



**Magellan's Introduction to Its Adopted Clinical Practice Guideline for
the Assessment and Treatment of Patients
with Eating Disorders**

Table of Contents

Magellan Practice Guideline Task Force	1
Purpose of This Document.....	1
Additional Recommendations Based on Recent Literature Review.....	1
Anorexia Nervosa	2
Bulimia Nervosa.....	4
Eating Disorders Not Otherwise Specified – Binge Eating Disorder	6
Obtaining Copies of the APA Guidelines.....	9
Provider Feedback	9
References	10

Magellan Practice Guideline Task Force

Robert Ciaverelli, M.D.
Kathleen K. Frampton, R.N., B.S.N., M.P.H.
Gary Henschen, M.D.
Richard Kamins, Ph.D.
Daniel P. McCarthy, Ph.D.
Anna Scherzer, M.D., F.A.A.P., F.A.A.C.A.P., F.A.P.A.
Charles Wadle, D.O., R.Ph., F.A.P.A.

Purpose of This Document

Magellan Behavioral Health has adopted the American Psychiatric Association's (APA) *Practice Guideline for the Treatment of Patients With Eating Disorders, Third Edition (2006)*¹ to serve as an evidence-based framework for practitioners' clinical decision-making with adult patients who have an eating disorder. The adopted guideline indicates that while APA practice guidelines are intended for the care of adults, this particular guideline for eating disorders includes recommendations that apply to adolescents, since anorexia nervosa and bulimia nervosa often begin during this period. This guideline makes special notations when recommendations apply exclusively to a certain age group.

An extensive literature review suggests that the APA guideline is among the most comprehensive, evidence-based clinical practice guidelines (CPGs) for this disorder, and in general, APA guidelines are widely used. The guideline covers most areas of psychiatric management of patients with eating disorders, from clinical features and epidemiology to numerous aspects of treatment approach and planning. Since this guideline is broadly accepted by managed behavioral healthcare organizations (MBHOs), this adoption will minimize the burden on practitioners serving multiple MBHOs.

As with all guidelines, these adopted guidelines and Magellan's Introduction are intended to augment, not replace, sound clinical judgment. As a matter of good practice, clinically sound exceptions to the treatment guidelines should be noted in the member's record. Additionally, this guideline does not supersede Food and Drug Administration (FDA) determinations or other actions regarding withdrawal or approval of specific medications or devices, and their uses. It is the responsibility of the treating clinician to remain current on medication/device alerts and warnings that are issued by the FDA and other regulatory and professional bodies, and to incorporate such information in his or her treatment decisions.

Additional Recommendations Based on Recent Literature Review

The APA guideline is based on a literature review through 2004. Magellan conducted a further review of the clinical literature on assessment and treatment of eating disorders published through December 2010. Key relevant recommendations from this more recent literature review are summarized here. Magellan encourages providers to be familiar with this information, as well as the information discussed in the guideline.

Epidemiology

More recent epidemiological data and trending on eating disorders in the United States have been published since the release of the APA guideline. According to the American Academy of Pediatrics (AAP) *Clinical Report – Identification and Management of Eating Disorders in Children and Adolescents*, “the epidemiology of eating disorders has gradually changed; there is an increasing prevalence of eating disorders in males and minority populations in the United States as well as in countries in which eating disorders had not been commonly seen. Of particular concern is the increasing prevalence of eating disorders at progressively younger ages. A recent analysis by the Agency for Healthcare Research and Quality revealed that from 1999 to 2006, hospitalizations for eating disorders increased most sharply – 119 percent for children younger than 12 years (AAP, 2010, p. 1240). Other new important information on the determinants of eating disorder symptomatology in adolescents was garnered through a very large epidemiology health survey (n=2,036) conducted in the Portugal school system (Costa et al., 2008). This study concluded that higher body mass index and higher depressive symptomatology were associated with more severe eating disorder symptomatology in both sexes. Additionally, a sex effect on the association between socioeconomic status and eating disorder symptomatology was found. Girls with higher socioeconomic status and boys with lower socioeconomic status presented with more eating disorder symptomatology. These investigators also shared in their report that “in the previous decade, the prevalence of eating disorders has progressively increased, whereas the severity of observed cases has decreased” signaling a substantial number of subclinical and intermediate forms of dieting and eating concerns (Costa et al., 2008, p. 1126).

Anorexia Nervosa

The APA guideline emphasizes that a clinician’s decision to use psychotropic medications for weight restoration in a patient with anorexia nervosa (AN) must be based on the patient’s individual presentation. The guideline notes that selective serotonin reuptake inhibitors (SSRIs) combined with psychotherapy are widely used in treating anorexia. The guideline also indicates that more research was needed to evaluate the efficacy of the second-generation antipsychotics (SGAs) where initial clinical impressions have suggested that they may be useful in patients with severe, unremitting resistance to gaining weight, severe obsessional thinking and denial of delusional proportions. In regard to this clinical issue, a randomized clinical trial of 34-day hospital patients with anorexia nervosa demonstrated that compared with placebo, a flexible dose regimen of the SGA, olanzapine (2.5 mg/day to 10 mg/day), resulted in a greater rate of increase in weight, earlier achievement of target body mass index and a greater rate of decrease in obsessive symptoms. Researchers reported that they found no serious adverse side effects (e.g., extrapyramidal symptoms, excessive sleepiness, dizziness, or galactorrhea) during weekly medical examinations. Additionally, blood glucose levels were randomly tested each week in all patients showing no evidence of impaired glucose tolerance or *de novo* development of diabetes mellitus in any participant (Bissada et al. 2008).

The APA guideline indicates that for children and adolescents, evidence supports that family treatment is the most-effective intervention. The guideline also emphasizes that for some outpatients, a short-term course of family therapy may be as effective as a long-term course if patients do not have severe obsessive-compulsive features or non-intact families. The efficacy of family therapy for adolescent anorexia was analyzed in a five-year follow-up of 40 patients in the United Kingdom who received either conjoint family therapy (CFT) or separated family therapy

(SFT) – i.e., where the adolescent was seen individually and the parents attending separate sessions with the same therapist. Their analysis showed that overall there was little to distinguish the two treatments at five years, with more than 75 percent of subjects having no eating disorders symptoms. Other findings showed no deaths in the cohort and only 8 percent of those who had achieved a healthy weight by the end of treatment reported any relapse. Researchers suggested that those patients who respond well to outpatient family therapy generally stay well (Eisler et al. 2007).

The APA guideline also indicates that cognitive-behavioral, interpersonal and psychodynamic approaches, or a combination of these approaches, have the most evidence and consensus for use in the treatment of adults with anorexia. In addition, the APA guideline suggests that individual psychotherapy may be required for at least one year or many more, due to the enduring nature of the illness and the need for support during recovery. A more recent clinical trial was conducted to evaluate the relative efficacy of family-based treatment (FBT) versus adolescent-focused individual therapy (AFT) for adolescents with anorexia nervosa. Therapy sessions were conducted in 24 outpatient hours over 12 months (Lock et al., 2010). The FBT modality was designed to focus on several goals: (1) helping parents not feel responsible for causing the disorder (2) reinforcing positive aspects of parenting (3) developing family strategies for weight restoration in the child with anorexia (4) transitioning weight and eating control back to the child and (5) establishing a new and healthy adolescent relationship with the parents. The AFT modality was based on the theory that individuals with anorexia manifest ego deficits and confuse self-control with biological needs. This intervention was designed to help patients learn to identify/define their emotions and to tolerate them, rather than using starvation as a mechanism to numb the affective states. Both treatments led to considerable improvement and were similarly effective in producing full remission at the end of treatment. However, at both the 6- and 12- month follow-up, FBT was significantly superior to AFT in facilitating full remission (Lock et al, 2010).

The issue of relapse in anorexia nervosa is only briefly discussed in the APA guideline. An observation put forth in the guideline is that many clinicians who report seeing patients with chronic anorexia do see these patients experience substantial remission after many years of struggling with their disorder. In light of this, relapse in anorexia was an area of clinical study focusing on body composition as a predictor of relapse. A follow-up analysis of 32 weight-recovered subjects with anorexia nervosa from the New York site of the Fluoxetine to Prevent Relapse in Women With Anorexia Nervosa clinical trial and the Energy Homeostasis in Anorexia Nervosa longitudinal study examined the effect of percent body fat, body mass index (BMI), anorexia nervosa subtype, waist-to-hip ratio, and serum cortisol and leptin levels on treatment outcome. Findings revealed that percent body fat at the time of hospital discharge was the only clinical variable significantly associated with treatment outcome– i.e., lower percent body fat was associated with poorer long-term outcome. Investigators indicated that, while additional data linking percent body fat as a risk factor for relapse is necessary, their findings suggested that increased body fat may be protective against relapse (Mayer et al. 2007).

Bulimia Nervosa

A large systematic review of 47 studies on the efficacy of treatments for bulimia nervosa (BN) was conducted to include studies of medication only, behavioral interventions only, and medication plus behavioral interventions for adults and adolescents. Findings of the review revealed that evidence for medication is strong in the use of fluoxetine (60 mg/day) for reducing core bulimic symptoms. While researchers noted that further studies are needed, preliminary evidence of efficacy exists for other second-generation antidepressants (trazodone and fluvoxamine), an anticonvulsant (topiramate), a tricyclic antidepressant (desipramine) and for a monoamine oxidase inhibitor (MAOI), brofaromine (prescribed with close dietary monitoring) in reducing vomiting in the treatment of bulimia. Similarly, the evidence was strong for the effectiveness of cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) while the data showed promising results for dialectic behavioral therapy (DBT) and guided imagery. However, the supportive evidence for effectiveness of self-help groups was weak. Also, the authors confirmed that the evidence for combined treatments is weak and that outcome differentiation by socio-demographic factors is nonexistent (Shapiro et al. 2007).

The current APA guideline recommends the use of SSRIs for treatment of bulimia and indicates they may be helpful for depression, anxiety, obsessions, certain impulse disorder symptoms, and for those patients with a suboptimal response to appropriate psychosocial therapy. The guideline also specifically cautions prescribers that tricyclic antidepressants (TCAs) should generally be avoided and their potential lethality and toxicity in overdose should be taken into consideration. Similarly, the guideline cautions that MAOIs should be avoided with chaotic binge eating and purging, and also that bupropion should be avoided in patients with bulimia because of seizure risk.

The APA guideline does not address the use of neurostimulation in the treatment of eating disorders. Repetitive Transcranial Magnetic Stimulation (rTMS) has been studied primarily in the treatment of refractory depression. Researchers have just begun to research rTMS in the treatment of bulimia since it is believed to be often associated with depressive symptoms. It is postulated that there is a shared deficient serotonergic transmission in both syndromes and involvement of the left dorsolateral prefrontal cortex in the regulation of eating behavior (Walpoth et al. 2008). A small randomized sample of 14 women with bulimia were submitted to sham treatment, followed by either three weeks of active or sham rTMS. Stimulation was delivered for three weeks with an intensity of 120 percent motor threshold using 20 Hz in one session per day. Ten trains of 10 s, with a train interval of 60 s, were performed per session. Patients got an amount of 2,000 stimuli per session up to a total of 30,000 stimuli in the actively treated group. Results of this study showed that the average number of binges per day declined significantly between baseline and the end of treatment in both groups. There was also no significant difference between sham and active stimulation, in terms of improvements in purging behavior, and depressive or obsessive-compulsive symptoms – indicative of a placebo effect (Walpoth et al. 2008).

CBT is recognized in the APA guideline as the most efficacious short-term intervention in the treatment of bulimia when specifically directed at eating disorder symptoms and underlying maladaptive cognitions. The adopted guideline also suggests that psychodynamic and psychoanalytic approaches in individual or group format are useful once bingeing and purging symptoms have improved. The guideline indicates that family therapy should be considered whenever possible, especially for adolescents still living with parents or for older patients with ongoing conflicted

interactions with parents. Additionally, the guideline indicates that support groups and 12-step groups may be helpful adjuncts to the initial treatment of bulimia and for subsequent relapse prevention, but are not recommended as the sole initial treatment approach.

Two studies on the effectiveness of family therapy in treating adolescents with bulimia were conducted with mixed results. One clinical trial with 85 study participants conducted in the United Kingdom compared the efficacy and cost-effectiveness of family therapy versus CBT guided self-care. While the study results showed that at six months, bingeing had undergone a significantly greater reduction in the CBT guided self-care group than in the family therapy group – this difference disappeared at 12 months. There were no other differences between groups in behavioral or attitudinal eating disorder symptoms, but the direct cost of treatment was lower for CBT guided self-care than for family therapy (Schmidt et al. 2007).

Another study of 80 adolescents with bulimia evaluated the relative efficacy of family-based treatment (FBT) and supportive psychotherapy (SPT). In this trial, family therapy showed superior efficacy in that significantly more of these patients were binge-and-purge abstinent at the end of the study and at six months, and showed treatment effects in favor of FBT on all measures of eating pathological features (le Grange et al. 2007). Researchers in this trial conducted a follow-up analysis of these results, which showed that lower eating concerns, as measured by the Eating Disorder Examination (EDE), are the best predictor of remission for adolescents with bulimia. Additionally, FBT may be most effective in those cases with low levels of eating disorder psychopathology (le Grange et al. 2008).

Two transdiagnostic CBT modalities designed for patients with eating disorders (i.e., bulimia nervosa and eating disorder not otherwise specified) were studied in order to compare a treatment (CBT-Ef) focusing solely on eating disorder psychopathology against a more complex treatment (CBT-Eb) that also addressed additional problems– mood, clinical perfectionism, low self-esteem and interpersonal difficulties (Fairburn et al. 2009). Patients in the two treatment conditions exhibited substantial and equivalent change, which was maintained during follow-up. Investigators reported that at the 60-week follow-up assessment, 51.3 percent of the sample had a level of eating disorder features less than one standard deviation above the community mean. Also, the treatment outcome was not dependant upon the specific eating disorder diagnosis and both types appeared to be suitable for the majority of outpatients with eating disorders. Further exploratory analysis conducted by the research team indicated that patients with substantial additional psychopathology, of the type targeted in CBT-Eb, did better with this treatment than the focused form, while the opposite was true for the remaining patients (Fairburn et al., 2009).

Innovative modalities in the area of school-based, peer-led programs to prevent obesity and eating disorders have begun to emerge and gain credence. Two studies in this area were published with positive findings. One study evaluated peer teaching on healthy living (i.e., nutrition, physical activity and healthy body image) from older to younger children (“buddies”). Findings showed that all students improved their knowledge and that weight velocity was decreased in older students. (Stock et al. 2007) Another study demonstrated the effectiveness of an interdisciplinary, school-based obesity prevention intervention where disordered weight control behaviors were reduced by two-thirds for the girls in early adolescence who participated (Austin et al. 2007). Similarly, an eating disorders prevention program using dissonance-inducing activities that reduce thin-ideal internalization showed superiority over another prevention program that promoted healthy weight management. Reductions in eating disorder risk factors, bulimic symptoms and obesity onset were

seen through the 12-month and three-year follow-ups, suggesting public health potential (Stice et al. 2006, Stice et al. 2008).

Eating Disorder Not Otherwise Specified – Binge Eating Disorder

A published clinical review on binge eating disorder (BED) treatments reported that new epidemiological studies have shown BED to be the most common of the eating disorders, with lifetime prevalence estimates in the community of 3.5 percent among women and 2 percent among men (Yager 2008). The author noted that obesity is seen in approximately 65 percent of patients with BED where it increases progressively over time. BED is currently consigned to the “eating disorders not otherwise specified” diagnosis, but it is speculated that it may achieve full status as an independent diagnosis in the future Diagnostic and Statistical (DSM) V Manual.

Since binge eating is prevalent in overweight and obese individuals with type 2 diabetes mellitus, the impact of behavioral weight loss treatments on eating disorders symptomatology has been analyzed by investigators in the Look AHEAD (Action for Health in Diabetes) clinical trial (Gorin et al., 2010). Overweight and obese individuals age 45 to 76 years (n=5,145), with and without BED symptoms, were treated with either intensive lifestyle intervention or to enhanced usual care (a diabetes support/education control condition). Investigators reported that participants who stopped binge eating (BE) appeared to be just as successful at weight loss as non-binge eaters after one year of treatment. Gorin et al. also noted that individuals reporting more BE also reported a more depressed mood and worse physical health than their non-BE peers. Nevertheless, investigators stressed that most individuals who reported BE at baseline stopped BE by one year, and these individuals were just as successful at weight loss as those who reported no BE. Additionally, they indicated that few individuals started BE during the one-year study period. The study team concluded that BE is not exacerbated by behavioral weight loss treatment and may be improved by participating in a structured weight loss program targeting lifestyle changes (Gorin et al., 2010).

The APA guideline specifies that both group and individual formats of CBT, behavior therapy, dialectical behavior therapy, and interpersonal therapy all have been associated with binge frequency reduction and abstinence rates along with evidence of maintenance of this change over a year follow-up. Since publication of the guideline, a more recent study (n=101) of Dialectical Behavior Therapy for Binge Eating Disorder (DBT-BED) by Safer et al. was compared to an active comparison group therapy (ACGT) in order to evaluate it against a credible control group (“active placebo”) (Safer et al. 2010). Both interventions used specific manual-based treatment protocols and used the same therapists in both conditions in order to minimize variability. The DBT-BED approach, which was based on Linehan’s DBT for borderline personality disorder and modified by Telch et al. for binge eating, consisted of three modules: mindfulness, emotional regulation and distress tolerance, concluding with relapse prevention. The ACGT approach, which was modeled after Markowitz and Sacks’ supportive therapy for chronic depression, was modified to address binge eating for the current study while focusing primarily on bolstering self-esteem (Safer et al. 2010). Study results showed that both DBT-BED and ACGT reduced binge eating, but DBT-BED showed significantly fewer dropouts and greater initial efficacy at posttreatment (e.g., 64 percent abstinence rate for DBT-BED vs. 36 percent for ACGT). Investigators reported that these differences, however, did not persist over the 3-, 6-, and 12- month follow-up assessments, e.g., 12-month follow-up abstinence rate equal to 64 percent for DBT versus 56 percent for ACGT (Safer et al. 2010).

Similarly, the adopted guideline acknowledges that CBT with the addition of exercise appears to augment both binge and weight reduction and that some guided self-help CBT programs show promise for binge remission. A more recent clinical study of obese patients with BED (n=205) compared interpersonal therapy (IPT) with behavioral weight loss treatment (BWL) and guided self-help based on cognitive behavior therapy (CBTgsh) where 20 sessions of each modality was conducted over 6 months. Results showed that there was no difference among the three interventions at posttreatment on binge eating, specific eating disorder psychopathology (i.e., body weight, shape and eating concern) or general psychopathology. At the 2-year follow-up, both IPT and CBTgsh were significantly more effective than BWL in eliminating binge eating. Investigators suggested that guided self-help CBT should be considered a first-line treatment for most patients with BED and that IPT be use as the treatment of choice for the subset of individuals with BED with low self-esteem and high level of specific eating disorder psychopathology (Wilson et al., 2010).

Another clinical trial demonstrated that self-help approaches were a viable alternative to therapist-delivered treatment. Findings from a study of 259 adults with BED where therapist-led, therapist-assisted or self-help group treatments were compared to a wait-list condition showed that patients in the therapist-led group had the highest rate of abstinence and fewest dropouts at the end of treatment. However, there were no significant differences between treatment groups at follow-up on any of the primary or secondary outcome measures. Investigators concluded that while the presence of a therapist may enhance short-term abstinence and reduce the likelihood of dropout, they suggested groups for individuals with BED with reduced or no therapist involvement may be used as alternative treatments (Peterson et al., 2009).

The APA guideline discusses the serotonin and norepinephrine reuptake inhibitor (SNRI) and appetite-suppressant drug, sibutramine, as a promising treatment based on findings of preliminary trials. Since release of the guideline, a large clinical trial of 304 patients with BED was conducted comparing sibutramine against placebo. The participants who received sibutramine had significantly greater reductions in weekly binge frequency, binge days, BMI and associated psychopathology (Wilfley et al. 2008). On October 8, 2010, the U.S. Food and Drug Administration (FDA) asked the drug manufacturer to voluntarily withdraw sibutramine from the U.S. market because of clinical trial data indicating an increased risk of cardiovascular adverse events, including heart attack and stroke, in the studied population. The manufacturer complied with the request and sibutramine no longer is available in the United States (FDA MedWatch, 2010).

The APA guideline also presented early positive findings of studies evaluating the efficacy of the anticonvulsant drug topiramate. More recently, findings of a large multi-center clinical trial with 407 patients with BED have been published. Patients receiving topiramate experienced highly significant rates of reduction in binge eating days and binge eating episode frequency, weight, BMI, overall severity and compulsive features of BED, compared with placebo. In addition, topiramate was associated with greater improvement in measures of hunger, impulsive features and disability (McElroy, Hudson et al. 2007). The novel antiepileptic drug agent zonisamide was also studied in a small single-center trial where it was associated with a significantly greater rate of reduction in binge eating episode frequency, body weight and severity of illness than placebo. However, researchers reported that zonisamide was associated with only fair tolerability and a relatively high treatment discontinuation rate (McElroy, Kotwal et al. 2006).

Treatment of BED with antidepressant medications, particularly the SSRIs, was recommended as a treatment option in the APA guideline with the cautionary note that while patients experience a short-term reduction in binge eating, there is usually no accompanying substantial weight loss. The guideline also indicates that use of SSRIs for this disorder is typically at the high end of the recommended dosage range. More recent clinical trials and meta-analyses have produced mixed results in their usage for this indication. A study comparing sertraline and fluoxetine in the treatment of obese patients with BED showed no differences between the two treatments and both demonstrated significant weight loss and improvement in binge eating core symptoms and psychopathology (Leombruni et al. 2008). Similarly, a trial of high-dose escitalopram was shown to be efficacious in reducing weight and global severity illness in obese patients with BED, but not in reducing obsessive-compulsive symptoms of BED (Guerdjikova et al. 2007). Conversely, a meta-analysis of seven antidepressant studies (i.e., fluoxetine, sertraline, citalopram, fluvoxamine and imipramine) concluded that their findings were not supportive in recommending the use of antidepressants as the only and first-choice therapy for remission of binge eating episodes and weight reduction of patients being treated for BED (Stefano et al. 2007). In another systematic review of studies, findings for SSRI antidepressant efficacy (i.e., sertraline, citalopram) were based primarily on a series of short-term, placebo-controlled medication trials. These agents demonstrated greater rates of reduction in target eating, and psychiatric and weight symptoms in individuals with BED than placebo. Researchers noted that these conclusions should be viewed tentatively due to high drop-out rates and placebo response rates (Brownley et al. 2007).

Researchers have indicated that novel drug treatments that reduce binge eating, the associated psychopathology and body weight, and are well-tolerated, are needed for the treatment of BED. Also, several drugs used to treat BED (i.e., orlistat, sibutramine, topiramate and zonisamide) have problematic side effects and relatively high discontinuation rates (McElroy, Guerdjikova et al. 2007). The highly specific norepinephrine reuptake inhibitor, atomoxetine, used in the treatment of attention-deficit hyperactivity disorder (ADHD), is associated with anorexia and weight loss. Since this drug is generally well-tolerated and may have antidepressant properties, it was chosen for study in a placebo-controlled clinical trial in order to determine its possible efficacy in the treatment of BED. Study results found atomoxetine to be superior to placebo in reducing binge frequency, weight and severity of illness. Researchers suggest that further studies of atomoxetine are clearly warranted (McElroy, Guerdjikova et al. 2007).

The APA guideline indicates that although evidence is limited, combined pharmacotherapy and psychotherapy treatment for BED is frequently helpful in clinical practice. The systematic review of studies previously cited by Brownley et al. (2007) revealed that use of cognitive behavioral therapy (CBT) combined with medications (i.e. fluoxetine, orlistat) or medication (desipramine) along with weight loss therapy, was superior to medication or weight loss therapy alone or when combined with placebo in the treatment of patients with BED (Brownley et al. 2007). Similarly, a marked reduction in binge eating, short-term weight loss and a significant decrease in psychopathology were shown in a clinical trial of topiramate (target dose 200 mg) plus CBT in obese patients with BED (Claudino et al. 2007). Another study demonstrated that the combination of cognitive-behavioral weight loss therapy (BWL) and sibutramine, leads to comparable weight loss in individuals suffering from obesity and subclinical binge eating disorder (sBED) as in obese non-bingers. However, BWL alone was an effective treatment in significantly reducing binge eating frequency in sBED without the augmenting effect of sibutramine (Bauer et al. 2006).

Modalities employing new technologies and psychosocial approaches continue to be developed and studied in the area of eating disorders treatment. One clinical trial of 105 male and female high school students examined the effects of an Internet-facilitated, weight management program on reducing binge eating and overeating, and preventing weight gain in a population of students at risk of being overweight. In comparing a 16-week online intervention compared to a wait-list control group, the study group found a strong effect for stabilization of weight gain and reduction in binge eating and overeating at the nine-month follow-up assessment. Researchers were encouraged with these findings using an easily disseminated, Internet-facilitated program (Jones et al. 2008). Adapted motivational interviewing (AMI) that was originally developed for addictive behaviors was studied in 108 women with BED. Both groups, where one was assigned to one session of AMI and use of a self-help handbook, or use of a self-help handbook only, showed improvement in binge eating and associated symptoms. After 16 weeks of intervention, the AMI group had a greater proportion of women who abstained from binge eating and no longer met the binge frequency criterion for BED DSM-V diagnosis (Cassin et al. 2008).

Obtaining Copies of the APA Guidelines

Copies of the APA *Practice Guideline for the Treatment of Patients With Eating Disorders, Third Edition* can be obtained through the APA at <http://psych.org/>, by calling (800) 368-5777, or by U.S. mail at:

American Psychiatric Publishing, Inc.
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901

Provider Feedback

Magellan welcomes feedback on adopted clinical practice guidelines. We take all suggestions and recommendations into consideration in our ongoing review of the guidelines. Submit your comments to:

Clinical Operations Coordinator
Re: CPG

Magellan Health Services
6950 Columbia Gateway Dr.
Columbia, Maryland 21046
CPG@MagellanHealth.com

References

1. American Psychiatric Association (2006). Practice Guideline for the Treatment of Patients with Eating Disorders, Third Edition. Available at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm, accessed March 8, 2007.
2. Rosen DS, and the Committee on Adolescence. Clinical Report- Identification and Management of Eating Disorders in Children and Adolescents. Pediatrics Volume 126, Number 6, December 2010.
3. Costa C., Ramos E, Severo M, Barros H, Lopes C. Determinants of Eating Disorders Symptomatology in Portuguese Adolescents. Arch Pediatr Adolesc Med/Vol 162 (No. 12) Dec 2008/
4. Bissada H, Tasca GA, Barber AM, Bradwejn J. Olanzapine in the Treatment of Low Body Weight and Obsessive Thinking in Women With Anorexia Nervosa: A Randomized, Double-Blind, Placebo-Controlled Trial. Am J Psychiatry 2008; 165: 1281-1288.
5. Eisler I, Simic M, Russell GFM, Dare C. A randomized controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: a five-year follow-up. Journal of Child Psychology and Psychiatry 48: 6 (2007).
6. Lock J, LeGrange D, Agras S, Moye A, Bryson SW, Jo B. Randomized Clinical Trial Comparing Family-Based Treatment With Adolescent-Focused Individual Therapy for Adolescents With Anorexia Nervosa. Arch Gen Psychiatry. 2010; 67 (10): 1025-1032.
7. Mayer LES, Roberto CA, Glasofer DR, Fisher Etu S, Gallagher D, Wang J, Heymsfield SB, Peirson RN. Does Percent Body Fat Predict Outcome in Anorexia Nervosa? Am J Psychiatry 2007; 164: 970-972.
8. Shapiro JR, Berkman ND, Brownley KA, Sedway JA, Lohr KN, Bulik CM. Bulimia Nervosa Treatment: A Systematic Review of Randomized Controlled Trials. Int J Eat Disord 2007; 40: 321-336.
9. Walpoth M, Hoertnagl C, Mangweth-Matzek B, Kemmler G, Hinterholz J, Conca A, Hausmann A. Repetitive Transcranial magnetic Stimulation in Bulimia Nervosa: Preliminary Results of a Single-Centre, Randomised, Double-Blind, Sham-controlled Trial in Female Outpatients. Psychother Psychosom 2008; 77: 57-60
10. Schmidt U, Lee S, Beecham J, Perkins S, Treasure J, Yi I, Winn S, Robinson P, Murphy R, Keville S, Johnson-Sabine E. A Randomized Controlled Trial of Family Therapy and Cognitive Behavior Therapy Guided Self-Care for Adolescents with Bulimia Nervosa and Related Disorders. Am J Psychiatry 16:4, 4, April 2007.
11. le Grange D, Crosby RD, Rathouz PJ, Leventhal BL. A Randomized Controlled Comparison of Family-Based Treatment and Supportive Psychotherapy or Adolescent Bulimia Nervosa. Arch Gen Psychiatry. 2007; 64(9); 1049-1056.
12. le Grange D, Crosby RD, Rathouz PJ, Leventhal B. Predictors and Moderators of Outcome in Family-Based Treatment for Adolescent Bulimia Nervosa. J Am Acad Child Adolesc Psychiatry. 47:4, April 2008.
13. Fairburn CG, Cooper Z, Doll HA, O'Connor ME, Bohn K, Hawker DM, Wales JA, Palmer RL. Transdiagnostic cognitive-behavioral Therapy for Patients With Eating Disorder: A Two-Site Trial With 60-Week Follow-Up. Am J Psychiatry 2009; 166:311-319.
14. Stock S, Mirand C, Evans S, Plessis S, Ridley J, Yeh S, Chanoine JP. Healthy Buddies: A Novel, Peer-Led Health Promotion Program for the Prevention of Obesity and Eating Disorder in Children in Elementary School. Pediatrics Volume 120, Number 4, October 2007.
15. Bryn Austin S, Kim J, Wiecha J, Troped PJ, Feldman HA, Peterson KE. School-Based Overweight Preventive Intervention Lowers Incidence of Disordered Weight-control Behaviors in Early Adolescent Girls. Arch Pediatr Adolesc Med/Vol 161 (No.9), Sep 2007.
16. Stice E, Shaw H, Burton E, Wade E. Dissonance and Healthy Weight Eating Disorder Prevention Programs: A Randomized Efficacy Trial. J Consult Clin Psychol. 2006 April; 74(2): 263-275.
17. Stice E, Marti N, Spoor S, Presnell K, Shaw H. Dissonance and Healthy Weight Eating Disorder Prevention Programs: Long-Term Effects From A Randomized Efficacy Trial. J Consult Clin Psychol 2008, Vol. 76, No. 2, 329-340.
18. Yager J. Binge Eating Disorder: The Search for Better Treatments. Am J Psychiatry 165:1, January 2008.
19. Gorin AA, Niemeier HM, Hogan P, Coday M, Davis C, DiLillo VG, Gluck ME, Wadden TA, West DS, Williamson D, Yanovski SZ for the Look AHEAD Research Group. Arch Gen Psychiatry/Vol 65 (No. 12), December 2008.
20. Safer DL, Robinson AH, Jo B. Outcome From a Randomized Controlled Trial of Group Therapy for Binge Eating Disorder: Comparing Dialectical Behavior Therapy Adapted for Binge Eating to an Active Comparison Group Therapy. Behavior Therapy 41 (2010) 106-120.
21. Wilson GT, Wilfley DE, Agras S, Bryson SW. Psychological Treatment of Binge Eating Disorder. Arch Gen Psychiatry. 2010;67(1):94-101.
22. Peterson CB, Mitchell JE, Crow SJ, Crosby RD, Wonderlich SA. The Efficacy of Self-Help Group Treatment and Therapist-Led Group Treatment for Binge Eating Disorder. Am J Psychiatry 2009; 166: 1347-2354.

23. Wilfley DE, Crow SJ, Hudson JI, Mitchell JE, Berkowitz RI, Blakesley V, Walsh BT. Efficacy of Sibutramine for the Treatment of Binge Eating Disorder: A Randomized Multicenter Placebo-Controlled Double-Blind Study. *Am J Psychiatry* 165: 1, January 2008.
24. FDA MedWatch: The Drug Safety Information and Adverse Event Reporting Program. Meridia (sibutramine hydrochloride) Information. Accessed website on January 5, 2010
<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm191652.htm>
25. McElroy SL, Hudson JI, Capece JA, Beyers K, Fisher AC, Rosenthal NR. Topiramate for the Treatment of Binge Eating Disorder Associated With Obesity: A Placebo-Controlled Study. *Biol Psychiatry* 2007; 61: 1029-1048.
26. McElroy SL, Kotwal R, Guerdjikova AI, Welge JA, Nelson EB, Lake KA, D'Alessio DA, Keck PE, Hudson JI. Zonisamide in the Treatment of Binge Eating Disorder With Obesity: A Randomized Controlled Trial. *J Clin Psychiatry* 67:12, December 2006.
27. Leombruni P, Piero A, Lavagnino L, Brustolin A, Campisi S, Fasson S. A randomized, double-blind trial comparing setraline and fluoxetine 6-month treatment in obese patients with Binge Eating Disorder. *Progress in Neuro-Psychopharmacology & Biological Psychiatry* 32 (2008) 1599-1605.
28. Guerdjikova AI, McElroy SL, Kotwal R, Welge JA, Nelson E, Lake K, Alessio DD, Keck PE, Hudson JI. High-dose escitalopram in the treatment of binge-eating disorder with obesity: a placebo-controlled monotherapy trial. *Hum. Psychopharmacol. Clin Exp* 2008; 23: 1-11.
29. Stefano SC, Bacaltchuk J, Blay SL, Appolinario JC. Antidepressants in short-term treatment of binge eating disorder: Systematic review and meta-analysis. *Eating Behaviors* 9 (2008) 129-136.
30. McElroy SL, Guerdjikova A, Kotwal R, Welge JA, Nelson EB, Lake KA, Keck PE, Hudson JI. Atomoxetine in the Treatment of Binge-Eating Disorder: A Randomized Placebo-Controlled Trial. *J Clin Psychiatry* 68:3, March 2007.
31. Claudino AM, de Oliveira IR, Appolinario JC, Cordas TA, Duchesne M, Sichieri R, Bacaltchuk J. Double-Blind, Randomized, Placebo-Controlled Trial of Topiramate Plus Cognitive-Behavior Therapy in Binge-Eating Disorder. *J Clin Psychiatry* 2007; 68: 1324-1332.
32. Brownley KA, Berkman ND, Sedway JA, Lohr KN, Bulik C. Binge Eating Disorder Treatment: A Systematic Review of Randomized Controlled Trials. *Int J Eat Disord* 2007; 40: 337-348.
33. Bauer C, Fischer A, Keller U. Effect of sibutramine and of cognitive-behavioural weight loss therapy in obesity and subclinical binge eating disorder. *Diabetes, Obesity and Metabolism*, 8, 2006, 289-295.
34. Cassin SE, von Ranson KM, Heng K, Brar J, Wojtowicz AE. Adapted Motivational Interviewing for Women With Binge Eating Disorder: A Randomized Controlled Trial. *Psychology of Addictive Behaviors* 2008, Vol. 22, No. 3, 417-425.
35. Jones J, Luce KH, Osborne MI, Taylor K, Cunnig D, Celio Doyle A, Wilfley DE, Taylor CB. Randomized, Controlled Trial of an Internet-Facilitated Intervention for Reducing Binge Eating and Overweight In Adolescents. *Pediatrics* Volume 121, Number 3, March 2008.