

Message from the President

James E. Mitchell, M.D.



This column will focus on the issue of parity: parity in providing benefits for mental health equal to those provided for medical illnesses. This has been a major problem in the provision of mental health services during the last two decades, and there are several issues of which we, as concerned providers of healthcare to patients who have eating disorders, need to be aware.

Currently, thirty-two states have passed some form of parity legislation. Each of these bills has been somewhat different in content. Unfortunately, eating disorders have not been specifically addressed in many of them. The laws in sixteen states specifically mention eating disorders or include language that should include eating disorders (South Carolina, Tennessee, Indiana, Alabama, Arkansas, New Mexico, Connecticut, North Carolina, Maryland, Kentucky, Minnesota, Missouri, California, Delaware, Georgia, and Louisiana). The wording in the legislation in four additional states suggests that eating disorders probably would be covered (Massachusetts, New Jersey, Pennsylvania, and Rhode Island). The wording in the legislation in twelve states (Colorado, Hawaii, Maine, Montana, Nebraska, Nevada, New Hampshire, South Dakota, Texas, Oklahoma, Vermont, and Virginia) suggests that eating disorders are excluded. Data on legislation by individual states is available on the National Alliance for the Mentally Ill website: www.nami.org. I would suggest that we all consult this site to find out how

our individual states are dealing with parity so that we can advocate strongly that eating disorders be included in any new legislation.

Parity has also been an issue at the national level. In 1996, the "Mental Health Parity Act" passed Congress, taking effect on January 1, 1997. Unfortunately, it is scheduled to expire on September 30th of this year. The Act contains a number of limitations. First of all, the Act only applies to policies with existing mental health benefits. Policies do not have to include mental health benefits under this parity act. It also only applies to employers with more than 50 employees, and it doesn't apply to employers whose insurance policies are self-insured. It doesn't restrict out-of-pocket expenses at all, and therefore insurance companies can charge large co-pays at their discretion.

In 1999, the "Mental Health Equitable Treatment Act" was introduced but not passed, and it has been reintroduced this year under the title, "The Mental Health and Substance Abuse Parity Act." This Act does restrict the amounts that can be charged for out-of-pocket expenses, but it is unclear how the legislation will fare. Senator Paul Wellstone of Minnesota will also be introducing parity legislation in the Senate, and there is some indication that eating disorders will be included.

Although insurers have protested that parity legislation will markedly increase their mental health costs, this has not been the case in states where the legislation has been implemented. While few of us are trained to be politically active, these issues are of great concern to our patients and their families. It is important that we try to stay abreast of what's going on both in our home states and at a federal level, with regard to legislation that will impact our eating disorder patients' care.



Message from the Editor

Lisa Lilienfeld, Ph.D.

I'm looking forward to seeing fellow Academy members in Vancouver next month. A summary of the entire program can be found in this issue. I've traveled a fair bit and I have to say that Vancouver is one of the most beautiful, enjoyable cities I have ever encountered.

The end of February marked national annual Eating Disorders Awareness Week 2001. I know there were many wonderful events going on around the country and I wanted to highlight our experience here in Atlanta. As I mentioned in my last column, the Atlanta Anti-Eating Disorders League was preparing for its first annual gala entitled, "Beyond the Looking Glass" with guest auctioneer Jane Fonda. She generously donated her time and effort to our cause. On the evening of February 17th, Jane gave a speech that no one could have predicted. I believe that the moving remarks by our League President, Dina Zeckhausen, prompted Jane to make a speech that she herself had probably not even planned. Jane revealed for the first time publicly that she has struggled with anorexia and bulimia for 25 years of her life. She announced that it was not until two years ago, at age 61, that she was able

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Academy for Eating Disorders

6728 Old McLean Village Drive
McLean, VA 22101-3906
(703) 556-9222 Fax (703) 556-8729
Email: aed@degnon.org
www.acadeatdis.org

President

James E. Mitchell, MD
Fargo, ND
Mitchell@medicine.nodak.edu

President-Elect

Allan S. Kaplan, MD
Toronto, Ontario
Allan.Kaplan@uhn.on.ca

Treasurer

Cynthia M. Bulik, PhD
Richmond, VA
cbulik@hsc.vcu.edu

Secretary

Michael J. Devlin, MD
New York, NY
mjd5@columbia.edu

Immediate Past-President

Stephen Wonderlich, PhD
Fargo, ND
StephenW@medicine.nodak.edu

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Minneapolis, MN

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Rockville, MD

Newsletter Editor

Lisa Lilienfeld, PhD
Atlanta, GA
LLilienfeld@gsu.edu

Executive Staff

George K. Degnon, CAE
Executive Director

Meg Gorham
Associate Director

Bette Anne German
Association Manager

Sarah-Jane Ziaya
Association Manager

Families of those with Eating Disorders Unite! Family Action Council

Kitty Westin, Family Action Council
Chairperson

Anna Westin died on February 17, 2000. After struggling with anorexia for 5 years, she committed suicide at the age of 21. Anna Westin is my daughter. Anna didn't have to die and as her mother I am haunted by that truth everyday.

With appropriate and adequate treatment, Anna's life could have been saved. How do we prevent such needless deaths? I believe a necessary first step is to change federal policy. For this reason, our family founded the Anna Westin Foundation and began to speak openly about her life and death. In doing so, we hope to help other families and change current life threatening policies. But we cannot do this alone. We need many families to carry the torch with us.

We invite you to join our movement bringing together families from across the nation to advocate for people suffering from eating disorders. Now is the time for us to change laws and policies that will save children's lives. We must improve access to care, have prevention programs, get more research dollars and bring the problem of eating disorders onto the national health agenda!

As my family and I were formulating a strategy for such a family centered advocacy movement, we learned about a new non-profit organization that very much shares our vision. As a result, we decided to work with this organization: the Eating Disorder Coalition for Research, Policy and Action (the Coalition). Current members of the Coalition include the Academy for Eating Disorders, the Eating Disorder Awareness & Prevention, Inc., the Harvard Eating Disorders Center, the National Association of Anorexia Nervosa & Associated Disorders, Dads and Daughters, and the Renfrew Foundation. This is a direct response to the federal government's misunderstanding of and inertia about eating disorder problems. The Coalition has made it a priority to actively involve families in their efforts to educate and influ-

ence Congress by creating a "Family Action Council" (FAC).

In my role as a representative of the Anna Westin Foundation, I was asked by the Coalition to serve as chairperson of the FAC. By combining our energies and resources, we will succeed at creating an eating disorders movement that will make a difference on Capitol Hill. The FAC will include at least one family member from each state and will meet in Washington, D.C. on April 24-25, 2001 to begin advocacy training and lobbying efforts.

This is an exciting opportunity for us to make a difference for people who suffer from eating disorders and their families. We believe that together we can accomplish our goals and ultimately save lives. If you or someone you know are interested in becoming a state representative, please contact me by e-mail at kitty@annawestinfoundation.org. Thank you for your support.



Special Interest Groups

Interested in joining or starting a Special Interest Group (SIG)? There has been time set aside during the 2001 Conference in Vancouver for SIG meetings and your participation is encouraged. Visit our web site at www.acadeatdis.org or contact Eric van Furth at vanfurth@worldonline.nl for further information.



We would like to publish information on Academy members so if you have received an award, been promoted, taken a new job, published a book, etc., let us know so that we can include it in the *Newsletter*.

Contact Lisa Lilienfeld at
LLilienfeld@gsu.edu.

A Bumpy Road: The Saga of an Intensive Ambulatory Eating Disorders Program in New York City

Charles A. Murkofsky, M.D.

As I write this, I am in a state of uncertainty as to whether the intensive ambulatory program that has been at the core of my professional work for the past 8 years is in a state of transition or a matter of history. I remain hopeful we will continue to function, but it is by no means a matter which is assured.

ProMed (The Program for Managing Eating Disorders) grew out of and overlapped with the inpatient program at Gracie Square Hospital (GSH). In mid 1984, I was asked by the GSH administration if I wanted to develop and head up an inpatient eating disorders program. I was known by the hospital for some 18 years by that time, first running the geriatric psychiatry service, and later serving as clinical director of the hospital.

The 20-bed inpatient program thrived for 7 years, and then died a managed care death. Two things had, by then, become crystal clear: 1) Notwithstanding the managed care intrusion, the quantity and intensity of eating disorder pathology was not diminishing and 2) Most of the work we were doing in an inpatient setting would subsequently have to be done on an outpatient basis.

Since, by this time I had seen and treated many hundreds of cases and was, at least by baptism of fire, an expert, I felt it to be a natural transition to create the outpatient program as part of my private practice. On clinical grounds, my confidence did not seem unwarranted. On administrative and business grounds, I bit off more than I could chew. As I look back on my college career, I still treasure the liberal arts, my opera survey courses, Goethe's "Faust" auf deutsch, etc. I just wish I had squeezed in something about business practices and accounting.

We settled ProMed into a townhouse milieu in Manhattan. The town house had been recently purchased by my wife (also a psychiatrist) and myself and housed our home, both of our offices and the Program (in lieu of a residential tenant). The staff

was primarily comprised of the clinicians I had worked with at GSH (psychologists, social workers, dieticians and sometimes a psychiatric nurse). The staff was all highly trained and professionally skilled. We crafted a 5 day/week, 9 hour/day program. The treatment day consisted of 2 monitored meals (lunch and dinner) plus a full program of group work and individual case management.

Our patients all were expected to have individual psychotherapy. This mostly consisted of continuing work with existing outside therapists. However, when there was no therapist already involved, our clinical staff had the opportunity to take program patients into their private practices.

The problems that arose over the years were not primarily clinical, though there were substantial clinical challenges. The largest paradigm shift from inpatient work was not having "control" of the environment. We could no longer control passes, limit visitation, or structure program progression in nearly the same fashion that we could when patient and program were both 100% on site. Our policies and procedure evolved with our ongoing clinical experiences, as I think they should.

The larger and enduring problems came from the pragmatic arena. The census would ebb and flow in an unpredictable fashion. We literally had sessions with 2-3 patients and other sessions with 24 in attendance. We had problems with rationalized absences (to avoid the monitored eating) and had to begin charging for missed program days. Since third parties could not be charged for undelivered services, the patients were charged. This led to our requiring cancellation deposits at the inception of treatment. This actually worked well, but a number of the HMOs protested this as a violation of their contractual agreements with their subscribers. It became necessary to change the program to 3 days/week in the 4th year to deal with the sporadic census.

Marketing and PR were enigmas. At varying times, I tried a PR firm, in house (i.e., unskilled) advertising campaigns, direct mailings, and a speaker's bureau. The most successful effort came from running a monthly support group, for many years alone and later in conjunction with AABA.

Reimbursement is, of course, the make-or-break element of viability. The major problem our program faced in this regard was not having a facility license. We functioned with my medical license. In New York State, at least, facilities are specifically characterized and defined according to function. Intensive outpatient programs (IOPs), partial hospital programs (PHPs) and continuing day treatment programs (CDTPs) all require different licenses. Acquiring such licenses is a cumbersome and lengthy process. A number of the insurers/HMOs ran afoul of the missing license. Notwithstanding their approval of our clinical model (we were site visited often), the license issue proved to be repeatedly problematic and led to single-case limited care agreements or, at times, refusal of coverage altogether. Medicare and Medicaid patients could not be treated without a facility license. This always struck me as ethically wrong. We need programs for the afflicted, not just for the affluent.

Given all this, I decided I needed to operate with a facility license. This led to affiliating with the PHP program at GSH being run by Psych Systems (a Maryland based company). Psych Systems was partners with GSH in this venture. Since I had spent so many years at the hospital and felt very comfortable there, I welcomed the arrangement. The date was then February, 1999.

No sooner had we changed venues, than Psych Systems announced it was trying to sell its PHP programs (there were 5 in the NYC metropolitan area). Apparently, the PHPs were not sufficiently profitable. This, as one might expect, was the harbinger of the frugal period that followed.

The first jolts to my sensibilities came around the issue of staff reimbursement and program hours. My PHP ran for 9 hours. The statutory requirement is for 6 hours. I paid staff at a level I felt was commensurate with their skills and with an eye toward private practice levels. In general, I was paying at least 25% more than the parent PHP was paying their staff. The combination of long hours and higher compensation rates clearly accounted for the red ink I'd been experiencing for many years. It was clear that my business manager (myself) was doing a poor job. We could not continue to operate in that way.

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to eat a bite of food without fear and anxiety. She tearfully described how neither of her husbands ever knew about her problem. This story was quickly picked up by dozens of newspapers around the country and found its way to a few in Europe as well. The auction raised \$150,000 for our League.

I now want to briefly direct your attention to two columns in this issue. Please take a moment to read about the Family Action Council if you aren't yet familiar with it. The Eating Disorder Coalition for Research, Policy and Action has worked to actively involve families in their efforts to educate and influence Congress. This is an exciting movement in our field where at least one family member from each state will convene in Washington DC at the end of this month to begin advocacy and lobbying efforts. The ultimate goal is to influence federal policy related to eating disorders. This is information that those of us working with families will want to share with them.

The second column I want to highlight is that written by Charles Murkofsky, which tells of the trials and tribulations involved with establishing and running an eating disorders treatment program. Those of us who have done clinical work in the world of managed care are likely to be familiar with many of the problems he has encountered. His story is an engaging and worthwhile read for all Academy members.

Finally, I want to alert all of you to an updated fact sheet on Binge Eating Disorder available on the web. The fact sheet is generated by the Weight-Control Information Network, which is a service sponsored by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health. This link can be found at www.niddk.nih.gov/health/nutrit/pubs/binge.htm.

As always, I welcome comments and suggestions from all Academy members.



Vancouver Highlights

Susan Yanovski, M.D. & Elliot Goldner, M.D., Program Co-Chairs

At the start of the new millennium, the year 2001 is an exciting one, with scientific breakthroughs at every turn. New technologies enable instant communication with our colleagues and patients, and hold promise for rapid dissemination of scientific knowledge. Many advances have been made in behavioral and biological treatments for eating disorders. Yet, many people with eating disorders remain underserved.

The conference theme "Eating Disorders in the New Millennium: Extending Our Reach", brings together experts in some of the cutting-edge technologies that may enhance delivery of care for those providing services to populations who have been less likely to receive treatment for eating disorders, such as members of racial and ethnic minority populations, gays and lesbians, men, and children. Keynote speaker, Dr. Shiriki Kumanyika, will challenge participants with her address on "Weight Management in Minority Populations: Treating Obesity When Obesity Has Become the Norm."

In addition to a plenary session on underserved populations, a session on Emerging Technologies will include discussions of the use of the internet, email, and telehealth to extend the reach of eating disorders treatments, as well as discussion of ethical and legal issues engendered by new technologies. In a session on Best Practices for the Treatment of Eating Disorders, internationally-known experts will present practical advice for clinicians on scientifically validated treatments.

As always, an abundance of exciting workshops are planned, on topics ranging from treating eating disorders in small communities to burnout among workers in the eating disorders field. Oral paper sessions and posters will provide attendees with the latest scientific research in the field. Special Interest Group meetings, including a "Transcultural SIG Symposium," as well as a repeat of the extremely well-received videotape and discussion on the Minnesota Semistarvation Experiment and its relevance to eating disorders, rounds out the program. Social activities provide a chance

to interact with friends and colleagues in a relaxed environment.

Last but not least is the opportunity to attend this exciting program in the city of Vancouver, situated on Canada's spectacular West Coast where towering mountains meet the Pacific Ocean. Vancouver's beauty is matched by its cosmopolitan style, superb restaurants and urban appeal.

See you in Vancouver!



Announcing the 2001 Academy Recruit-a-Member Campaign

Kelly Klump, PhD & Beth McGilley, PhD, Membership Recruitment & Retention Committee Co-Chairs

Starting at the 2001 International Conference on Eating Disorders and Teaching Day, May 17-19 in Vancouver, you will be offered the chance to win a six-day, five-night stay at the Westin Innisbrook Resort in Palm Harbor, Florida (US) near Tampa.

There are two ways to qualify for the drawing:

1. Recruit new members for the Academy and receive one raffle entry per recruited member. To redeem your entry, simply ask the new member to note your name on his/her membership application.
2. Join the Academy as a new member and receive one raffle entry.

All entries must be received by December 31, 2001. The drawing will take place in January 2002.

Your promotion of the Academy will make it a stronger, more effective organization to meet the needs of its members. Recruit early and often to increase your chance of winning! To learn more about the new campaign, contact the Academy office at aed@degnon.org. You can also view the website of the Westin Innisbrook Resort at www.westin-innisbrook.com.



2001 International Conference on Eating Disorders and Clinical Teaching Day

Eating Disorders in the New Millennium: Extending Our Reach

May 17 - 19, 2001

Sheraton Wall Centre - Vancouver, BC Canada

Thursday, May 17

9:00am – 10:00am

SIG Chair Meeting

10:00am – 12:00noon

SIG Meetings

1:00pm – 4:00pm

Teaching Day Workshops

1. *Enhancing Motivation for Change in the Treatment of Eating Disorders*
Kelly Vitousek, PhD, Josie Geller, PhD
2. *Obesity Update*
Marsha D. Marcus, PhD
3. *Nutritional Management of Eating Disorders Patients: A Primer for the Professional*
Linda Watts, MA, RD, Cheryl L. Rock, PhD, RD, Donald Barker, RDN
4. *When Treatment of the Eating Disorder Patient is Especially Difficult: Addressing Patient and Therapist Characteristics that Threaten Clinical Care*
Kathleen M. Pike, PhD, Allan S. Kaplan, MD
5. *The New Biology of Anorexia and Bulimia Nervosa: Good News for Psychotherapy*
Walter H. Kaye, MD, Cynthia Bulik, PhD
6. *Treatment of Children and Adolescents with Eating Disorders*
Rachel Bryant-Waugh, PhD, James Lock, MD, PhD

7:00pm – 9:00pm

Transcultural SIG Workshop

Transcultural Influences on the Recognition, Provision of Services and Community Response to Eating Disorders
Patricia O'Hagan, PhD, Pierre Beumont, MD

Friday, May 18

8:30am – 8:45am

Opening Remarks

Susan Z. Yanovski, MD, Elliot Goldner, MD, Conference Co-Chairs

8:45am – 9:45am

Keynote Address

Weight Management in Minority Populations: Treating Obesity When Obesity Has Become the Norm
Shiriki K. Kumanyika, PhD, MPH

9:45am – 11:45am

Plenary Session I:

Underserved Populations

Moderator: *Melanie Katzman, PhD*
Racial/Ethnic Minorities, *Ruth Striegel-Moore, PhD*; Men, *Arnold E. Andersen, MD*; Children, *Rachel Bryant-Waugh, PhD*; Gay/Lesbian Issues, *James Lock, MD, PhD*

11:45am – 1:00pm

Lunch Sponsored by Price Foundation

1:00pm – 2:30pm

Workshop Session I

2:30pm – 3:00pm

Break

3:00pm – 5:00pm

Plenary Session II:

Emerging Technologies in the Treatment of Eating Disorders

Moderator: *Susan Z. Yanovski, MD*
Internet, *Denise E. Wilfley, PhD*; Telehealth for Rural Populations, *James E. Mitchell, MD*; E-mail as an Adjunctive Tool in Managing Ambulatory Eating Disorders Patients, *Joel Yager, MD*; Ethical and Legal Aspects of Electronically-Mediated Intervention, *Keith Humphreys, PhD*

5:30pm – 7:00pm

Poster Session and Reception

7:00pm - 8:00pm

Videotape and Discussion

Follow-up of the Minnesota Semistarvation Study Participants
Scott Crow, MD, Elke D. Eckert, MD

Saturday, May 19

7:00am – 8:00am

Continental Breakfast

7:30am – 8:30am

SIG Meetings

8:30am – 10:00am

Workshop Session II and Oral Paper Sessions

10:00am – 10:15am

Break

10:15am – 10:30am

President's Address

James E. Mitchell, MD

10:30am – 12:30pm

Plenary Session III:

Best Practices for Treatment of Eating Disorders

Moderator: *Amy Baker Dennis, PhD*
Anorexia Nervosa, *Kelly Vitousek, PhD*; Bulimia Nervosa, *G. Terence Wilson, PhD*; Binge Eating Disorder, *Marsha D. Marcus, PhD*; Psychopharmacology, *B. Timothy Walsh, MD*

12:30pm – 2:00pm

Lunch Buffet, AED Business Meeting and Induction of Fellows

2:00pm – 3:30pm

Workshop Session III

3:45pm – 5:45pm

SIG Meetings



Please contact the Sheraton Wall Centre Vancouver directly for hotel reservations and mention that you are with the AED meeting to receive the special rate of \$205 CAD (approximately \$135 US). The cut-off date for hotel reservations is April 17, 2001.

For further program details, registration materials, and information on what to see and do in Vancouver, BC, visit our web site at www.acadeatdis.org or contact the national office at AED@degnon.org



Book Review Corner

Debra L. Franko, Ph.D.

Treatment Manual for Anorexia Nervosa: A Family-Based Approach

James Lock, MD, PhD, Daniel leGrange, PhD, W. Stewart Agras, MD & Christopher Dare, MD

(Guilford Press 2001, ISBN 1-57230-607-6, \$35.00, 278 pages)

Family therapy often seems both extraordinary and mysterious - extraordinary in its effectiveness with young anorexic patients, and mysterious in that its complexity makes it hard to understand exactly how it is practiced. This book provides an empirically-based family approach to the treatment of anorexia nervosa. It is a resource that promises to be of tremendous help to those working with such families. In exquisite detail, the authors describe the phases of treatment, clarify exactly why and how interventions are made, and provide the clinician with valuable insight into the thinking behind this important approach to the treatment of anorexic patients. I strongly recommend this book for professionals of all disciplines who work with patients with anorexia nervosa.

Before describing the three phases of treatment, the authors provide comprehensive summary chapters on both anorexia nervosa and family treatment for this disorder. I found these chapters to be a wonderful background to the rest of the text. The first chapter offers an overview of epidemiology, comorbidity, and etiology before summarizing the data on inpatient, outpatient, and pharmacological treatments for anorexia nervosa. The summary reminds us that "recovery appears to be best for patients who are treated early in their course," and sets the stage for the second chapter. The summary of family treatment for anorexia nervosa in chapter 2 is short but exhaustive in its review of the empirical literature on family therapy. Different types of family therapy (e.g., strategic, structural) are described, as is the Maudsley method, upon which this book is based. The chapter ends with an instructive section on appropriate and inappropriate candidates for the therapy described in the manual. A very detailed outline of the three phases of family therapy is pro-

vided ("refeeding the patient, negotiations for a new pattern of relationships, and adolescent issues and termination").

The next seven chapters are devoted to phase I, which is said to encompass the first 10 sessions of treatment. The first chapter, "Initial Evaluation and Setting Up Treatment" was notable for its level of detail, from the first telephone contact to a sample confirmation letter to be sent to the family prior to the first visit. I found this to be a very useful chapter and believe it would be an excellent orientation for the clinician as to how to get treatment started. Also instructive were the short sections on different types of families (e.g., single-parent family, single-child family) and the ways that personality disorders and traits may influence treatment. The chapter ends with a Q and A section on "Common Difficulties in Setting Up Treatment" which provides suggestions for the inevitable pitfalls that clinicians will run into in their clinical practice.

Session one, "The First Face-to-Face Meeting" is covered in two chapters. In the first, the details of the session are documented. In the second, a transcript of a session, interspersed with commentary, gives the reader a real sense of what actually occurs in the treatment. This format was excellent for both understanding and implementing the therapy. In the first chapter on session one, the authors carefully describe the goals of the sessions and the interventions used to accomplish them. They spend considerable time orienting the reader to the therapeutic paradox that they have found to be "at the heart of engaging the family in treatment." In this chapter, the reader gets a very clear understanding of the authors' thinking and experience with family therapy through their use of the following format. For each intervention described (e.g., greeting the family in a sincere but grave manner, separating the illness from the patient), the authors provide the "why" and the "how." Using this format, the reader quickly comes to understand the reasons behind the intervention as well as how to actually carry out the intervention with the family.

Session two, "The Family Meal" is also divided into one chapter devoted to an explanation of the goals and interventions

using the "why/how" format, and a second chapter with a transcript of an actual family session with author commentary. The family meal is designed to continue the assessment of the family dynamics, while at the same time giving the message to the parents that, as a united pair, they can refeed their daughter over the course of the first phase of treatment. In addition, the therapist works to strengthen the sibling bond so that the patient can receive support and help from her brothers and sisters as treatment proceeds. We are also reminded in this chapter of the authors' belief about how treatment occurs: "Family therapy is effective not because it undoes a hypothetical family etiology but rather because it changes the way a family responds and manages their daughter's eating disorder." (p. 81)

The next few chapters detail the remainder of the first phase of treatment. The continued use of the why and how format is very helpful, as is the lengthy section on "Common questions for sessions 3 through 10." Another session in action helps the reader to better understand some of the differences between the early sessions and these later sessions, particularly with regard to dealing with parental and sibling criticism of the anorexic patient.

The focus in Phase II is on returning the responsibility for eating to the adolescent, while at the same time making sure that progress continues to move forward. The authors provide clear guidelines for when the family is ready to move into the second phase of treatment (e.g., weight is at 87% or more of ideal body weight, patient and parent do not struggle over the patient's eating). The goals of this phase are to maintain parental control over the patient's eating until she can do so independently, and once that occurs, to help the adolescent continue to gain weight until she is at a healthy weight. Treatment at the end of this phase begins to focus more on adolescent development in relationship to anorexia nervosa. The authors point out that sessions during this phase are more widely spaced (every 2-3 weeks) and total from 2 to 6 sessions.

Finally, Phase III is a brief period of treatment which begins when the adolescent is at a stable weight, is no longer restricting

her eating, and has full control over eating and weight. The authors state, "the central theme here is the establishment of a healthy adolescent-parent relationship in which the illness does not constitute the basis of interaction." (p. 207). The goal of Phase III is to help the family deal with normal developmental issues in adolescence such as increasing autonomy, leaving home, and sexuality. The work of the family therapist in this phase is to "launch" the family so that they can continue the work of ongoing adolescent development together without the help of therapy.

The last chapter is a case report that summarizes one family's work throughout the three phases of treatment. It very nicely pulls together what comes before it and gives the reader a good sense of how this therapy might proceed from start to finish.

In all, an excellent and decisive book that is sure to be an important resource for clinicians who work with adolescents with anorexia nervosa and their families.



A Bumpy Road, cont. from page 3

By early 2000, I worked out an arrangement with Psych Systems (still unsold). They would hire my staff and assume the overhead risks. I retained full clinical stewardship. To achieve this, we had to accept a 6 1/2 hour program day, and the staff had to accept a much more modest compensation level. My fears about loss of quality of care were largely unfounded. We managed to continue to deliver very good care. Soon after this deal was struck, GSH bought out Psych Systems. That proved to be both good and bad. The good related to the simpler communications around decision-making. The bad had to do with the hospital's continuing space shortage. Our space was repeatedly encroached upon and ultimately we were moved to an outlying building in unaesthetic surroundings. This was part of the bitter that came with the sweet of institutional license and support.

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Upcoming Conferences

Family Action Council Advocacy Training

April 24-25, 2001, Washington, D.C.
The FAC will include at least one family member from each state to begin advocacy training and lobbying efforts. The coalition is a collaborative effort by many groups working toward the common goal of influencing federal policy related to eating disorders. Please visit www.eatingdisorderscoalition.org for further information.



Workshop: Understanding and Treating Binge Eating Disorder May 4, 2001 - 9:00am-4:15pm Cincinnati Psychotherapy Institute Cincinnati, Ohio

For more information or to have a registration packet sent to you, contact Dr. Christine Kidwell at (513) 791-1470.



Academy for Eating Disorders 2001 International Conference on Eating Disorders and Clinical Teaching Day May 17-19, 2001 Sheraton Wall Centre, Vancouver, BC Visit www.acadeatdis.org or contact AED@Degnon.org for more information.



Fairwinds Treatment Center One Day Eating Disorder Conference for Professionals May 25, 2001, 8:30am-5:00pm University of Central Florida - Orlando 6 hour workshop for Physicians, Therapists and Counselors. National experts Pauline Powers, M.D. & Amy Baker-Dennis, Ph.D. will discuss the latest state of the art treatment for eating disorders. For more information call Sam Teresi at 1-877-ANOREXIA.



XVII World Congress of World Association for Social Psychiatry October 27-31, 2001 Hotel Jaypee Palace, Agra, India An Eating Disorders Symposium is scheduled for this conference. Contact Professor Shridhar Sharma at wasp_congress@vsnl.com or visit www.17thwaspcongress.com for more information.

Eating Disorders Research Society 2001 Meeting November 29-December 2, 2001 Hyatt Tamaya Resort Hotel Albuquerque, New Mexico

EDRS meetings are focused on the rapid dissemination of new research findings in the field, discussion of research methodology, training of junior researchers, and facilitation of cooperation of researchers across the globe. Colleagues who are not EDRS members but are interested in attending this meeting are encouraged to contact the current president, Dr. Ruth Striegel-Moore, at rstriegel@wesleyan.edu for further information.



Academy Member Honored

Lisa Lilienfeld, Ph.D.

The Academy Member highlighted in the current newsletter is **F. Richard Ferraro, Ph.D.** Richard has recently been accepted into the Academy for Eating Disorders. He is in the Department of Psychology at the University of North Dakota (where he is surrounded by numerous other talented eating disorder colleagues...)

In 2000, Richard was named Executive Editor of two Psychology journals (Journal of General Psychology and Journal of Psychology), both of which are broad in scope. His initial terms as editor run until 2003. Both journals accept single experiment studies, as well as multi-experiment reports and theoretical papers. Journal of Psychology gets over 100 submissions per year and Journal of General Psychology receives 50-60 submissions per year.

Congratulations Richard! Your recent editorial appointments reflect well upon our entire field of eating disorder researchers. We are very happy to have you in the Academy.

If you would like to see an Academy member highlighted in the AED Newsletter, please send suggestions to LLilienfeld@gsu.edu



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A Bumpy Road, cont. from page 7

Ultimately, we experienced the corporate coup de grace. The Board of New York Hospital, (GSH's parent) decided the entire outpatient center at GSH (PHP, drug and alcohol program and us) was to close by the end of January, 2001. We had 6 weeks notice and 23 active patients at the time of the announcement. We froze admissions and worked through this closing with our patient group which was still 20 strong at the close.

I immediately began the hunt for a new facility licensed partner. That search has been strikingly frustrating. Many of the large hospitals in NYC felt eating disorders were "too small" to make for a profitable program. PHPs have recently done poorly in general. The times are "too risky" for program expansion. This I find remarkable in populous NYC, which only has one other similar program (Renfrew). We did find one receptive ear, however. The St.Luke's-Roosevelt Hospital is interested in us. We would synergize well with several of their existing programs. They

have a CDTP with a strong emphasis on character pathology, a credible center (Van Italie) that treats obesity, space available in their outpatient center, and, of course, facility licenses. They're in the midst of their due diligence currently.

I'm inclined to discuss one more point. Why do I want to do this? It has cost me a small fortune personally to date. Even if St. Luke's-Roosevelt offers to take us on, I doubt that running this program will remotely compete with private practice in terms of remuneration. (I, gratefully, have a very busy practice). I believe what compels me is the sense of community with patients and colleagues that develops in the struggle for recovery from an eating disorder. I've learned close up what a colossal struggle it is. I have had the joy of working with wonderfully committed and intelligent colleagues. I confess to having the arrogant notion that my involvement can make a difference, and, I don't seem to be able to resist the fray.



Academy Newsletter

Please send all suggestions for articles, job opportunities, information regarding upcoming events or meetings, letters to the Editor, awards and honors received by Academy members, published books, and all other items of interest to:

Lisa Lilienfeld, PhD

Department of Psychology
Georgia State University

Atlanta, GA 30303

Phone: 404-651-1291

Fax: 404-651-1391

E-mail: LLilienfeld@gsu.edu

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All contributions to the Newsletter must be submitted to the Editor via e-mail or disk in Microsoft Word format.