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IN THIS ISSUE

Focus of the Month:
The Treatment of Eating Disorders

Effective Psychiatric Medications for Eating Disorders

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Dr. Ashih reports no financial relationships with any commercial companies related to this article.

Because of the dearth of FDA – approved medications for eating disorders,psychotherapy has gradually become the treatment of choice. Nonetheless, clinical trials of off-label uses of various medications have yielded a few impressive results, particularly for bulimia and binge eating disorder. Here's a quick run down of various meds that may be worth a try.

Anorexia Nervosa (AN)

Antidepressants. Both amitriptyline and fluoxetine have been studied in double-blind placebo-controlled trials, and neither has been shown to be more effective than placebo for either weight gain or weight maintenance. Nonetheless, fluoxetine did decrease both depression and anxiety in anorectic patients in one study (Kaye et al., *Biol Psych* 2001; 49:644-52). In a different study, amitriptyline was found ineffective for depressive symptoms in patients with AN (Biederman et al., *J Clin Psychopharm* 1985; 5:10-16).

Cyproheptadine (Periactin). Cyproheptadine is a potent histamine & serotonin antagonist. Most often used to treat migraines, it has been shown to be an effective appetite stimulant in cystic fibrosis (Homnick et al., *Ped Pulm* 2004; 38(2):129-34). In a double-blind study of 81 anorectic females, a subgroup of patients (those who had experienced complications at birth) gained approximately 5 kg on cyproheptadine vs. less than 2 kg on placebo (Goldberg et al., *Brit J Psych* 1979, 134: 67-70). In another double-blind study of 72 patients, cyprophetadine significantly reduced the number of days to reach normal weight in anorectic patients when compared to amitriptyline or placebo (Halmi et al., *Arch Gen Psych* 1986; 43(2): 177-81). Because of its relatively safe side-effect profile, cyproheptadine dosed at 2 mg QID and titrated up to 10 mg QID (max 40 mg daily – as per Halmi et al's protocol), seems a reasonable option during the weight-restoration phase of treatment.

Olanzapine (Zyprexa). In an attempt to use olanzapine's weight gain side effect to clinical advantage, researchers funded by Eli Lilly randomly assigned 34 anorectic patients to either olanzapine (final mean dose, 6.6 mg/day) or placebo. Both groups

—— *Continued on Page 3*

Learning objectives for this issue: 1. List the medications with evidence of efficacy in eating disorders. **2.** Describe the most effective psychotherapy techniques for eating disorders. **3.** Describe creative behavioral strategies for treating patients with eating disorders. This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Psychotherapy for Eating Disorders: A Review of the Current Evidence

By Dhwani Shah, MD
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Dr. Shah reports no financial relationships with any commercial companies related to this article.

A variety of psychotherapy techniques work well for eating disorders, particularly for bulimia nervosa and binge eating disorder. Below is a brief summary of the evidence from controlled clinical trials.

Cognitive Behavioral Therapy (CBT).

The Technique. The theory behind CBT for bulimia nervosa (BN) is that these patients have developed distorted cognitions about both their weight and body image. Because they over-value thinness, they restrict their food intake in a rigid and unrealistic manner. This food restriction causes hunger, which leads to bingeing, which in turn triggers lowered self esteem, guilt and anxieties about gaining weight. The patient then purges, self-starves, or exercises compulsively to compensate for the binge, leading into the binge-purge cycle. CBT treatment consists of encouraging a regular pattern of eating that includes previously avoided foods, teaching more constructive skills for coping with high risk emotional situations, and modifying distorted perceptions of food and eating. (For some interesting clinical examples of the technique, see this month's interview with Joel Yager, MD).

The Research. CBT for BN has been shown to be superior to both waiting list control groups and medication alone in several trials (Shapiro et al, *Int J of Eating Disorders*, 2007 40:4 321-336). One large trial randomly assigned 220 bulimic patients to either CBT or interpersonal psychotherapy (IPT). After 20 weeks, patients receiving CBT did significantly better than IPT patents, both in terms of the percentage of patients recovered (29% vs. 6%), and the percentage remitted (48% vs. 28%). ("Recovered" meant no binge eating or purging during the previous 28 days and "remitted" was defined as binge eating and purging less than twice per week over the previous 28 days.) However, at one year follow-up there were no significant differences between the two treatments (Agras, et al., *Arch Gen Psychiatry*, 2000; 57:459-466). In most studies of CBT, the technique works quickly over the first months of treatment, and there is evidence that early progress in CBT best predicts long term outcome (Agras, et al., *Am J Psychiatry*, 2000; 157:1302-8). Unfortunately, neither CBT nor IPT have been shown to be effective for treating anorexia nervosa (AN). In fact, one randomized controlled trial of 56 women with AN found that, after 20 weeks, nonspecific supportive psychotherapy was actually superior to both CBT and IPT, implying that manual-driven psychotherapies may alienate these patients (McIntosh, *Am J Psychiatry*, 2005;162:741-7).

Interpersonal Psychotherapy (IPT).

The Technique. IPT focuses on ways that problematic relationships cause psychiatric symptoms. After evaluating how the eating problem first developed, the therapist works with the patient to understand the context of the eating disorder symptoms in interpersonal problem areas such as role transitions, grief, role disputes, or interpersonal deficits. The therapist avoids detailed discussions of the disordered eating symptoms and instead encourages the patient to explore the interpersonal context in which the symptoms occur (Apple, *Psychotherapy in Practice*, 1999; 55, 715-725).

The Research. IPT has shown benefits for patients with BN (see study comparing it with CBT above) and there is evidence that it is effective for patients with Binge Eating Disorder (BED) as well. One RCT (Wilfey, *Arch Gen Psychiatry*, 2002; 59: 713-21) randomly assigned 162 overweight patients with BED to 20 weekly sessions of either group CBT or group IPT. Binge-eating recovery rates were equivalent for both groups after completion of the 20 week therapy (CBT, 64 of 81, 79%; IPT, 59 of 81, 73%) and at one year follow-up (CBT, 48 of 81, 59%; IPT, 50 of 81, 62%).

Mindfulness-Based Approaches.

The Technique. Both DBT (Dialectical Behavioral Therapy) and ACT (Acceptance and Commitment Therapy) view disordered eating as being motivated by a need to escape painful emotional states. Therapy encourages patients to develop what is termed "noncritical awareness" of intense negative emotions. By accepting their emotions without acting on them, and using CBT techniques to modify their behavior, patients ultimately increase their ability to curb their impulsivity and thereby develop self esteem.

The Research. One RCT compared 20 weeks of DBT versus waiting list control in 44 women with DSM-IV BED. At the end of treatment, 89% of the participants in DBT had stopped binge eating, compared to 12.5% of the wait list group. At six month follow up, 56% of the DBT participants continued to be abstinent from binge eating (Telch, *J Consult Clin Psychol*, 2001; 69: 1061-5). Another 20-week RCT that

Continued on Page 3

Effective Medications for Eating Disorders

Continued from Page 1

reached their target weight by the end of the study period, although the olanzapine group got there sooner (8 weeks vs. 10 weeks). Both groups improved similarly on depression and anxiety scales, but olanzapine was more effective than placebo for obsessive symptoms. Unfortunately, because of an enormous overall dropout rate (only 14 of the original 34 remained in the study at the 10 week end point), it is hard to draw clear conclusions from the results (Bissada et al., *Am J Psychiatry* 2008;165: 1281-1288).

Bulimia Nervosa (BN) / Binge Eating Disorder (BED)

SSRIs. Fluoxetine (Prozac) is the only FDA-approved SSRI for bulimia; few other SSRIs have been studied for this indication. While two small placebo-controlled studies have endorsed the effectiveness of fluvoxamine (Luvox) 200 mg/day for BN (Milano et al., *Adv Ther* 2005; 22:278-83; Fichter et al., *J Clin Psychopharm* 1996; 16: 9-18), a large double-blind study of 267 patients found fluvoxamine up to 300mg/day to be no better than placebo (Schmidt et al., J *Clini Psychopharm* 2004; 24: 549-552). Most SSRIs appear effective for binge eating disorder (BED), including fluoxetine at 40-80 mg/day (Arnold et al., *J Clin Psych* 2002; 63: 1028-1033), fluvoxamine at 260 mg/day (Hudson et al., *Am J Psychiatry* 1998; 155: 1756-62), citalopram at 60 mg/day (McElroy et al., *J Clin Psych* 2003; 64: 807-813), and sertraline at 100-200 mg/day (Leombruni et al., *Hum Psychopharm* 2006; 21: 181-188). Of note, escitalopram (Lexapro) at 26.5 mg/day was the only SSRI that was not associated with reduced binge-eating episodes when compared to placebo, though a statistically significant weight loss of 1 kg (vs. wt gain of 0.5 kg on placebo) was noted (Guerdjikova et al., *Hum Psychopharm* 2008; 23: 1-11).

Tricyclics. Imipramine (Pope et al., *Am J Psych* 1983; 140: 554-558) & desipramine (Barlow et al., *Can J Psych* 1988; 33:129-133) have both been shown to be effective for BN, at average doses of 150-200 mg/day. However, one study of 32 women found no superiority of amitriptyline (150 mg/day) over placebo (Mitchell et al., *J Clin Psychopharm* 1984;4:186-193).

Topiramate (Topamax). Several placebo-controlled trials have endorsed the effectiveness of topiramate 250-300 mg/day for both BN and BED. The most common side effects were parasthesias, taste perversion, and difficulty with concentration/attention (Nickel et al., *Int J Eat Disord* 2005; 38: 295-300; McElroy et al., *Biol Psych* 2007; 61: 1039 - 48)

Naltrexone (Revia). Naltrexone, an opiate antagonist used to treat alcoholism, may also be effective for BN, though the evidence is mixed. One double-blind, placebo-controlled cross-over trial reported that it reduced binge-purge episodes for 18 of 19 outpatients (Marrazzi et al., *Int Clin Psychopharm* 1995; 10: 163-172), but a similarly designed study of 16 bulimic women showed no clinically significant improvement (Mitchel et al., *J Clin Psychopharm* 1989; 9: 94-97). A single study of naltrexone for BED found no advantage over placebo (Alger et al., *Am J Clin Nutr* 1991; 53: 865-71).

Sibutramine (Meridia). Sibutramine, an FDA-approved weight loss agent, appears to be effective for the treatment of BED. In a recent study (Wilfley et al., *Am J Psych* 2008; 165: 51-58), 304 patients with BED were randomized to sibutramine 15 mg/day or placebo. At 24 weeks, patients on active treatment had a greater reduction in binge eating (2.7 fewer episodes per week vs. 2.0 fewer on placebo) and greater weight loss (4.3 kg vs. 0.8 kg on placebo) than patients on placebo.

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Psychotherapy for Eating Disorders: A Review of the Current Evidence

Continued from Page 2

compared 31 women who received DBT with a waiting list control condition found significant treatment effects for the frequency of both binge eating and purging behaviors (Safer, *Am J Psychiatry*, 2001; 158:632-4).

Family Based Psychotherapy (FBT).

The Technique. As we covered in the October 2007 issue of *TCPR*, FBT is a type of family therapy in which parents are initially encouraged to become re-involved in their child's care to and take full control of food decisions. Once the patient achieves a normal weight, the second part of the therapy slowly gives control over food back to the patient with a focus on the effects the eating disorder has had on the child's school and social life.

The Research. FBT has shown efficacy for adolescents with both BN (Le Grange et al., *Arch Gen Psychiatry*, 2007; 64:1049-1056) and AN (Paulson-Karlsson et al., *Eat Disord*, 2009 ; 17:72-88). For further details, please see *TCPR* October 2007.

TCPR VERDICT: *Psychotherapy for Eating Disorders is effective. It may turn out that some types work better than others over the long term, or with particular types of patients, but we don't yet have the answers.*

Q&A With the Expert

This Month's Expert:

Tips on Treating Eating Disordered Patients

Joel Yager, MD

Professor of Psychiatry, University of Colorado School of Medicine

Dr. Yager has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

TCPR: Dr. Yager, what is your procedure for evaluating patients with eating disorders?

Dr. Yager: Before I see patients for the first time, I have them fill out several questionnaires. I use the EDQ-9 (the eating disorder questionnaire, version 9), a copy of which we put into the *Clinical Manual of Eating Disorders* (Yager J and Powers P, APPI, 2007). I also ask people to fill out an elaborate life history questionnaire that I designed about a dozen years ago. This has an extensive family history, a psychodynamic history, an interpersonal history, a cognitive behavioral history, and an assessment of the patient's beliefs about the nature and causes of their problems. I also obtain some basic screening labs, such as CBC, electrolytes, liver functions, thyroid stimulating hormone, creatinine, and BUN (blood urea nitrogen). Depending on the situation, I might also add lipids, serum amylase level (a crude marker of vomiting activity), magnesium (if there is a concern about laxative use), and, if they have had menstrual irregularity or amenorrhea for six months or more, I will order a bone density scan.

TCPR: How long is your typical evaluation session?

Dr. Yager: I schedule my first visit for two hours. In the case of adolescents, I ask their parents to come as well. I start by spending 15 minutes with the patient and parents, just to make sure that we all have the same goals for the assessment and treatment. Next I see the patient alone for about an hour, then the parents alone for 20 minutes, and then I bring everybody in together for a summary and planning session.

TCPR: We cover the latest evidence on medications for eating disorders elsewhere in this issue. Can you describe your non-pharmacologic approaches to treatment?

Dr. Yager: There are several different components, all of which are necessary to address. First is nutritional rehabilitation. I ask patients a series of questions to get at their attitudes toward food. I want to know "What are you eating? What should you be eating? What prevents you from eating appropriately? What are your obsessions about food and eating? What rituals do you engage in with your food preparation and eating? What underlying core beliefs about foods, eating and the impact of food on your body affect what you do? Are there certain foods that so freak you out that you can't even come near them? Do you *really* need to be vegetarian? And is your vegetarianism based on religious or cultural attitudes that existed in your family before you even developed an eating disorder, or is your vegetarianism sort of a front for your eating disorder?"

TCPR: Do you have them monitor their food intake?

Dr. Yager: Yes, but I frame it in terms of asking them to become more self-aware, a kind of "Zen 101." I'll ask patients to record what they eat and to bring in a diary so we can estimate both the kind of food and the quantity of food. I show them websites with what are called "metabolic equivalence tables (METs)," which tell them what their caloric expenditure will be for certain kinds of activity and what their nutritional needs are (one is available from the Centers for Disease Control at http://tinyurl.com/ccr8gf).

TCPR: Do you recommend any workbooks for patients to monitor their diet and activity?

Dr. Yager: There are several educational and cognitive-behaviorally oriented books that have a therapist and a patient version so you can work through these issues together. I recommend *Overcoming Eating Disorders* by Stewart Agras and Robin Apple, *Eating Disorders: The Journey to Recovery* by Laura Goodman and Mona Villapiano, and, for patients with bulimia nervosa, binge eating disorders and even anorexia nervosa of the binge eating/purging subtype, one by Chris Fairburn called *Overcoming Binge Eating*. A great website is http://www.gurze.com which is a publishing and distributing company that specializes in eating disorder resources. For patients, I also suggest looking at the National Eating Disorders Association website (www.neda.org). For professionals, there is the Academy of Eating Disorders, and its website, www.aedweb.org, which will identify clinicians in your area who specialize in eating disorders.

Continued on Page 5

Q & A With the Expert

Continued from Page 4

TCPR: So what is the next phase of treatment of eating disorders after nutritional rehab?

Dr. Yager: Then I focus on the self-destructive eating disorder behaviors, such as binging, purging, and excessive exercising. I use a basic cognitive behavior therapy approach to modifying these behaviors. I'll say, "Let's be honest, and let's see how often you are doing these things and let's try to identify some of the triggers." I'll typically go through a basic "ABC" behavioral analysis, identifying the Antecedents, the Behavior, and the Consequences.

TCPR: Can you give me an example of a behavioral approach?

Dr. Yager: One of my most successful treatments was with a celebrity in LA. This was a women in her 30s who had had severe anorexia nervosa with binge-purge behavior for 15 years by the time I first met her. She had tried all kinds of treatments with various medications and psychotherapies, but nothing had worked with her. So I did a very rudimentary kind of behavior therapy, similar to what I would do with my grandson to get him potty-trained.

I said, "Let's start out by your committing to one day in the month when, by hook or by crook, you are not going to starve yourself or purge. You are going to white knuckle it through the day and then you are going to give yourself a happy face on the calendar." She said it was very hard but she knew that the day afterwards she could do anything she wanted with eating and purging, so she was able to do it. And then we simply progressively worked through the weeks by adding more happy faces to her calendar. It took two to three months and she was totally symptom free by that time. It was remarkable. I think you have to sometimes use creative gimmicks in this business to explore various approaches. Some strategies that work with some patients won't work at all for others, and the trick is individualizing and finding the leverage points for each patient.

TCPR: This is fascinating. Do you have another example?

Dr. Yager: I had one patient, a college student in her 20s, for whom the idea of touching anything containing fat – let alone eating it – induced a panic attack. So I had her bring a little bottle of olive oil into my office. I desensitized her first by just having her fingers rest in olive oil. It may sound silly, but in fact she had this phobic fantasy that her body would soak up olive oil and that the olive oil absorbed through her skin would immediately turn into fat globules in her blood stream. So desensitizing her to that fear then allowed her to imbibe some olive oil, and that step then began to break her eating disorder cycle.

I once had another patient, a woman who weighed 86 pounds, who felt comfortable eating only in my office – nowhere else. My office became the only safe place that she experienced. She was actually able to eat ice cream in my office without purging it afterwards. So I had my secretary allow her into my empty office during hours I wasn't there so that she could come and eat, which she did several times a week, and this practice gradually helped desensitize her so that she could ultimately eat elsewhere without purging as well.

The key in all these cases is to discover the "thought chains" and the "fantasy chains" that lead patients to harm themselves and avoid healthy behaviors. Then you design individual behavioral programs to help patients break those chains so they can move ahead.

TCPR: Do you give patients homework assignments?

Dr. Yager: I generally do, but the nature of the assignment varies dramatically. The homework may be to go out and meet somebody, or it may be to do self-monitoring, or to say something five times in front of the mirror, or to be nice to your mother two days a week so that she doesn't want to kill you. Or in some cases, when there is a chronically destructive ongoing family dispute, I will ask the patient to get a tape recorder and put it in the middle of the kitchen table. The rule in that intervention is that anybody in the family can turn on the tape recorder at any time, and then they have to bring the tape in so that I can hear it. This assignment has the function of increasing self-monitoring and self-awareness so that people recognize what they sound like and what they are doing to each other. It shows them how the criticism in the family may be destructive and often gets people to own what they are doing to one another.

TCPR: Do you ever give patients assignments to *avoid* certain things?

Dr. Yager: Yes. For example, there are some patients who continuously reinforce their negative self-image by reading women's magazines. So my assignment may be: "I want a list of all the magazines that you regularly read and then we are going to put you on a restriction diet, so that you can't read women's magazines anymore. And let's try a week without television at home." What happens is that the women first become aware that they have this constant interaction with an image that makes them feel bad about themselves. Suddenly their whole way of thinking about themselves and about their bodies may shift and become more free.

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Research Updates IN PSYCHIATRY

Section editor, Glen Spielmans, PhD

ADHD

Study Investigates Long-Term Course of ADHD

A recent follow-up of the Multisite Treatment Study of Children with ADHD (MTA) study investigated the long-term course of ADHD and the impact of short-term treatment on long-term outcomes. A decade ago, children with ADHD were randomly assigned to one of four treatments for 14 months: stimulant medication, behavioral treatment, combined medication and behavioral treatment, or usual care in the community. At the endpoint, medication and combined treatment showed significantly greater improvement than behavioral treatment or usual care, though all groups showed improvement over the initial study period (MTA Cooperative Group. *Arch Gen Psychiatry* 1999;56:1073-1086), After 14 months, all participants' families were free to seek treatment in the community as they deemed appropriate, and researchers monitored the children's ADHD symptoms periodically. By the end of three years, the initial advantage of medication treatment over behavioral treatment disappeared (Jensen PS et al., *J Am Acad Child Adolesc Psychiatry* 2007;46:989-1002). The present study, which is the eight-year follow-up of the same patients, again found that having been in one of the medication groups for the initial study did not influence long-term outcomes. In general, children in the MTA study continued to lag behind non-ADHD children on academic and mental health measures (Molina SG et al., 2008 *J Am Acad Child Adolesc Psychiatry* 2009;48:484-500).

TCPR's Take: While some commentators believe these long term data indicate that stimulants have little long term efficacy, such a conclusion does not necessarily follow from the data. Since patients' treatment was no longer randomized after 14 months, over the ensuing years some children originally assigned to medication discontinued stimulants, while some originally assigned to therapy started medication. Unfortunately, the long-term physical impact of stimulants has received little study, though three year follow-up of MTA participants found that newly medicated patients grew an average 0.9 inches less and gained 5.95 fewer pounds than the non-medicated children in the study (Swanson JM et al., *J Am Acad Child Adolesc Psychiatry* 2007;46:1015-1027).

SUICIDALITY

Predictors of Suicidal Behavior in Adolescent Treatment-Resistant Depression

Researchers assessed predictors of suicidal events and non-suicidal self-harm in a group of 334 moderately to severely depressed adolescents (ages 12-18) who had not responded to at least eight weeks of SSRI treatment. Participants were switched to one of four treatments: a different SSRI, venlafaxine, a different SSRI plus cognitive-behavior therapy (CBT), or venlafaxine plus CBT. Initially, the researchers examined suicidal events and non-suicidal self-harm through spontaneous reports from participants. Halfway through the study, because of concerns raised by the FDA about antidepressants and suicidality, researchers switched to using a more systematic method of assessing suicidality and self-harm, asking specific questions about suicidal intent and behavior on a weekly basis. (Not surprisingly, researchers detected that participants reported significantly more suicidal events (20.9% vs. 8.8%) and non-suicidal self-injury events (17.6% vs. 2.2%) when the more systematic method of evaluating suicidality was utilized.) Generally, there were no significant differences between treatment groups; however, patients whose baseline suicidal ideation was higher than average were significantly more likely to experience a suicidal event on venlafaxine during the study than patients receiving SSRIs (37.2% vs. 23.3%). Regardless of treatment, patients with any of three characteristics – a history of non-suicidal self-injury, severe drug use, or serious family conflict – were more likely to experience suicidal events during the study (Brent DA et al., *Am J Psychiatry* 2009;166:418-426).

TCPR's Take: There is a lot going on in this study. Regarding treatment options for adolescents, the study suggests that venlafaxine may be riskier for adolescents than SSRIs, although the numbers are small. What is perhaps more interesting for clinical practice, though, are some of the secondary findings. The study points to three significant factors that should be carefully assessed in adolescent patients: history of suicidal behavior, current drug use, and level of family conflict. The change in the method of evaluating suicidality was also noteworthy. While systematic monitoring revealed a much higher rate of suicidal behavior and of self-harm than did spontaneous report, both methods caught about the same number of serious events (defined as those that led to hospitalization, or that were life-threatening or disabling). Nevertheless, one of the lessons from this study is: Don't wait for your patients to volunteer information on suicidal ideation – instead, ask explicitly about this at each visit.

ANTIPSYCHOTICS

Discontinuing Antipsychotics May Decrease Mortality Risk in Dementia

In a 2005 public health advisory, the FDA warned that antipsychotics appear to increase the rate of mortality in elderly patients with dementia. The implication is that we should discontinue such agents in this population when possible. But

— *Continued on Page 8*

CME Post-Test

To earn CME or CE credit, you must read the articles and complete the quiz below, answering at least four of the questions correctly. Visit www.TheCarlatReport.com to take the test online and print your certificate or mail a photocopy or fax the completed page (no cover sheet required) to **Clearview CME Institute, P.O. Box 626, Newburyport, MA 01950**; **fax (978) 499-2278**. For customer service, please call (978) 499-0583. Only the first entry will be considered for credit and must be received by Clearview CME Institute by April 30, 2010. Acknowledgment will be sent to you within six to eight weeks of participation. This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the sponsorship of the Clearview CME Institute. Clearview CME Institute is accredited by the ACCME to provide continuing medical education for physicians. Clearview CME Institute is also approved by the American Psychological Association to sponsor continuing education for psychologists. Clearview CME Institute maintains responsibility for this program and its content. Clearview CME Institute designates this educational activity for a maximum of one (1) AMA PRA Category 1 Credit™ or 1 CE for psychologists. Physicians or psychologists should claim credit commensurate only with the extent of their participation in the activity.

Please identify your answer by placing a check mark or an X in the box accompanying the appropriate letter. Note: learning objectives are listed on page 1.

1. FDA-approved medications for eating disorders include: (Learning Objective #1)

[ ] a. Fluoxetine for anorexia nervosa and bulimia nervosa.

[ ] b. Fluoxetine, sertraline, and paroxetine for bulimia nervosa.

[ ] c. Fluoxetine for bulimia nervosa.

[ ] d. There are no FDA-approved medications for eating disorders.

2. A double blind study showed that cyproheptadine: (L.O. #1)

[ ] a. Caused weight reductions in bulimic patients.

[ ] b. Caused increased weight in anorectic patients.

[ ] c. Worked only in anorectic patients with bulimic symptoms.

[ ] d. Was less effective than olanzapine for weight increase.

3. Dialectical Behavioral Therapy (DBT) and Acceptance and Commitment Therapy (ACT) are both categorized as "mindfulness-based" techniques. (L.O. #2)

[ ] a. True [ ] b. False

4. Regarding Cognitive Behavioral Therapy (CBT): (L.O. #2)

[ ] a. One large trial found it more effective than interpersonal therapy for bulimia.

[ ] b. It is more effective than supportive therapy in anorexia.

[ ] c. Trials have consistently found it to be effective for both anorexia and bulimia.

[ ] d. The technique focuses on the effect of relationships on symptoms.

5. According to Dr. Yager, a key initial component of eating disorders treatment is nutritional rehabilitation. (L.O. #3)

[ ] a. True [ ] b. False

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Your evaluation of this CME/CE activity (i.e., this issue) will help guide future planning. Please respond to the following questions:

1. Did the content of this activity meet the stated learning objectives? L.O.#1: [ ] Yes [ ] No L.O.#2: [ ] Yes [ ] No L.O.#3: [ ] Yes [ ] No
2. On a scale of 1 to 5, with 5 being the highest, how do you rank the overall quality of this educational activity? [ ] 5 [ ] 4 [ ] 3 [ ] 2 [ ] 1
3. As a result of meeting the learning objectives of this educational activity, will you be changing your practice performance in a manner that improves your patient care? Please explain. [ ] Yes [ ] No

4. Did you perceive any evidence of bias for or against any commercial products? Please explain. [ ] Yes [ ] No

5. How long did it take you to complete this CME/CE activity? ___ hour(s) ___ minutes
6. **Important for our planning:** Please state one or two topics that you would like to see addressed in future issues.

 Continued from Page 6

does this actually decrease the mortality risk? A recent randomized trial attempted to answer this question. In this study, 165 patients with dementia who were already taking antipsychotics were randomly assigned to either continue their antipsychotic regimen or switch to placebo for one year. During that year, more of the patients taking an antipsychotic died of any cause (30%) than did those taking placebo (23%). After a year, the randomized treatments were discontinued and patients were placed on treatment as deemed appropriate by their physicians. When the original two groups were compared after three and a half years (42 months), there were significantly more survivors from the placebo group (53%) than from the antipsychotic group (26%) (Ballard C et al., 2009 *Lancet Neurol* 2009;8:151-157).

TCPR's Take: The researchers did not track which medications were received by patients after the initial 12-month trial, so some of the patients in the placebo group likely restarted antipsychotics, while some patients who initially took antipsychotics may have discontinued them. That said, the group receiving antipsychotics during the 12-month trial quite likely had a greater cumulative exposure to the drugs than did the placebo group. Prior research has suggested minimal benefits and increased risk of mortality for antipsychotics in treating dementia (Schneider et al., 2006 *Am J Geriatr Psychiatry*;14:191-210). The bottom line is that we should minimize demented patients' exposure to antipsychotic medications.

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This Month's Focus:
The Treatment of Eating Disorders

Next Month in *The Carlat Psychiatry Report*: Generic Medications in Psychiatry, including an explanation of the generic approval process and reviews of recent controversies on the effectiveness of generics.