support for all of the missions of the Academy, particularly our research agenda. This is a large step, but we believe that it is necessary for the Academy to meet our professional and scientific goals and objectives. A fourth goal is to maintain and develop a comprehensive Academy owned publications program. Paralleling our efforts to extend our education and training through new technology, we also wish to expand our ability to publish scholarly, clinically relevant information on the nature of eating disorders, as well as their treatment and prevention. Finally, we intend to increase our public affairs activities through deliberate media and public policy strategies. The Academy needs to develop a dialogue with media and government officials to enhance awareness about the problem of eating disorders and also to help educate the public, government officials, and media leaders about the potential risks inherent in the messages many of our children receive in magazines, television, movies, etc. To this end, I am pleased to announce that in December the Academy joined a number of other eating disorder advocacy and professional organizations in Boston and agreed to create a coalition that will establish a Washington presence to address public policy and legislative issues which are pertinent to the eating disorders. This could be an important first step in our public affairs work.

By the time our strategic planning session ended, most of us were tired but excited about the future. Never before has the Academy been so well organized in our goals and objectives. I believe that it is truly a time of significant change for the Academy, and that all of our members will benefit. Furthermore, and very importantly, we will need your help. The initiatives that we have set forth provide a wide array of opportunities for you to get involved. Whether it be in terms of education, membership issues, or public affairs, we will be needing and looking for help.

Finally, you will soon be hearing about an Academy survey which will be conducted through our web page. A number of Academy commit-

tees and task forces have expressed an interest in learning more about member opinions and needs. The survey will ask questions about general member needs and preferences, volunteer interests, research opportunities, interest in telehealth, and even specific questions about availability of treatment for young children and early adolescents who have eating disorders. Not only will this give us an opportunity to gain information from you, but it is also an interesting and exciting way for our organization to gather data. The Academy is truly becoming technologically sophisticated!

In our next newsletter, I look forward to telling you about some of the innovative activities and events at our upcoming New York meeting and other exciting changes and new developments in the Academy. Thank you once again for your support of the Academy and I look forward to working with you in the year 2000. See you in New York on May 4-7! Best regards.

ICED 2000: *EVALUATING THE PAST AND ENVISIONING THE FUTURE*

As you can see from the program on page 4, we are planning a full schedule of activities for the 9th International Conference on Eating Disorders. Health care professionals involved in the treatment of eating disorders are invited to attend so please mark your calendar and invite a colleague. It is set at an advanced level to meet the following objectives:

1. Provide up to date information on empirically validated treatments for eating disorders.
2. Inform participants of new developments in our understanding of genetic and environmental risk factors for eating disorders and biological mechanisms of these disorders.
3. Stimulate further thinking and research concerning the prevention of eating disorders.
4. Assist practitioners in understanding how to overcome barriers to treatment delivery for patients with eating disorders.

Look for your copy of the preliminary program in the mail soon or visit our web page at www.acadeatdis.org for registration information. Join your colleagues in making this the most successful meeting yet!

***Have you returned
your 2000 Dues Renewal
notice?***

Academy for Eating Disorders Call for Nominations

Marsha D. Marcus, Ph.D.

The AED Nominating Committee requests members to submit suggestions for nominations for the following Academy leadership positions: President-Elect, Secretary, two Board Members-At-Large, and two members of the Nominating Committee.

President-Elect

James Mitchell, MD will become President, Steve Wonderlich, PhD will become Immediate Past President and Marsha D. Marcus, PhD will complete her term as Immediate Past President.

Secretary

Leah Graves, RD, LD will complete her term as Secretary.

Two Board Members-At-Large

Felicia R. Boyd, MS, ARNP and Cheryl L. Rock, PhD, RD will complete their terms as Board Members-At-Large.

Two Nominating Committee Members

John L. Levitt, PhD and Preston Zucker, MD will complete their terms as members of the Nomination Committee.

Nominations should be received by the AED office no later than February 29, 2000. Please send nominations to:

Nominations
Academy National Office
6728 Old McLean Village Drive
McLean, VA 22101
FAX (703) 556-8729
email AED@Degnon.org

A recommended slate will be distributed in early March for voting at the Annual Membership Meeting Friday, May 5. We look forward to receiving your valued input by February 29, 2000.

Plan Now for 2001

Mark your calendar now for the 2001 Annual Meeting and Clinical Teaching Day of the Academy for Eating Disorders. It will be held May 17 - 19 at the Sheraton Wall Centre in Vancouver, Canada. Plan now to attend this 2 1/2 day conference.

Guidelines, from page 1

- ◆ Diagnoses: Although the DSM IV is followed, controversies in current diagnostic schemes are acknowledged (e.g. should amenorrhea continue to be a requirement for the diagnosis of AN? how do eating disorders differ across cultures? how shall we think about “atypical” eating disorders?). The revision recognizes how clinically important and prevalent patients with Eating Disorders Not Otherwise Specified (EDNOS) are in practice, and discusses Binge Eating Disorder at some length under this rubric.
- ◆ The guideline reviews recent epidemiological data and clinical features. Tables outline the major physical complications and abnormal laboratory test results found in anorexia nervosa and bulimia nervosa and offer guidelines for laboratory work-ups.
- ◆ The value of using standardized instruments for clinical assessment is stressed, and the table listing representative assessment instruments can guide clinicians in choosing appropriate ones for their practices.
- ◆ Treatment approaches for anorexia nervosa and for bulimia nervosa are detailed by approach (nutritional rehabilitation; psychosocial treatments; and medications). The various approaches are then discussed with respect to goals and goal setting, available data regarding the efficacy of that approach, side effects and toxicities that may be encountered and how to deal with them, and implementation strategies. For example, the discussion of nutritional rehabilitation includes consideration of determining goal weights, caloric prescriptions and progression, dealing with difficult situations, considerations regarding nasogastric feeding, and medical monitoring. Psychosocial treatments for anorexia nervosa consider structured inpatient and partial hospital programs, individual psychotherapies, family psychotherapy, psychosocial interventions based on the addiction model, and support groups. The medication discussion reviews recent studies showing that SSRI medications appear to add little to good usual nursing care during hospital-based weight gain programs, but that some SSRIs may be useful during weight maintenance phases. (The guidelines also alert clinicians to the fact that the SSRI citalopram has been associated with weight loss in the treatment of outpatient anorexia nervosa relative to psychotherapy alone.)
- ◆ For bulimia nervosa, cognitive-behavioral therapy remains the strong psychosocial intervention, but combinations of psychotherapy together with certain medications, particularly SSRIs, and also interpersonal psychotherapy strategies have also been

shown to have considerable value). The use of professionally written and guided “self-help” manuals may benefit many patients, including those in formal treatment as well as those with little access to treatment.

- ◆ Perhaps the single most significant new feature of the revised guidelines concerns “choosing a site of treatment”. Table 5, “Level of Care Criteria for Patients with Eating Disorders”, is based largely on the work of Walter Kaye and the Academic for Eating Disorders Insurance and Managed Care Committee, originally presented as a poster presentation by Maria La Via et al at an AED annual meeting. These criteria were modified for children and adolescents based on extensive input from members of the Society for Adolescent Medicine, all of which contributed to this table. Guidelines for outpatient, intensive outpatient, partial hospitalization/full day programming, residential and inpatient care are offered based on characteristic medical complications, levels of suicidality, weight concerns, motivational levels, co-morbid disorders, need for structure, ability to care for oneself, environmental stressors, availability of treatment facilities, and living situations associated with each level of care. We anticipate that patients, families, clinicians, institutions, and insurance companies will find the recommendations included in this table to be much more specific and helpful than the more broadly written recommendations of the original 1993 guideline.
- ◆ Discussions of collaborative models of care have been enhanced.
- ◆ Other sections address issues the chronicity of eating disorders, the impact of specific co-morbid conditions and/or concurrent medical conditions such as diabetes mellitus or pregnancy on assessment and management, and special considerations related to demographic/ setting features related to male gender, age, culture, athletics, high schools and colleges.

Those wishing to purchase copies of the guideline may call the American Journal of Psychiatry Circulation Department (202-682-6158). Ask for the January issue of the American Journal of Psychiatry including the supplement. I believe that the price is \$17.25 for the single issue. Once these issues are sold out you should be able to purchase copies of the guideline (fancier edition, bigger print) from the American Psychiatric Press, Inc (1-800-368-5777); I don't know what the price will be for that version. Be certain to ask for the January 2000 revision so that you do not inadvertently receive a copy of the older edition.

Exhibit Space Available

The Academy for Eating Disorders will be offering table top exhibit space at the 9th International Conference on Eating Disorders. If you are interested in purchasing space, please contact the National Office at (703) 556-9222 or AED@Degnon.org.

Share Membership Information with a Colleague

The Academy for Eating Disorders is a multidisciplinary professional organization focusing on Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and related disorders. Founded in September of 1993, we believe that effective treatment for eating disorders patients requires professionals from various disciplines working together to:

- ❖ **Promote** the effective treatment and care of patients with eating disorders and associated disorders
- ❖ **Develop** and **advance** initiatives for the primary and secondary prevention of eating disorders
- ❖ **Provide** for the dissemination of knowledge regarding eating disorders to members of the Academy, other professionals and the general public
- ❖ **Stimulate** and **support** research in the field
- ❖ **Promote** multidisciplinary expertise within the Academy membership
- ❖ **Advocate** for the field on behalf of patients, the public and eating disorder professionals
- ❖ **Assist** in the development of guidelines for training, practice and professional conduct within the field
- ❖ **Identify** and **reward** outstanding achievement and service in the field.

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cyproheptadine taken in small doses (2-4 mg.) 30 minutes prior to intercourse may be useful in reversing the symptom of delayed orgasm. An occasional patient will have symptoms of serotonin excess and may have symptoms of increased anxiety including jitteriness, dilated pupils, and hyper-alertness. These patients may respond to reduced doses. Another problem that may occur is the phenomenon called "tachyphylaxis"; in this situation, fluoxetine may be initially effective and then, over time, for unknown reasons, lose its effectiveness. Compared to the other SSRIs, fluoxetine has a long half-life. This can be an advantage because fluoxetine can usually be abruptly stopped without emergence of a discontinuation syndrome.

There are several problems in the use of antidepressants, including fluoxetine, for BN. Only a small percentage of patients respond completely and patients with co-morbid psychiatric disorders are less likely to respond fully. Relapse is common (often after discontinuation of the drug and sometimes while the patient is still taking the drug). Furthermore, the needed duration of treatment with medication is unknown, but likely to be at least 6-12 months after full remission of symptoms.

Promising Medications

Drugs that offer promise include naltrexone and ondansetron. Naltrexone is an opiate antagonist currently approved for the treatment of alcohol dependence. Although there is great controversy over whether or not the eating disorders might represent addictive processes, there is some early pilot work suggesting that naltrexone may reduce binge eating and purging³. The dosages used were higher than used for alcohol dependence and the safety of these dosages has not yet been established. Ondansetron, a 5-HT₃ receptor antagonist used as an anti-emetic in cancer patients, has been shown in a small study⁵ to reduce episodes of binge-eating and vomiting in BN patients. Both naltrexone and ondansetron should be considered experimental treatments at this time.

Anorexia Nervosa

In considering medication for AN, two phases of treatment need to be recognized: the weight restoration phase and the weight maintenance phase. No medications have been shown to be clearly effective for the weight gain phase. Although widely used, fluoxetine is not effective in the this phase⁶ and in some patients may facilitate further weight loss or precipitate vomiting. The only drug that has been shown statistically to have benefit in facilitating weight gain in restricting AN patients is cyproheptadine⁷ but this benefit was only demonstrated in the context of an inpatient treatment program already aimed at weight gain. Various other drugs have been tried to facilitate recovery from anorexia

nervosa but none have been found effective in controlled clinical trials. Interestingly, few drugs that might be helpful for specific symptoms have been studied. For example, medications that cause weight gain such as mirtazepine have not been evaluated. In general, antipsychotic medications that might decrease cognitive or perceptual distortions have not been tried. There have been recent clinical observations suggesting that olanzepine, a new atypical antipsychotic, may have some benefit during the weight gain phase.

During the weight maintenance phase of AN, fluoxetine has been shown to decrease the likelihood of relapse⁸.

Binge Eating Disorder

Both antidepressants and CBT decrease binge eating and depressive symptoms in BED patients in the short run. Fluoxetine may also promote short-term weight loss, particularly if provided in combination with behavioral treatments⁹.

Precautions in Using Psychotropic Medications Bupropion Contraindicated in Eating Disorder Patients

Bupropion is sold in the United States under two brand names: Wellbutrin is marketed as an antidepressant and Zyban is marketed as a smoking cessation aid. Bupropion is contraindicated in eating disorder patients because of a higher frequency of seizures in BN patients than in non-ED patients¹⁰.

Psychotropic Medications for Co-Morbid Psychiatric Disorders

Co-morbid psychiatric disorders frequently occur with eating disorders. Among BN patients, alcohol use disorders are particularly common. Naltrexone is currently FDA-approved for the treatment of alcohol dependence and, in combination with various CBT strategies, may be helpful for BN patients with alcohol use problems. Liver function should be routinely monitored since elevated liver enzymes have been reported in obese patients on naltrexone. Affective disorders are also very commonly associated with the eating disorders. The potential cardiac arrhythmias associated with electrolyte disturbances that may be worsened by the quinidine-like effects of tricyclic antidepressants should be carefully considered before using these drugs. For patients with bipolar disorder who require lithium, very careful monitoring of electrolytes and lithium levels are necessary to avoid lithium toxicity.

Pregnancy

Most patients with bulimia nervosa are fertile and some female patients with long-standing anorexia nervosa are fertile even if they have amenorrhea. If possible, patients should be advised to delay pregnancy until recovery from the eating disorder. When pregnancy occurs while the patient is still symptomatic, it is helpful to remember that semi-starvation and purging are

dangerous to both mother and fetus and to balance this risk against the potential risk of medications¹¹. For many patients with bulimia nervosa, fluoxetine is less risky than continued purge behavior. Since CBT is marginally superior to fluoxetine for bulimia nervosa, this should be tried first but, if ineffective, fluoxetine should be considered.

Conclusions

The psychopharmacologic armamentarium for the treatment of eating disorders is still sparse. In part, development of more effective medication treatments has been hampered by the unproven belief that psychological and cultural factors are largely responsible for eating disorders. As we come to recognize some of the biological aspects of these disorders, more effective medication treatments may be found.

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Psychologist River Centre Eating Disorder Program

The River Centre Eating Disorder Program is seeking a clinical psychologist to join a multidisciplinary team in providing services to eating disorder clients. Responsibilities could include assessment, psycho-education, individual, family, and group treatment, clinical supervision and the opportunity to participate in clinical research. Previous experience with eating disorder clients is preferred and qualified candidates will have a Ph.D. in psychology and will be licensed or license eligible in the State of Ohio. The River Centre Eating Disorder Program is a progressive, private treatment facility that is strongly influenced by empirically-based approaches to treatment and the scientist-practitioner model. Position available immediately. Please send letter, resume and the phone numbers of three references to: David M. Garner, Ph.D., Director, River Centre, 5465 Main Street, Sylvania, OH 43560. (garner@river-centre.org; 419-885-8800).

Academy Newsletter

Please send all suggestions for articles, items of interest, job opportunities, information regarding upcoming events or meetings and letters to the Editor:

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