

Joel Yager  
Michael J. Devlin  
Katherine A. Halmi  
David B. Herzog  
James E. Mitchell  
Pauline S. Powers  
Kathryn J. Zerbe

# Guideline Watch: Practice Guideline for the Treatment of Patients With Eating Disorders, 2nd Edition

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This guideline watch highlights some of the more salient developments since publication of the APA's *Practice Guideline for the Treatment of Patients With Eating Disorders*, 2nd edition (1), in 2000. The authors comprise a work group developing a third edition of the guideline that is scheduled for 2006 publication. Other practice guidelines on eating disorders published over the past 5 years include a practice guideline in Britain under the auspices of the National Institute for Clinical Excellence (available online at <http://www.nice.org.uk/page.aspx?o=101239>), a practice guideline by the Australia and New Zealand Royal College of Psychiatrists (2), and a practice guideline for pediatricians and adolescent medicine specialists (3). Several systematic Cochrane reviews (4–7) have also been published. This watch is organized to follow the presentation of the 2000 guideline.

## **DEVELOPING A TREATMENT PLAN FOR THE INDIVIDUAL PATIENT**

### **PSYCHIATRIC MANAGEMENT**

*Clinical assessment.* Although amenorrhea is one of the DSM-IV-TR criteria for anorexia nervosa, many patients with preserved menstruation but all of the other features of anorexia nervosa have a similar course as those who become amenorrheic (8). Furthermore, obtaining an accurate menstrual history from these patients is difficult, because many report menstruating regularly when at best they may have spotty and irregular menstrual activity.

Second, clinically significant distinctions have been made between so called “typical” anorexia nervosa, in which patients have marked body image distortion and remain convinced that they are actually too fat, and “atypical” anorexia nervosa, in which patients acknowledge that they are too thin but nevertheless feel helplessly compelled to continue restrictive dieting behaviors. Patients with atypical features may have a somewhat better prognosis, possibly due in part to the fact that they are more willing to engage and remain in treatment (9, 10).

Third, several predominant personality styles have strong associations with prognosis. Regardless of DSM eating disorder diagnosis, patients who have healthy relationships but perfectionistic self-standards have better prognoses than those who are avoidant-constricted or have somewhat chaotic emotional dysregulation (11). In anorexia nervosa, several additional clinical features have been identified that may offer clinicians important targets for psychological intervention. For example, it may be helpful to assess motivational stage (12–14), interpersonal attachment style (15), and the patient's overall sense of attachment to life (16), because findings in these dimensions may be relevant for determining appropriate psychosocial approaches and treatment settings.

*Laboratory assessments.* For patients who have lost considerable weight, and especially for those who show any cardiovascular signs or symptoms, a cardiac ultrasound may be considered, because in one study 71.4% of 15 patients but only 10% of control subjects were found to have silent pericardial effusion on echocardiographic examination (17).

## FORMULATION AND IMPLEMENTATION OF A TREATMENT PLAN

### CHOOSING A SITE OF TREATMENT

In choice of treatment sites, increasing attention is being given to the essential features of various treatment programs. For example, effectiveness of partial hospital programs has been directly related to their intensity. Whereas 12-hour, 6 day per week programs may approach inpatient programs in effectiveness, programs with fewer hours and fewer days of the week have poorer outcomes (18, 19).

### CHOICE OF SPECIFIC TREATMENTS FOR ANOREXIA NERVOSA

*Nutritional rehabilitation.* For acquiescing patients, new studies have reopened discussions about the potential utility of supplementary nasogastric feedings. Initial liquid formula feedings in hospitalized patients were beneficial in one randomized study, and in special settings nasogastric tube feedings have hastened weight gain. However, no long-term studies have been conducted, nor have additional long-term benefits been demonstrated for these interventions (20, 21).

*Psychosocial interventions.* Research studies have found difficulties in initiating and sustaining cognitive behavior therapies (CBTs) for patients with anorexia nervosa (22). However, following weight gain, application of CBT has been found to reduce risk of relapse (23).

With regard to family psychotherapy with anorexia nervosa, conjoint family therapy and separated family therapy were equally effective on global measures of outcome in an outpatient study of 40 randomly assigned adolescent patients. However, symptomatic change was more marked in the separated family group, whereas psychological change was more prominent in those receiving conjoint family therapy (24). Among adolescents with anorexia nervosa hospitalized for inpatient treatment, an equivalent extent of weight restoration was found for family therapy as for family group psychoeducation, a less expensive form of treatment (25). Finally, in a randomized outpatient study in which adult patients with anorexia nervosa were assigned to one of four treatment arms consisting of 1 year of focal psychoanalytic psychotherapy, 7 months of cognitive analytic therapy, 1 year of family therapy, or low-contact routine treatment, the specialized therapies were found to be effective (26).

Evidence-based research on the use of psychotherapy for anorexia nervosa remains limited in

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many ways. It is often difficult to carry out rigorously designed trials of psychotherapies, and as with pharmacotherapy trials, long-term follow-up periods are uncommon. Thus, clinicians are advised to consider the available studies and integrate those findings that may be useful into their clinical decision-making.

*Medications.* For anorexia nervosa, several studies of adjunctive medication show no additional advantage to good nursing care in undernourished patients being treated in structured eating disorder-specific programs in hospital settings. For weight maintenance, the only randomized, placebo-controlled trial to date using an antidepressant (fluoxetine in variable dosages from 20 to 60 mg) studied 35 patients with restricting type anorexia nervosa and found a significant advantage for active medication achieved in increasing weight and decreasing core eating disorder symptoms (27).

For patients with treatment-resistant illness, or in settings where eating disorder-specific protocols are not well developed or implemented, several case reports and open studies suggest that second-generation (i.e., atypical) antipsychotic medications such as olanzapine (28–34) might be useful. Most

of these reports, the largest of which involved 20 patients with anorexia nervosa, suggest that second-generation antipsychotics may improve the rate of weight gain in patients with anorexia nervosa. However, placebo-controlled, randomized trials have yet to appear.

Case series have also suggested value for supplementing with omega-3 fatty acids (34). However, other nutritional supplements including L-tryptophan did not increase the effectiveness of fluoxetine in a double-blind, placebo-controlled trial involving 26 patients with anorexia nervosa (35). Finally, with regard to addressing the fearful problems of osteopenia and osteoporosis in anorexia nervosa, approaches remain experimental (36, 37). At the present time, the best guidance is still to provide nutritional rehabilitation assuring sufficient dietary protein, carbohydrates, fats, calcium, and vitamin D.

### CHOICE OF SPECIFIC TREATMENTS FOR BULIMIA NERVOSA

*Psychosocial interventions.* Studies have continued to demonstrate effectiveness for CBT and for interpersonal therapy (IPT) in both individual and group settings. Increasing attention is being given to the possibility that certain patients with bulimia nervosa and binge eating disorder may be effectively treated using "self-care," i.e., self-management strategies using a variety of professionally written CBT-oriented manuals (38–43) or online or CD-ROM-based programs (39). In stepped care programs in which other clinical considerations such as complexity and/or severity are not overriding, such self-care strategies may be appropriately tried as a first line of intervention. A study comparing supervised self-help with CBT actually found higher remission rates for self-help than for CBT, but many patients evidently accessed additional treatment resources (38). Another study comparing the efficiency of manual-based self-help with fluoxetine, self-help and fluoxetine in combination, and placebo in outpatient women with bulimia nervosa found that both fluoxetine and the self-help manual were effective in reducing the frequency of target eating behaviors and, furthermore, acted additively with the best outcome occurring in the group receiving both active treatments (44). However, limitations of self-help or supervised self-help approaches have been evident in other studies. For example, in a study comparing the relative efficacy of fluoxetine with guided self-help in primary care settings, a majority of patients did not complete the trial. Guided self-help appeared ineffective, whereas treatment with fluoxetine was associated with better retention and better symptomatic improvement

(45). Newer studies are beginning to examine specific factors in self-help programs that may be effective. In one study that compared a self-help manual based on CBT with a control manual focusing on self-assertion skills and with a waiting list control, both manuals showed significant benefit, with no particular advantage for the CBT-based manual over the control manual (43).

With regard to other psychosocial interventions for bulimia nervosa, a 20-week course of dialectical behavior therapy focusing on training in emotion regulation skills resulted in significant improvement in bingeing and purging behavior compared with a waiting list control group (46). In the first dismantling study of its type for bulimia nervosa, cognitive therapy either alone or in combination with nutritional therapy was more effective than nutritional therapy alone or a control support group (47). In a study comparing individual with group CBT for patients with bulimia nervosa, significantly more patients became abstinent immediately following individual treatment, but this difference was no longer evident at follow-up, at which time results of the two treatments were essentially identical (48).

Studies of bulimia nervosa patients who fail to respond to an initial course of CBT have examined the potential utility of subsequent IPT or medication management. Dropout rates were high for both treatments, and abstinence rates of 16% for those assigned to IPT and 10% for those assigned to medication suggest that offering lengthy sequential treatments appears to have little value (49). However, in a different controlled study, 13 patients failing CBT who were then assigned to fluoxetine did considerably better than the 9 assigned to placebo, at least with respect to achieving substantial reductions in the frequency of days of both binge eating and purging (50).

With regard to relapse prevention, in patients successfully treated with CBT no differences were found between those subsequently offered follow-up only or a crisis intervention model consisting of additional visits if they became symptomatic. Because none of the 30 subjects who relapsed during the follow-up sought additional treatment visits, it appears ineffective to simply tell patients with bulimia nervosa who appear to have been successfully treated to return if they develop additional problems (51).

*Medications.* For bulimia nervosa several additional agents have been reported to be effective, largely in industry-sponsored studies. Among selective serotonin reuptake inhibitors (SSRIs), sertraline was shown to be effective for bulimia nervosa in an open 8-week trial of 18 women (52). Of the

oretical as well as clinical interest, in open trials involving 7 and 22 patients, respectively, the selective noradrenergic receptor inhibitor (SNRI) reboxetine has recently been found to be effective for bulimia nervosa (53, 54). In a double-blind, placebo-controlled crossover study involving 12 patients in each of two 6-week arms, inositol was shown to be effective for bulimia nervosa and binge eating disorder (55). In a double-blind controlled study involving 64 patients for 10 weeks, topiramate demonstrated efficacy in treating bulimia nervosa (56, 57). In contrast to higher rates of adverse events related to topiramate seen in the binge eating disorder studies described in the following section, only one of 35 patients receiving the drug withdrew from this study because of adverse events.

### EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS)

Treatment of binge eating disorder (BED), currently categorized as an EDNOS, has been assessed in multiple studies. However, conclusions about actual effectiveness should be made with caution because symptoms of BED are highly labile and have high placebo response rates in numerous studies.

*Psychosocial treatments.* Studies have compared the relative effectiveness of different psychotherapies and have attempted to bundle and unbundle components of psychotherapies and traditional weight loss programs. In a study of 162 men and women with BED, retention rates and remission rates were high for both CBT and IPT. Some deterioration was seen over 12 months of follow-up, but overall no differences were found between the two treatments (58). In another study, subjects with BED receiving CBT were randomly assigned to exercise instruction with exercise membership/staff monitoring, maintenance CBT treatment consisting of biweekly sessions over 6 months, both of these, or neither. Exercise, but not maintenance treatment, helped reduce binge frequency. The largest overall changes were seen in patients receiving both exercise and maintenance CBT (59). Another study found no advantages for involving spouses in the active phase of outpatient CBT treatment for BED (60).

*Pharmacotherapy.* A number of new studies have appeared, the majority industry funded. Several SSRIs have been found effective in treating BED. In a 6-week double-blind, placebo-controlled trial of fluoxetine in which 60 patients were enrolled, significantly greater reductions in binge eating were found in patients taking the active drug. The fluoxetine patients on average lost 3.3 kg over 6 weeks, whereas the placebo patients gained 0.7 kg

(61). Similarly, in a 6-week double-blind, placebo-controlled trial in which 38 patients were enrolled, citalopram was superior in terms of binge frequency reduction, with 47% of the patients on active drug achieving remission. Citalopram patients also lost more weight (2.1 kg vs. 0.2 kg) (62). In a small placebo-controlled, randomized trial of fluvoxamine for BED subjects in which 20 patients were enrolled, both fluvoxamine and placebo resulted in significant improvements, but no significant differences between treatments were found, perhaps because of the small sample size (63). In a 12-week randomized, double-blind, placebo-controlled trial in which 60 obese patients with BED were enrolled, the SNRI sibutramine was superior to placebo for binge eating reduction, with evidence of divergence between the groups in the first 2 weeks. Binge remission occurred in 52% of those receiving sibutramine who completed the trial (64).

Several second-generation anticonvulsants have also shown promise for BED. In a 14-week randomized, placebo-controlled, double-blind trial, topiramate yielded a 64% remission rate as well as greater reduction in target symptoms and greater weight loss than placebo (65). However, of 57 patients receiving topiramate in open-label or double-blind trials, 14 discontinued treatment because of adverse events and another 17 were dropped from the trial because of protocol nonadherence. In an open-label trial zonisamide was found to be helpful in BED subjects (66). Here too, a substantial number of individuals did not complete the trial, with four discontinuing because of adverse events and four for other reasons.

*Pharmacotherapy compared with or in combination with psychotherapy.* In a 12-month study comparing two SSRIs and/or CBT for BED, CBT was found to be more effective than fluoxetine or fluvoxamine; effects of CBT on eating behavior appeared to be enhanced by the addition of fluvoxamine, but not fluoxetine (67). Similarly, in a large study of CBT and/or fluoxetine for BED, CBT with or without medication was superior to the other treatments, and adding fluoxetine did not yield additional benefit (68). In a slightly different vein, in a study in which BED subjects receiving a 16-session group behavioral treatment were also randomly assigned to additional treatment with either a 20-session course of individual CBT, fluoxetine at 60 mg/day, or placebo, individual CBT without fluoxetine significantly augmented the group effect. Some of the data suggested that fluoxetine had beneficial effects on depressive symptoms relative to placebo (M. Devlin, personal communication, 2005).

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