

Message from the President

Stephen Wonderlich, Ph.D.

Greetings to you all. As we approach the New York International Conference on Eating Disorders, which for the first time will be fully sponsored by the Academy, I am pleased to report on a variety of exciting and important developments. This year, the Board has worked diligently to restructure our governance in a manner that we believe will more effectively address the needs of our membership. In my last President's message, I described the strategic planning session that the Board held in Toronto in October of 1999. We have continued our work and as a result of that meeting have devised a structure for the Academy that should more effectively help us to reach our goals. We have constructed five councils that will provide direction and support to our nearly twenty committees. The Education and Training Council will be co-chaired by Mike Devlin and Amy Baker Dennis. This council will oversee all affairs relating to our education and training program, including our annual meetings, teaching days, and all new training and education programming. Our Membership Council is chaired by Pat Fallon. This council will work to recruit and retain members, as well as assessing developing membership needs. For example, this council has been developing the concept of Special Interest Groups, which you will hear much more about in New York, and hopefully will provide another avenue for members to organize and support their professional activities. I am very pleased to announce that Eric Von Furth has agreed to be the chair our Special Inter-

Continued on page 8

Change in Newsletter Editor

David M. Garner, Ph.D.

I want to sincerely thank the Academy Board for the opportunity to serve as the Newsletter Editor for the past 5 years. I also want to thank many fine colleagues who have generously donated their time to provide feature articles for each issue of the Newsletter. In fact, I do not believe that there has been any instance in the past 5 years in which a colleague has declined the invitation to contribute an article. The exceptional academic and clinical quality of these contributions has made the Newsletter a valuable resource for the Academy Membership. I am sure that the Newsletter quality will achieve new highs with the selection of the next Editor, Lisa Lilienfeld. Dr. Lilienfeld will bring fresh ideas and creativity to the Academy Newsletter.

As the Academy Newsletter Editor, I have had the pleasure of witnessing the evolution of the Academy from the insecurity of organizational infancy to its present role as the premier professional ambassador for the eating disorders field. It has been an honor to work closely with a series of exceptionally talented colleagues who have shown tireless dedication to the development of our professional organization. The outstanding Academy Presidents, Pauline Powers, Ruth Striegel-Moore, Timothy Walsh, Joel Yager, Marsha Marcus and Stephen Wonderlich, have led us through organizational growing pains with enthusiasm, creativity, patience, and good humor. Enlisting the exceptional administrative skills of Degnon and associates has allowed the Academy to move to new levels of effectiveness and efficiency.

The theme of this issue of the Newsletter is a continuation of the last issue on "Standards of Care". Dr. Pauline Powers contributed an excellent article on Standard Laboratory and Medical Evaluation that should be useful to all clinicians who evaluate eating disorder patients. Dr. Craig

Johnson provides a thoughtful article on the use of recovered patients in eating disorder treatment programs. Finally, Professor Peter Beumont has given us a view of the Australian perspective on standards of care for those with eating disorders. Hopefully, the last two issues of the Newsletter along with the recently published American Psychiatric Association Practice Guidelines for the treatment of patients with eating disorders (revised) will allow all us to improve the quality of care.

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Inside This Issue

Page

- | | |
|----|---|
| 1 | Message from the President |
| 1 | Change in Newsletter Editor |
| 2 | Standard Laboratory and Medical Evaluation |
| 3 | The Use of Clinicians with Personal Recovery in the Treatment of Eating Disorders |
| 4 | Australian Experience with Practice Guidelines |
| 7 | ICED 2000 Program Schedule |
| 10 | Positions Available |

Important AED List Serve Information

The University of New Mexico list-server has been hiccupping and as a consequence several members of the AED list have inadvertently been dropped. If you haven't been receiving e-mail messages from the Academy, or if you would like to join the list serve, please drop a note to Joel Yager (jyager@unm.edu) with your current correct e-mail address and ask to be reinstated.

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Standard Laboratory and Medical Evaluation

Pauline S. Powers, M.D.

Introduction

The medical and laboratory evaluation of a patient suspected of an eating disorder (ED) can eliminate the unusual causes of weight loss or binge eating and purging behavior and identify the common physiological complications of eating. The diagnosis of an eating disorder should be made on the basis of positive findings of the typical symptoms and should not be a diagnosis of exclusion. The standard medical assessment includes a detailed medical history, physical examination, and laboratory testing. The ongoing medical assessment of the patient can identify physiological problems that frequently occur during re-feeding, eating normalization, and the cessation of purging.

The initial assessment may also help identify patients at particular risk of developing a chronic or fatal course. Assisting the patient recognize the connection between his or her behavior and the symptom, sign, or laboratory test can be useful in establishing a therapeutic relationship with the patient.

Differential Diagnosis

In considering other diagnostic possibilities, it is worth remembering that anorexia nervosa (AN) is the most common cause of significant weight loss in adolescent girls in the United States. Other causes of weight loss include inadequate caloric intake (e.g. systemic disease such as cancer or congenital heart disease), decreased caloric absorption (such as cystic fibrosis), excessive caloric utilization (e.g. hyperthyroidism), and excessive caloric loss through urine or stool (e.g. diabetes mellitus or ulcerative colitis)¹. Table 1 lists the common other causes of weight loss with typical symptoms and signs and associated illness. Examples of specific aspects of the physical examination that should be emphasized include visual fields by confrontation to detect bitemporal hemianopsia (that may occur with pituitary gland tumors), and observation for exophthalmos and quick reflexes in patients with hyperthyroidism.

Various conditions have been associated with over-eating episodes but they do not usually meet the criteria for binge eating. Patients with Kluver Bucy syndrome, the Prader Willi syndrome, or Klein-Levin syndrome consume large quantities of food but typically without a feeling of loss of control and these patients do not purge.

Physiological Consequences of Eating Disorders

In this section, the various physiological complications of AN and bulimia nervosa (BN) are

considered together as many patients may develop symptoms of both conditions during the course of their illness². The following factors mediate the severity of the presenting physiological complications: pre-morbid health including weight; rapidity and severity of weight loss; type, frequency, and intensity of purge behavior; and frequency and intensity of binge behavior. Of the types of purge behavior, the likelihood of increased risk of various physiological complications increases with equivalent use as follows: vomiting, thyroid medication abuse, laxative/enema abuse, diuretic abuse, and ippecac use.

Cardiac Complications

Multiple signs, symptoms, and laboratory tests indicate cardiac dysfunction³. In AN patients, vital signs often reveal bradycardia, hypotension, and orthostatic hypotension (a drop of 20mm Hg in systolic pressure or 10 mm Hg in diastolic pressure associated with a rise in pulse of 20 beats per minute⁴). Ipecac has a direct cardiac toxicity. Arrhythmias are common in both AN and BN. An electrocardiogram (ECG) may reveal a prolonged QT interval or abnormal QT dispersion (range of QT interval in various leads). Prolonged QT interval may be associated with sudden death in ED patients. Although cardiac arrhythmias are often associated with electrolyte abnormalities (especially with hypokalemia), total body potassium stores may be depleted even in the presence of a normal serum potassium and, hence, predispose to arrhythmias⁵. Other ECG abnormalities include u waves (suggesting hypokalemia or hypomagnesemia) and ST-T wave abnormalities. The presence of a mid-systolic click and a late systolic murmur are suggestive of mitral valve prolapse, which is more common in AN patients than in the general population.

Brain Abnormalities

Patients with EDs have multiple symptoms that could indicate brain abnormalities including difficulty concentrating, memory losses, perceptual disturbances (e.g. body image disturbances), inflexible and concrete thinking, obsessions, and compulsions. Physical examination rarely reveals any specific neurological sign. Brain scanning in AN patients has revealed enlarged ventricles and sulci and these abnormalities do not necessarily return to normal with weight restoration. Although there are abnormalities on neuropsychological testing and positron emission testing these findings are inconsistent.

Osteoporosis

Approximately 60% of patients with AN who have been ill more than six months have osteoporosis⁶. Osteopenia is defined as a bone mineral deficiency 1-2.5 standard deviations (SDs) below the mean peak value in young adults and osteoporosis is greater than 2.5 SDs below

Continued on page 4

The Use of Clinicians with Personal Recovery in the Treatment of Eating Disorders

Craig L. Johnson, Ph.D.

Introduction

As the field of eating disorders matures, it becomes increasingly incumbent upon us to tackle thorny issues that we have avoided up to this point. One of these issues is the role for clinicians that have personal recovery from eating disorders in the treatment of this patient population. The issue has far reaching implications — from delicate human resource management laws to subtle counter transference questions regarding the use of self-disclosure in psychotherapy. The task of this paper will be to open a broad-based dialogue in hopes of having an evenhanded and productive discussion of the relative advantages and disadvantages of having clinicians with personal recovery involved in the treatment process. The eventual goal would be for our field to offer guidelines regarding this issue.

Existing Data Base Regarding Guidelines

Although I did not do an exhaustive literature search, I found it difficult to find any written information about guidelines, policies, etc. regarding clinicians with personal recovery treating eating disorder patients. In an effort to not reinvent the wheel, I extended my inquiry into the chemical dependency area and found it to be equally undeveloped. The Academy for Eating Disorders has no written guidelines or policies on the issue. They did, however, request that I present a paper on this topic as part of an ethics panel at their annual conference (Johnson, 1999). They have also begun the process of establishing a committee to address the issue. The International Association of Eating Disorders Professionals has not addressed the issue directly either, but they did include sections in their code of ethics that broadly relates. Overall, it appears that our field has not formally addressed the issue. Large

Program's Experience and Informal Positions

In an effort to gather some data, I contacted ten established programs in the United States to explore their experience and current position regarding the use of recovering staff. Of the ten programs, five were not for profit and five were for profit. None of the programs had written policies or guidelines regarding the hiring or monitoring of staff who had personal recovery. All of the program representatives mentioned the potential legal issues related to the American Disabilities Act. Four of the programs actively embraced hiring staff with personal recovery, five programs were mixed (meaning that personal recovery was not a hiring consideration one way or the other) and one program actively

avoided the hiring of clinicians with personal recovery. Among the four programs that embraced hiring staff with personal recovery, the estimates of staff with recovery ranged from 30% to 95%, although none of the sites had specific numbers. None of the four sites that embraced hiring recovering staff had formal definitions or criteria for recovery or relapse. They also did not have specific mechanisms for monitoring the individual's recovery. Reassuringly, two of the sites informally had two-year recovery criteria and two sites had one-year recovery criteria. Recovery was loosely defined as normal weight and abstinence from bingeing and purging. Interestingly, and I believe appropriately, the clinical leaders of these programs were more concerned about the recovering staff's overall comfort with their size and shape. This appeared to be a bell-weather issue, but once again guidelines or criteria for monitoring were fuzzy at best. Although I was disappointed with the lack of formal guidelines and criteria in the programs, I was quite impressed with the level of awareness and overall thoughtfulness regarding the clinical and legal issues related to this topic. All of the programs were interested in receiving guidelines from our professional organizations.

Relapse Rates

None of the programs surveyed had data on staff relapse rates. Among the programs that actively embraced hiring staff with personal recovery, estimates of relapse ranged from 10 to 20 percent. The program that actively avoided hiring recovering staff had recruited staff with recovery in their early years and had reversed positions over the last few years. They estimated that 75% of their recovering staff had relapsed while working at the treatment center. In talking with the leadership of that program, it was unclear why the relapse rates were high in relationship to other programs.

Laureate Experience

When I began developing the Eating Disorders Program at Laureate, I actively recruited staff that had personal recovery. This was an effort to directly learn what the costs and benefits were of adding this dimension to a treatment program. My goal was to hire a mix of recovering and non-recovering staff of different theoretical perspectives. The theoretical perspectives included Psychodynamic, Cognitive-Behavioral, Feminist, 12 step, Christian and Systems. The task was to experiment with integrating these different models of recovery. I am pleased to report that it has been an interesting and productive exploration. Over the last ten years, 11 staff with personal recovery have worked in our program. This included two PhDs, six Masters prepared Licensed Therapists, one RN and two psychtechs. Overall, these clinicians have made an unusual and outstanding contribution to the program. The fact that we have staff with recovery is consistently mentioned in patient sat-

isfaction surveys as one of the strengths of the program.

From my perspective, the benefits have outweighed the cost, but there have been problems along the way. Among the eleven recovering staff that we have had over the ten-year period, three wobbled with their recovery, one had what I would regard as a moderate relapse and one had a profound relapse. The three staff that wobbled did not relapse behaviorally, but reported feeling psychologically vulnerable. This resulted in a modest intensification of supervision and this vulnerability abated within several weeks in all three cases. The one moderate lapse included a behavior relapse that resulted in the staff receiving some outpatient therapy. The behavioral relapse was remedied in several weeks. During this time, we decreased the staff's direct patient contact and then gradually increased the contact once the behavioral relapse was remedied. The staff member who had a serious relapse required residential treatment. This staff member did not return to the program by mutual agreement.

How Prevalent Are Eating Disorders Among Professionals Who Specialize in the Field

Unfortunately, there has been little systematic study of the nature and extent of eating disorders among professionals in the area. One study is in the process of being completed by Bloomgarten, Gerstein and Moss (Personal Communication). They surveyed 150 staff members of a large treatment program regarding self and/or family history of eating disorders. Forty-three percent of the respondents reported having personal experience with an eating disorder. Twenty-nine percent had struggled with one themselves and fourteen percent had a family member with an eating disorder. Of those who reported a personal history of eating disorder, 84% had received treatment. None of these staff were currently in treatment and the average length of time since they had had the disorder was 11.6 years. Interestingly, the site of the survey was one of the programs that I had interviewed. They fell into the neutral category regarding hiring staff with personal recovery, meaning that they neither openly embraced nor rejected individuals with a history of eating disorders. It is important to note that this neutral position would be in compliance with the American Disabilities Act. The dilemma that is created by the American Disabilities Act is that it appears that conservatively about 30% of staff that work in specialized treatment settings had personal recovery. The neutral position cited by the American Disabilities Act creates an atmosphere that errs in the direction of a "don't ask, don't tell" mentality. The danger of this is that if staff is struggling, it makes it more difficult for them to ask for help.

Continued on page 6

Australian Experience with Practice Guidelines

Pierre J. V. Beumont, M.D.

Readers of the Academy Newsletter may be interested to hear that the Royal Australian and New Zealand College of Psychiatrists has commissioned Clinical Practice Guidelines for anorexia nervosa. I am the chairperson of a large and diversified consortium charged with the task, with Professor Stephen Touyz and Professor David Ben-Tovim as joint co-chairs.

Our approach to the issue has been rather different from that of the APA, in which Stephen and I were fortunate to have had some involvement. First, the guidelines relate only to anorexia nervosa, not to the other so-called eating disorders. The reasons for this decision are: anorexia nervosa is by far the most serious of these illnesses, and is indeed the most common serious illness of adolescent girls and young women in Australia and New Zealand; there is a dearth of evidence-based literature pertaining to its treatment, unlike bulimia nervosa, hence the opportunity for unfounded "wonder" cures; although many patients present with ED NOS rather than anorexia or bulimia, by introducing a system of staging anorexia we are able to include incipient cases as well as acute and chronic patients.

The second difference from the APA approach is that we have drawn on the views of a wide variety of different professional groups—general practitioners, internists, pediatricians, dietitians, social workers, and nurses as well as psychiatrists and psychologists.

We have also included consumers, viz patients, past-patients and carers. It is our aim to have the guidelines endorsed by the various related professional associations (e.g. College of Physicians and College of General Practitioners), and to produce a special version of the guidelines for consumers in order to clearly articulate their needs.

Third, the document will distinguish between 3 kinds of guidelines: value judgments, such as decisions relating to the treatment of unmotivated patients or the provision of a better quality of life for chronic patients; consensus opinion for questions that will probably never be answered by research, such as the relative benefits of restoring nutrition by using only normal foods as compared with dietary supplements of even tube feeding; and third, questions that should be amenable to research solutions even if the final results are not in at this stage, e.g. the use of prophylactic phosphate to prevent the refeeding syndrome, the choice of strict versus lenient behavioral programs, and the value of family therapy.

The guidelines are due for completion by the end of 2000, and committees throughout New Zealand and Australia are working on issues such as Medical and Nutritional Management; Psychological treatments; Continuum of Care; Clinical Indicators, and Evidence-Based Medicine. The process started in September with a conference held in Sydney. The APA generously sponsored Joel Yager to attend and give his advice from his experience as chairperson of the APA Committee, and have allowed us access to their impending guidelines, with due acknowledgement. Our other overseas advisers were Laird Birmingham who contributed from his extensive knowledge of medical issues, and Elliot Goldner on the establishment of an integrated service.

Professors Yager and Birmingham and I will be holding a workshop at the New York Conference in May about clinical practice guidelines. We would like to hear the views of all interested parties.

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Continued from page 2

this value. The osteoporosis that occurs in AN is worse than postmenopausal osteoporosis because there is both a decrease in bone formation and an increase in bone resorption. Several classic findings in AN patients increase risk including low body weight and low fat mass, inadequate dietary calcium, Vitamin D deficiency, amenorrhea and hypo-estrogenemia, elevated cortisol levels, and insulin-like growth factor-1 deficiency. Male patients with AN are also at risk. Patients who have had six months of low weight associated with amenorrhea (even if currently at normal weight) should have a dual energy x-ray absorptiometry and an estradiol level (in males, testosterone level). The only current treatment that decreases further loss of bone mineral is weight gain; estrogen has not been shown to be protective.

Renal Complications

Renal complications include pre-renal azotemia and occasionally renal failure⁷ (from repeated episodes of volume depletion and hypokalemia), decreased creatinine clearance, and, rarely, episodes of gout. Orthostatic hypotension, xerostomia, and dry skin may be the only signs of dehydration. Painful, swollen, red joints, particularly the big toes, may be seen with gout. Laboratory testing may reveal elevated specific gravity on urinalysis; hypokalemia; elevated blood urea nitrogen, creatinine or uric acid; or decreased 24-hour creatinine clearance.

Gastrointestinal Complications

Patients may have multiple gastrointestinal

symptoms including early satiety, abdominal pain particularly after eating, bloating, and constipation. Physical examination is often unremarkable. Laboratory testing may reveal mildly elevated liver enzymes. Radiographic studies of AN patients often show delayed gastric emptying that is worse with solid foods than with fluids. Many patients with long-standing purge behavior also have radiographic evidence of gastroesophageal reflux disorder. Patients with BN may have swollen painless parotid glands (and sometimes other salivary glands) and may have elevated salivary amylase levels. Dental erosion, particularly of the lingual surfaces, is common in BN.

Signs and Symptoms During Weight Restoration

Medical surveillance is important during the weight gain phase in AN. The most dangerous complications that may emerge are related to cardiac abnormalities. Rapid fluid and electrolyte changes may predispose to cardiac arrhythmias and fluid overload may result in congestive heart failure. Although the other problems that occur during the weight gain phase are often less dangerous, they may undermine the patient's commitment to recovery and should be addressed by the physician. Table 2⁸ lists these common problems.

Laboratory Testing

The standard laboratory tests recommended for all patients are listed in Table 3. The special circumstances in which additional tests are needed are also indicated. Laboratory testing may be helpful in predicting the course of the illness⁹. Low serum albumin levels have been shown to correlate with a lethal course (as does weight 60% below IBW) at presentation. Furthermore initial high serum creatinine levels and uric acid levels have been shown to predict a chronic course.

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TABLE 1: Differential Diagnosis: Symptoms of Other Conditions Associated with Weight Loss

Organ System	Symptoms	Possible Signs	Diagnosis
Brain	headache visual complaints seizures	bitemporal hemianopsia	pituitary tumor
Gastrointestinal	abdominal pain diarrhea	rectal fistula	Crohn's disease
Endocrine	polyuria polydipsia poor wound healing	ketosis on breathe	diabetes mellitus
	quick speech anxious/jumpy heat intolerance diarrhea	quick reflexes exophthalmos	hyperthyroidism
Joints	joint pain joint swelling	tender swollen joints butterfly rash	systemic lupus erythematous
Cardiorespiratory	chest pain	various findings on auscultation	congenital heart disease
	shortness of breathe	decreased respiratory excursion	cystic fibrosis

TABLE 2: Signs and Symptoms During Weight Restoration*

- Mood changes related to decline in endorphins
- Fatigue
- Decreased physical activity
- Gastrointestinal symptoms: fullness, bloating, cramps (may be due to delayed gastric emptying)
- Unmasked electrolyte disturbances after hydration (e.g., tetany from low calcium or arrhythmias from hypokalemia)
- Loss of viral immunity
- Generalized or pedal edema may be 'refeeding' edema or sign of serious complication
- Signs and symptoms of congestive heart failure—quick weight gain, edema, shortness of breath, rales, gallop
- Signs and symptoms of pulmonary emboli—chest pain, hemoptysis
- Quick weight gain—from relinquishing various purging techniques and consequent decrease in loss of fluids and electrolytes
- Acne, breast enlargement, menstrual cramping—return of hypothalamic pituitary activity which recapitulates puberty
- Abdominal pain—acute gastric dilatation or perforation especially with nasogastric feedings

*Adapted from Powers PS. Therapeutic use of symptoms, signs and laboratory data. In Powers PS, Fernandez RC (Eds). *Current Treatment of Anorexia Nervosa and Bulimia*. Karger, New York, 1984, p. 231. Used with permission.

TABLE 3: Laboratory Testing

Standard

Complete Blood Count (CBC) with differential
 Urinalysis
 Complete Metabolic Profile: Sodium, Chloride, Potassium, Glucose, Blood Urea Nitrogen, Creatinine, Total Protein, Albumin, Globulin, Calcium, Carbon Dioxide, AST, Alkaline Phosphatase, Total Bilirubin
 Serum magnesium
 Thyroid Screen (T3, T4, TSH)
 Electrocardiogram (ECG)

Special Circumstances

15% or more below ideal body weight (IBW)
 Chest x-ray
 Complement 3 (C3)
 24 Hour Creatinine Clearance
 Uric Acid
 20% or more below IBW or any neurological sign
 Brain scan
 20% or more below IBW or sign of mitral valve prolapse
 Echocardiogram
 30% or more below IBW
 Skin testing for immune functioning
 Weight loss 15% or more below IBW lasting 6 months or longer at any time during course of eating disorder
 Dual Energy x-ray absorptiometry (DEXA) to assess bone mineral density
 Estradiol level (or testosterone in males)

Recovered from Anorexia or Bulimia?

The Eating Disorders Research Program of UPMC Health System seeks women who are recovered from anorexia or bulimia to participate in research studies. We are doing research on understanding why people develop eating disorders. This research will help us develop more effective treatments and preventative measures. New technology now permits us to safely measure the activity of parts of the brain serotonin system in people using brain imaging and other methods. These studies will help to identify what biological and psychological variables are involved in the etiology of eating disorders. Your participation can enable therapists and physicians to better understand and treat these complex and serious disorders. Participants must be medication-free women (birth control pills are acceptable) between the ages of 18 and 45. Participants will be paid up to \$900 upon completion of the studies as well as reimbursed for their travel. For more information, call toll-free: 1-888-895-3886 or e-mail: EDResearch@msx.upmc.edu

Clinical Advantages of Staff with Recovery

Understanding, hope and motivation Many of our patients, after years of struggling with the illness, are exhausted, defeated and quite hopeless. These are predictable side effects given that the outcome literature suggests that if a patient does not respond quickly to treatment in the first year, then recovery can become quite protracted. Strober, (1997), in an elegant long-term outcome study, reported 21% of patients who had received a complete treatment at their center, had partial recovery and 1% had full recovery two years after discharge. It wasn't until the 4-year mark that patients began showing significant improvement with 55% in partial recovery and 18% in full recovery. The rate of recovery continues to accelerate until the eighth year, when 80% are in partial recovery and 67% are in full recovery. This data demonstrates that the course of recovery can be quite long and tedious. Staff who have successfully accomplished recovery are often able to quickly establish that recovery does occur and that one can lead a stable and productive life. They are able to become a concrete representation of the "light at the end of the tunnel." Words can often be too abstract when patients are completely overwhelmed and defeated by the illness. Clinicians who have successfully mastered recovery become a living, breathing example that recovery is attainable. Clinicians who have not walked this valley simply do not have as much credibility. Former patients in our program consistently report that one of the most important aspects of our program is the hope and motivation they experience from the recovering staff when they first arrive.

Empathy and Trust

There is no substitute for having "stood in someone else's shoes" for facilitating empathy. As a former athlete I have a first hand understanding of the challenges of managing fear of failure, anxiety and the effects of adrenaline when you are in a "clutch" situation. If you have not been in that situation, it can be difficult to explain the profound interactions that occur. Likewise, I think it is difficult for non-recovering staff to fully grasp the profound struggle that recovery can pose for individuals. The recovering staff's experience of having been there and done that generally allows for the rapid development of rapport, which is the bedrock of trust. Trust is absolutely crucial with our patients because we are often dealing with a phobic-like fear of change. Our patient's ability to recover often requires them to take a "leap of faith." They are asked to take risks that feel catastrophic to them. Engaging the patient in a trusting therapeutic relationship is not the greatest challenge for the recovering staff. They usually accomplish this more quickly than the non-recovering staff. Their large challenge is usually guiding the patient's recovery in a manner that al-

lows the patient to write their own version of recovery. It can sometimes be difficult for recovering staff to realize that there is not a single truth about how to recover. This will be addressed more fully in the disadvantage section that follows.

Shame Abatement

Many of our patients have created false selves that cover what they feel is their shameful underbelly. They fear that if others discover the full extent of their primitive thoughts, feelings and actions they will recoil in horror and disgust. Ultimately, the patient fears he will be abandoned as worthless and defective. When patients see clinicians who have personal recovery being valued and occupying positions of status within treatment programs, it can send a powerful message that they can expose these shame-filled aspects of themselves, master them and then use the experience to consolidate a more authentic self system that can be valued by others. This invitation to become more authentic by staff who have openly and successfully confronted this issue is one of the most powerful experiences that I see occur in our treatment center.

Challenging Narcissism and Grandiosity

There are many roads to self-centeredness. Some of our eating disorder patients arrogantly wear their illness like badges of honor. Unconsciously, if not consciously, they enjoy the competition and "one-upmanship" around issues of size and shape. This is a subgroup of patients that can often "hook" younger staff who have fewer years of recovery and provoke them into nonproductive counter transference acting out (I will speak more to this in the next section). It is a pleasure to watch the more senior recovering staff gradually confront and bend these patients self-centeredness towards greater humility and community service. Understandably, the recovering staff seems to be given greater license by the patients to confront this grandiosity and self-centeredness. A subtle, but equally pernicious form of self-centeredness can occur with patients who are swamped in despair and hopelessness. Unwittingly, these patients can become so preoccupied with their despair that they begin to drown in self-pity. Staff who have not experienced this kind of emotional hardship can become too sympathetic and can become immobilized by over identifying with the patients sad state. Overall, the patient is seen as fragile and tragic. The recovering staff is usually quick to point out the folly of this way and are less ambivalent about confronting the patient's immobilization. They seem to be given greater license to confront self-pity, helplessness, etc. because they have actually had to deal with it. Although I have never heard it articulated, the implicit message that gets communicated by the recovering staff is something like "been there, done that; learned how to manage it and moved on. If I can do it, so can you."

A Different Perspective

In a previous manuscript, I argued for the importance of actually working with the patient on symptom management strategies while simultaneously listening for and interpreting transference issues (Johnson and Connors, 1987). From my perspective, effective symptom management is best accomplished by moving back and forth between these two tasks. The traditionally trained, non-recovery staff can sometimes become enamored with the process and dynamics of a patient and neglect the need for symptom improvement (i.e. weight gain, abstinence from bingeing and purging, exercise, etc.). I have always found that the recovering staff can be exceptionally effective at reminding the team that it is really hard to have much psychological insight when you are actively engaged in the thoughts, actions and feelings of the illness. They can represent a consistent perspective on the importance of stopping the active practice of the patient's illness while we are trying to help them understand the underlying dynamics.

Recovered vs. Recovering

Whenever I present about the issue of staff with personal recovery, I am usually asked whether our treatment program believes that people can fully recover or do we subscribe to the notion that one is always in the process of recovering. Clearly, the outcome data tells us that after ten years about 75% of the patients with eating disorders who have received treatment from outpatient to intensive inpatient will be recovered. This data can be somewhat misleading, however, when you consider that most patients with eating disorders usually carry multiple Axis I and Axis II diagnosis. This suggests that patients who do not respond rather quickly to informed outpatient interventions, are probably dealing with a number of vulnerabilities that will make their life more difficult than the average person. For this subgroup, the concept of recovering is a better fit in that it implies that they will need to actively manage their vulnerabilities throughout their lives. Even if their eating disorder symptoms are solved, they may manifest other psychiatric related symptoms over the course of time. Recovered vs recovering is a somewhat moot point in our program. We usually see our task as being to use the current symptom struggle as an opportunity for the patient to develop a wisdom base that allows them to develop coping strategies that they will use throughout their lives. We see our task as somewhat larger than just recovering from the symptoms of eating disorders.

Clinical Disadvantages

Risk of relapse: The most obvious disadvantage of hiring staff with personal recovery is the risk of relapse. Interestingly, I have never had a

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

1:00pm - 4:90pm

**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

Sponsored by John Wiley and Sons, Inc., publisher of the *International Journal of Eating Disorders*

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**

Ruth Striegel-Moore, PhD
W. Stewart Agras, MD
Susan Z. Yanovski, MD
Beatrice Bauer, PhD

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's Remarks

Stephen Wonderlich, PhD

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

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

**2:00pm - 4:15pm Plenary Session II:
New Clinical Trials**

Melanie Katzman, PhD
G. Terence Wilson, PhD
Kathleen M. Pike, PhD
Wolfgang Herzog, MD
Aila Rissanen, MD, PhD

4:15pm - 4:45pm Break

4:45pm - 6:15pm Workshop Session III

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**

Kenneth Kendler, MD
Cynthia M. Bulik, PhD
Dorothy E. Grice, MD
Michael Strober, PhD
Stephen Wonderlich, PhD

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

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

As you can see from the outline above we have a full schedule of events this year with a few new opportunities for learning and collaboration. On Thursday evening there will be three different discussion panels including *Therapist Issues in the Treatment of Eating Disorders*, *Maximizing Access to Care and Insurance Coverage for Patients with Eating Disorders*, and *The Use of Technology in the Treatment of Eating Disorders*. Friday evening will be a videotape and discussion session to follow up on the Minnesota Semistarvation Study participants. We encourage you to attend--please visit our web site at www.acadeatdis.org for descriptions about each of these sessions.

For registration information visit our web site or contact the Academy's National Office at AED@Degnon.org.

non-recovering staff member develop an eating disorder as a result of working with this patient population. As mentioned earlier, however, I have had several recovering staff experience moderate to severe relapses. It has become increasingly clear to me over the years that the risk of relapse is highly correlated with the length of time of recovery and the level of training of the clinician. The longer the time of recovery and the more sophisticated the training, the less likely relapse will occur. There was a time when I thought that recovering staff should test the stability of their recovery by beginning with treatment of patients on an outpatient basis. I was fearful that the more intensive settings would be difficult. I have subsequently reversed my perspective. I think that the greater isolation that usually accompanies outpatient work, as well as the difficulty with containment of the patients, actually makes outpatient work riskier. I prefer that recovering staff begin in settings where there is ongoing peer contact and the patients are being more highly supervised. I believe the more intensive settings can provide more protection for staff that is moderately new in their recovery.

Counter transference vulnerabilities: In addition to the increased risk of relapse, I think there are a variety of counter transference issues that recovering staff can be more vulnerable to. If staff has recovered vis-à-vis a particular treatment strategy, they can err in the direction of becoming quite narrow and inflexible in their beliefs about how recovery occurs. Interestingly, the passion they feel for a technique, philosophy, or strategy is simultaneously their greatest strength and their greatest weakness. Clearly, there are times when our patients need straightforward, direct recommendations about how to recover. Sometimes, however, the reason the patient has the illness is because they need to explore what the right path of recovery needs to be for them. Recovering staff can sometimes have difficulty allowing the patient to flounder around a bit as they search for their path of recovery.

Sense of mission: Recovering staff that has had good, powerful, healing experiences with therapists, sponsors, etc can feel substantial pressure to help others as they have been helped. These are extraordinarily dedicated staff that will always go above and beyond the call of duty to help patients. Unwittingly, their dedication can slip into a situation where the therapist is shouldering more responsibility for recovery than the patient. One would never want to dilute this type of staff's commitment to helping people recover. The art is to help them make sure that the patient is at least working as hard as they are.

Conclusions

Both the Academy for Eating Disorders and the International Association of Eating Disorder Professionals need to create guidelines so that professionals who have personal recovery can have benchmarks to evaluate their readiness to enter the field. The criteria need to be as specific and concrete as possible. I would further recommend that the two organizations work collaboratively so as to avoid confusion regarding criteria. Overall, I feel that the organizations need to acknowledge the useful contributions these clinicians can make to the field. My hope is that by openly embracing this group we can focus our energies on how to maximize their strengths and minimize their vulnerabilities.

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- ◆ Keynote Presentation by: Judith V. Jordan, Ph.D., Jean Baker Miller, MD, Irene P. Stiver, Ph.D., David Calof, R.M.H.C., D.A.P.A., Laura S. Brown, Ph.D., Michael Levine, Ph.D., Kathryn J. Zerbe, MD.
- ◆ Full-day Training Sessions
- ◆ Panel Discussions
- ◆ Special Events

est Group Committee. Our Publication Council is chaired by Tim Walsh and will deal with all types of publications offered by the Academy. This will include existing features, such as our web page and our excellent Academy Newsletter, but also will involve the development of new publications that we think will be of particular interest to our membership. Stay tuned because I know the Publications Council has some exciting ideas that we will be able to share with you soon. Our Research and Foundation Council is currently chaired by Jim Mitchell. This council will work to develop research activity within the Academy and also to establish a foundation that will be used to support various programs in the Academy. Finally, our Public Affairs Council is chaired by Ruth Striegel-Moore and will focus on issues pertaining to government relations, media issues, third-party reimbursement, and advocacy. Furthermore, this council will be working closely with the newly established Eating Disorders Coalition to enhance our input into legislative and governmental issues that pertain to eating disorders and their treatment.

Each of the Academy Committees will fall under one of these councils. Although new committees are likely to spring up over time, below you will see our council and committee structure, along with our current chairs.

This new structure, its associated leadership, and the many excellent individuals from our membership who will join the committees associated with each council will move the Academy's agenda ahead with a level of organization and vision which has not been seen previously. Each of you may be asked to contribute time, energy, or knowledge to help us to move ahead. When that time comes, I am confident that the dynamic, multidisciplinary, and energetic membership of the Academy will step up and make the contribution. It is a great time for the Academy and I look forward to your future involvement. If you are interested in any of the committees, please contact the Committee Chair.

It is also time for me to bid farewell to several Board members and key individuals within the Academy. Our immediate past-president, Marsha Marcus, has served the Academy in too many ways to note. She led us through our very significant administrative transition last year, guided our first West Coast annual meeting, and continues to be an active participant in our media affairs. Leah Graves, officially served as secretary for the past four years, but unofficially serves as the Academy's autobiographical memory bank, by-laws interpreter, and policy and procedure scribe. Her steady and careful accounting of our process and history has been invaluable. Two Board Members-At-Large,

Felicia Boyd and Cheryl Rock, will also see the end of their terms. Both reliably and competently helped shaped the affairs of the Board, particularly in terms of developing liaisons to their specialty areas, nursing and dietetics/nutrition. Cheryl will continue on as the chair of the Teaching Day Committee for the next year.

Several other key individuals will also be stepping down. Amy Baker Dennis has in some ways defined the terms “education and training” for the Academy. Although she will be staying on as the Co-Chair of the Education and Training Council, her term as chair of the Teaching Day Committee comes to an end. Her contributions to the Academy have been extensive and we are fortunate to have her continuing guidance in our education and training endeavors. David Garner essentially established our Academy Newsletter and has been its only editor since 1995. Every good professional organization needs to establish a newsletter. David saw that need and responded reliably and consistently with thoughtful columns, announcements, and important professional information. His editorial skills and talents will be handed off to Lisa Lilendorf, who will assume the role of newsletter Editor and chairperson of the Newsletter Committee. We can count on Lisa to carry on David’s tradition and develop and expand the newsletter in ways that will benefit us all.

Finally, and very importantly as we prepare to go to New York for our Ninth International Eating Disorder Conference, we need to thank Mike Devlin and Kathy Pike, co-chairs of this years meeting. The countless hours donated by these two in putting together the exciting program, facilities, announcements and communication, and everything else that goes into such an extraordinary meeting will never be fully appreciated. As we immerse ourselves in this year’s meeting, consider taking a minute to thank Mike and Kathy, along with their excellent Program Committee, for all of their contributions. Take a minute to review their outstanding program that we can all look forward to in New York, May 4-7.

Finally, given that this is my last column as President, I would like to thank and acknowledge the many people who have helped me to serve you over the last year. In particular, I am indebted to our talented board members and committee chairs. Also, many thanks to our executive staff Linda Kozlowski, Meg Gorham, and especially George Degnon, all of Degnon Associates. Their collective wisdom and talents made my life easier and our organization better. Thank you for the opportunity to serve you and the people of our world afflicted with eating disorders.

Council/Committee	Chairs
Education/Training Council <ul style="list-style-type: none"> • Year 2000 Conference Committee • Year 2001 Conference Committee • Teaching Day Committee 	Amy Baker Dennis; Mike Devlin Mike Devlin; Kathy Pike (Cindy Bulik, Scott Crow - June 2000) Susan Yanovski; Elliott Goldner Amy Baker Dennis (Cheryl Rock - June 2000)
Membership Council <ul style="list-style-type: none"> • Special Interest Groups Committee • Recruitment/Retention Committee 	Pat Fallon Eric Von Furth Kelly Klump; Beth McGilley
Publication Council <ul style="list-style-type: none"> • Web Page Committee • Newsletter Committee • Annual Review Committee 	Tim Walsh Doug Bunnell David Garner (Lisa Lilendorf - June 2000) Tim Walsh, Jim Mitchell, Ruth Striegel-Moore
Research/Foundation Council <ul style="list-style-type: none"> • Research Committee 	Jim Mitchell Janet Treasure, Jim Mitchell
Public Affairs Council <ul style="list-style-type: none"> • Government Relations Committee • Media Committee • Third Party Reimbursement Committee 	Ruth Striegel-Moore Pat Santucci Marsha Marcus Walt Kaye
Other Important Working Groups Outside of Council Structure: <ul style="list-style-type: none"> • Child Adolescent Task Force • Telehealth Task Force • Fellowship Task Force • Nominations Committee • Awards Committee 	Rachel Bryant-Waugh, Tim Brewerton Armando Barriguete, Joel Yager, Jim Mitchell Pauline Powers, Diane Mickley Marsha Marcus (Steve Wonderlich - June 2000) Jim Mitchell (Steve Wonderlich - June 2000)

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Center for Eating Disorders Management, Inc.

The Center for Eating Disorders Management, Inc. is a privately owned, nurse practitioner operated, multidisciplinary outpatient treatment center with locations in Dover and Manchester, New Hampshire. For twelve years the Center has been providing medical evaluation and monitoring, nutritional counseling, psychological services, peer support groups, professional training and consultation, and community outreach programs. As CEDM, Inc. provides specialized treatment programs for the full range of eating disorders. Known for our supportive and compassionate approach to treatment, CEDM, Inc. integrates spiritual care into the recovery process, and Christian programming is available. Qualified candidates must be licensed or license eligible in New Hampshire. They will be proficient in medical history taking, physical examination, EKG and laboratory analysis, medication evaluation and management, as well as medical and nutritional monitoring, utilizing cognitive behavioral strategies. The individual will be comfortable counseling clients of all ages and their families, as well as groups. Eating disorder experience is preferred but not essential. Training and supervision will be provided as needed. Please send resume to Laura Clauss

ARNP-C, Suite 5, 466 Central Ave., Dover, N.H., 03820, fax 603-742-0589, email clauss2000@delnet.com or call (603) 742-0047.

Academy Newsletter

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

Lisa R. Lilienfeld, PhD

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Deadline submission:

June 15, 2000

All contributions to the Newsletter must be submitted to the Newsletter Editor in hardcopy and on 3 1/2" disk in IBM compatible form.