# Capitalizing on an Evolving Evidence Base

## 6th Biennial EDAC-ATAC Conference

## October 12-13, 2018

Ottawa Marriott Downtown
Ottawa, Ontario

**Scientific Syllabus**

## Conference Objectives

- To discuss current evidence-based approaches in the field of Eating Disorders.
- To describe and discuss program evaluation approaches and findings across treatment programs.
- To describe recent advances in eating disorder research.
- To describe effective treatments that can be offered efficiently to patients with eating disorders.

## Keynotes

A1. **What Neuroimaging and Neurostimulation Can Tell Us About the Psychology of Eating Disorders**
Blake Woodside, MD, FRCPC, Toronto General Hospital, Toronto ON
Learning Objectives:
1. Describe current techniques to image brain functions.
2. Describe various brain circuits that are involved in the psychology of eating disorders.
3. Describe how neurostimulatory techniques inform our understanding of both initiating and maintaining psychological factors in eating disorders.

A2. **Where Angels Fear to Tread: When Your ED Client is Engaging in Behaviors that Interfere with Treatment**
Lucene Wisniewski, PhD, FAED, Center for Evidence Based Treatment, Ohio & Case Western Reserve University, Cleveland OH USA
Learning Objectives:
1. Identify client behaviours that interfere with progress.
2. Identify therapist behaviours that interfere with progress.
3. Review skills that will help the therapist address TIBs between and within session.

## Plenaries

B1. **Canadian Eating Disorder Priority Setting Partnership: A Collaborative Journey to Build Shared Research Priorities**
Nicole Obeid, PhD, Children's Hospital of Eastern Ontario, Ottawa ON
Learning Objectives:
1. Review patient-oriented research principles and priority setting exercises.
2. Describe the process by which shared research eating disorder priorities were determined.
3. Describe and discuss the designated top 10 research priorities and how they can best be utilized by the field.

B2. **10 Hot Topics in Canadian Mental Health**
Ian Manion, PhD, CPsych, The Royal's Institute of Mental Health Research, Ottawa ON
Learning Objectives:
1. Discuss the status of some of the key mental health issues surfacing on the Canadian scene with their implications for service providers and individuals with eating disorders.
2. Describe a lifespan perspective to the continuum of mental health and eating disorders care including an appreciation for transitional issues.
3. Discuss strategic opportunities to inform policy in mental health and eating disorders both provincially and nationally.

## Papers

C1. **Evolving methods for enhancing Canadian men's engagement in specialized outpatient assessment and treatment of an eating disorder: Description of a designated track for men**

Brad A MacNeil, PhD, George Mason University, Fairfax VA USA (Presenting)
Chloe Hudson, MSc, Queen's University, Kingston ON

Learning Objectives:

1. Describe males' experiences of eating disorders and barriers to accessing care.
2. Describe a specialized assessment and treatment track for males with eating disorders (MATT).
3. Discuss research that demonstrates that MATT is associated with increased engagement in outpatient eating disorder assessment and later treatment for men with eating disorders.

Abstract:

Background**:** Men with eating disorders are understudied, undertreated, and not well understood. Many individuals continue to assume that eating disorders only affect women and men with the illness report holding stigmatizing beliefs about eating disorders. These misconceptions may unintentionally lead to men being reluctant to seek assessment and treatment for the illness. There is a need for novel methods for engaging men in specialized outpatient programs, and descriptive information on males' experiences of eating disorders. Objectives**:** We examined referrals and engagement in a specialized male assessment and treatment track (MATT) that was positioned as part of a broader group-based program at a tertiary level hospital-based outpatient adult eating disorders program. We evaluated whether the addition of the MATT would result in a greater number of referrals for men to the outpatient program. To control for other factors that may influence referrals, we also assessed changes in the number of referrals received for women during the same time period. A second objective was to explore whether the addition of MATT would result in more men attending assessment and treatment for an eating disorder post referral. Design/Method**:** Data was collected over four years. During the first two years (i.e., September 2013 to August 2015), the outpatient program offered assessment and treatment as usual (ATAU) to both men and women with no designated track for men. During the next two years (September 2015 to August 2017), a designated track for men or MATT was piloted. The track provides an opportunity for men to receive specialized assessment, individual cognitive behavior therapy-enhanced, and information on recovery-based resources for men. MATT also provides a place for men to discuss issues related to stigma, isolation, and their unique experience of the illness. Goals of the designated track include normalizing men's unique experiences of eating disorders, psychoeducation on the biological basis of the illness and environmental factors, and providing men with support that that they are not alone in their struggles. Additional topics include the negative impact of the eating disorder on daily living, the fathering role, relationships, and sport. Both groups of men completed measures of demographic characteristics, life satisfaction, depressive and anxiety symptoms and eating disorder symptoms. Results/Discussion**:** During ATAU, 283 referrals were received (275 women, 8 men), with 3 men engaging in assessment and treatment. After instatement of a MATT, 320 referrals were received (300 women, 20 men), with 14 men engaging in the specialized assessment and treatment. Significantly more referrals for men, but not women, were received after the instatement of the MATT (i.e., a 250% increase). Significantly more men engaged in specialized assessment and treatment after the instatement of the MATT (i.e., a 467% increase in engagement). Conclusions**:** Providing a dedicated track for the unique needs of men with eating disorders may offer a practical approach for pre-existing outpatient programs to get men in the door for specialized assessment and care. Our results suggest that men can be engaged in outpatient services if they are available.

C2. **Long-Term Follow-up of an Emotion-Focused Family Therapy Workshop: A Mixed Methods Study**

Adele Lafrance, PhD, Laurentian University, Sudbury ON (Presenting)
Patricia Nash, MEd, Eating Disorder Foundation of Newfoundland and Labrador, St. John's NL (Presenting)
Cathy Skinner, Eating Disorder Foundation of Newfoundland and Labrador, St. John's NL (Presenting)
Amanda Stillar, MA, University of Alberta, Edmonton AB
Marika Renelli, MSc, Laurentian University, Sudbury ON
Breeanna Streich, BA, Laurentian University, Sudbury ON

Learning Objectives:

1. Discuss the long-term outcomes of group-based EFFT for caregivers.
2. Recognize ways that EFFT directly supports and improves caregiver ability to support their loved one with an eating disorder.

Abstract:

Background: Influenced by the theory and science of interpersonal neurobiology, the essence of Emotion-Focused Family Therapy (EFFT) is to support caregivers to increase their role in ED recovery, including: (1) meal support and symptom interruption, (2) emotion processing and (3) leading the repair of relational injuries if applicable. Throughout treatment, the EFFT clinician also seeks to transform "emotion blocks" in caregivers who struggle to implement interventions. Preliminary research on EFFT has demonstrated positive outcomes for caregivers across a number of domains (Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2014; Strahan et al. 2017). Objectives: Despite these promising findings, mixed-method follow-up studies are necessary to determine whether gains related to participation in an EFFT two-day caregiver workshop are maintained over time. Method: Data were collected from 74 caregivers who participated in EFFT workshops led by a not-for-profit ED foundation in an underserviced area in Canada. Data were collected at three time intervals: T1 = pre-treatment, T2 = post-treatment, T3 = 6 months follow-up. Of the total sample, 44.6% completed follow-up measures (n=33; 23 women). The mean age of the affected individual was 21.30 years (SD= 7.54). Qualitative data were also collected from a subset of caregivers (n=8) who then participated in a semi-structured interview. Ethics approval was obtained by the authors' associated Research Ethics Boards. Results: Repeated measures ANOVA were used to assess change in parental self-efficacy, parental blocks related to supporting their child's recovery, and accommodating and enabling behaviors over time. Results revealed that participants experienced a statistically significant improvement in parental self-efficacy immediately following the group ($\Delta$T1-T2 = -6.710, $p$<.001) that was maintained at 6-month follow-up ($\Delta$T1-T3 = -2.742, $p$=.001), a statistically significant decrease in emotion blocks immediately following participation in the group ($\Delta$T1-T2 = 12.310, $p$<.001) that maintained at 6-month follow-up ($\Delta$T1-T3 = 6.931, $p$=.04), and a statistically significant decrease in accommodating and enabling behavior from pre-group to 6-month follow-up ($\Delta$T1-T2 = 14.417, $p$=.003). Thematic analysis was conducted with qualitative transcripts. A total of five themes were identified and related to increases in self-efficacy; working through emotion blocks; stronger interpersonal relationships within the family; experiencing a sense of togetherness among caregiver-participants and benefiting from the practice of chair-work. All but one sub-theme were endorsed by 75% of participants, indicating a strong level of agreement. Discussion/Conclusion: The results from this study extend previous findings suggesting that the 2-day EFFT workshop is associated with positive caregiver outcomes, and that these are maintained over time. High concordance was observed between the quantitative and qualitative data, which strengthens the results and sheds light on potential mechanisms of change, including ways in which to enrich the workshop delivery. Clinical and policy implications will be discussed.

C3. **Efficacy of the ECHO Approach for Patients with Eating Disorders and their Carers**

Aaron Keshen, MD, FRCPC, Nova Scotia Health Authority, Halifax NS

Thomas Helson, BSc, Nova Scotia Health Authority, Halifax NS
Sarrah Ali, BSc, Nova Scotia Health Authority, Halifax NS (Presenting)
Learning Objectives:
1. Describe the effects, both positive and negative, that carers can have on patients with eating disorders.
2. Describe the results of the current study, as well as future directions for improving carer distress.
Abstract:
Background: Research has shown that the distress that carers of individuals with eating disorders (EDs) experience can have a negative impact on those individuals with EDs. These findings point to the need to engage carers in the treatment process such that they experience enhanced efficacy in handling the illness and supporting recovery; thereby reducing the distress levels of themselves and their loved one. Objectives: The current study aimed to determine the efficacy of the newest version of The Expert Carers Helping Others (ECHO) intervention, a two and a half hour unguided self-help DVD that demonstrates how individuals with eating disorders and their carers can improve coping, reduce expressed emotion, and manage eating disorder behaviours. Method: Eating disorder outpatients (n = 58) were able to identify up to two carers as potential participants, resulting in a sample of 62 carers. Patients and their carers were randomly assigned to either the Treatment as Usual (TAU) group, a group-based outpatient treatment program for patients, or the ECHO plus TAU group, which provided carers the ECHO intervention for patients receiving standard treatment. Carers and patients were asked to complete questionnaires at baseline, after 4-weeks of treatment, and at 3-month follow-up that assessed carers' levels of distress, self-efficacy and expression emotion, the impact of eating disorder symptoms on carers, eating disorder symptom severity, and qualitative feedback regarding the DVD. Results/Discussion: The results failed to provide supportive evidence for the primary hypothesis that carers in the ECHO plus TAU group would report lower distress levels compared to carers in the TAU group at post-treatment and follow-up. This finding, within the context of the current literature, suggests that there may not be significant benefit to carers who use the newest version of the ECHO intervention in an unguided self-help approach. This intervention may benefit from being studied in conjunction with other forms of carer-focused interventions, such as emotion-focused therapy, in order to ameliorate carer distress and in turn, patient distress. Further implications and future directions for improving carer distress will be discussed.

C4. **PTSD Predicts Dropout/Premature Termination from Day Hospital Treatment for Bulimia Nervosa and OSFED**

Kathryn Trottier, PhD, University Health Network, Toronto ON (Presenting)
Learning Objectives:
1. Describe a Day Hospital program for adults with BN and OSFED.
2. To review research that demonstrates that patients with BN or OSFED and co-morbid PTSD have a higher prevalence of other comorbidities.
3. Describe how patients with BN or OSFED and co-morbid PTSD have a greater likelihood of premature termination from treatment and a poorer prognosis.
Abstract:
Background**:** Posttraumatic stress disorder (PTSD) frequently co-occurs with eating disorders (ED) and has been identified as a potential maintaining factor of ED. Individuals with co-occurring ED and PTSD (i.e., ED-PTSD) are thought to have difficulty tolerating and engaging with ED treatment due to a functional relationship wherein ED behaviors (e.g., binge eating, purging) modulate PTSD symptoms. This bidirectional relationship is thought to reinforce and maintain both disorders. Thus, PTSD is thought to be one reason why some individuals who initiate ED treatment do not complete treatment. Objectives**:** The primary aim of this study was to determine whether PTSD predicts drop out and/or

premature termination from day hospital ED treatment. The secondary aim was to compare individuals with ED-PTSD to those without co-occurring PTSD on clinical characteristics. Method**:** One hundred and sixty-four patients with BN or OSFED admitted to day hospital treatment completed the study measures at pre-admission. In our program, a complete duration of day treatment for BN and OSFED is 6 to 8 weeks with a minimum dose clinically defined as 4 weeks. Thus, dropout/premature termination was defined as completing less than 6 weeks of treatment. The PTSD Checklist-5 was used to screen for the presence of PTSD consistent with DSM-5 criteria. Eating disorder symptom frequencies and diagnoses were assessed via the Eating Disorder Examination (EDE). Other measures administered at the start of treatment included: Young Schema Questionnaire, Beck Depression Inventory, EDE-Questionnaire, and Clinical Impairment Assessment. This study was approved by the author's institutional research ethics board. Results**:** Patients who screened positive for PTSD reported significantly higher ED psychopathology, clinical impairment, and other psychopathology (i.e., depression, maladaptive schemas) than individuals who did not screen positive for PTSD ($p$s < .001). Cox regression revealed that PTSD significantly predicted dropout/premature termination after controlling for duration of ED, financial status, degree of clinical impairment, depression and ED severity (overall model, $X^2(9) = 20.21$, $p = .017$; Δ from previous block, $X^2(1) = 3.99$, $p = .046$). Chi-square analysis indicated a significant association between PTSD and treatment completion ($X^2(2) = 11.12$, $p = .004$). Eighty-one percent (81%) of those without PTSD and 69% of those with PTSD completed treatment. However, the majority (78%) of those who completed less than a minimum dose of treatment (i.e., 4 weeks) screened positive for PTSD. Discussion**:** Individuals with ED-PTSD present to intensive treatment with more severe ED psychopathology, levels of impairment, negative schemas, and depression than those without co-occurring PTSD. Most individuals with ED-PTSD complete day hospital treatment for their eating disorder. However, results of this study suggest that much of the attrition seen in the initial phase of treatment is related to PTSD which is consistent with the hypothesized functional relationship between ED and PTSD symptoms. Interventions to facilitate ED treatment engagement and retention for individuals with co-occurring PTSD may have the potential to enable more individuals to complete treatment and experience good ED treatment outcomes.

C5. **The Mediating Role of Low Self-Esteem and Negative Mood in the Associations Between Adolescents' Perceptions of the Quality of Interpersonal Relationships and Eating Disorder Symptom Severity**

Jade Pelletier Brochu, PhD Candidate, Montreal University, Montreal QC (Presenting)
Dominique Meilleur, PhD, Montreal University, Montreal QC (Presenting)
Giuseppina DiMeglio, MD, McGill University, Montreal QC
Danielle Taddeo, MD, Sainte-Justine University Hospital Center, Montreal QC
Eric Lavoie, MD, Sherbrooke University Hospital Center, Sherbrooke QC
Julius Erdstein, MD, McGill University, Montreal QC
Robert Pauzé, PhD, Sherbrooke University, Sherbrooke QC
Caroline Pesant, MD, Sherbrooke University Hospital Center, Sherbrooke QC
Isabelle Thibault, PhD, Sherbrooke University, Sherbrooke QC
Jean-Yves Frappier, MD, Sainte-Justine University Hospital Center, Montreal QC

Learning Objectives:

1. Review and outline the predictive value of perceived levels of trust, communication and alienation in the relationships with mother, father and peers in the severity of ED symptoms in adolescent females.
2. Describe research examining the relation between aspects of interpersonal relationships and severity of anorexia nervosa symptoms in adolescent females.

Abstract:

Background: Distressed interpersonal relationships have been suggested as a core component contributing to the development and maintenance of ED pathology. Although existing evidence has

supported the association between difficulties in interpersonal relationships with close others and ED symptoms, previous research has generally limited its scope to focusing on one particular type of relationships, mainly parent-child interactions, and has mostly been conducted with adult samples. Few studies have examined how the perceived quality of multiple interpersonal relationships is related to ED symptom severity in adolescents and how psychological variables may influence this association. Objectives: The aim of this study is to determine whether the perceived levels of trust, communication and alienation in the relationships with mother, father and peers are predictive of ED severity in adolescent females and to test the mediating effects of low self-esteem and negative mood in these associations. Methods**:** Adolescent females aged 12 to 18 years old (N=186) with a diagnosis of AN-R or ANB/P completed self-report measures evaluating the perceived quality of interpersonal relationships with mother, father and peers (Inventory of Parent and Peer Attachment; IPPA), ED symptom severity (Subscales of the Eating Disorder Inventory; EDI-3), low self-esteem (Subscale of the EDI-3) and negative mood (Beck Depression Inventory; BDI-3). Results: Multiple regressions revealed that the levels of perceived alienation, but not communication and trust, in the relationships with mother and peers were positively associated with ED symptom severity in a sample of adolescents with AN. In contrast, neither the positive nor the negative aspects of the relationship with father were significantly associated with the severity of eating pathology. In addition, it was found that low self-esteem and negative affect act as mediators in the associations between more severe ED symptoms and higher levels of alienation in the relationships with mother and peers separately. Conclusion: The findings highlight the differential associations between the perceived quality of multiple types of relationships (mother, father and peers), different aspects within these interactions (communication, trust, alienation) and ED symptom severity in adolescents. Considering that high levels of perceived alienation in the relationships with mother and friends appear to be associated with more severe ED symptoms through their impact on self-esteem and mood, improvements of the quality of these interactions is likely to be an effective target of intervention in adolescents. Treatments focusing on specific relationship difficulties (e.g.: communication, conflict resolution) and helping adolescents regain a sense of efficacy and experience positive affect in their familial and social interactions are important. In addition, given the crucial role of friendships during adolescence, the inclusion of the peer group, in addition to the family, as partners in the prevention and treatment of ED is an important aspect to consider for the elaboration of more effective interventions.

C6. **Mediating Effect of Illness Perception and Psychological Distress on the Link Between Caregiving Experience and Expressed Emotion of Parents of Hospitalized Adolescents with Anorexia Nervosa at Early Stage of the Illness**

Soline Blondin, PhD, Université de Montréal, Montreal QC (Presenting)
Dominique Meilleur, PhD, Université de Montréal, Montreal QC (Presenting)
Danielle Taddeo, MD, CHU Sainte-Justine mère-enfant, Montreal QC
Jean-Yves Frappier, MD, CHU Sainte-Justine mère-enfant, Montreal QC

Learning Objectives:

1. Describe the effect of the caregiving experience of parents of adolescents hospitalized for anorexia nervosa at the beginning of the illness on the dimensions of expressed emotion.
2. Discuss psychological distress and perception of symptoms of caregivers of youth with anorexia nervosa at treatment onset and during treatment.

Abstract:

Background: Increasing research is taking interest in the experience of caregivers of adolescents suffering from anorexia nervosa (Anastasiadou et al., 2014). Expressed emotion, conceptualized as the way a person interacts with the person presenting an eating disorder, has been associated to a poorer treatment outcome in anorexia nervosa (Duclos et al., 2012). Illness perception and psychological distress have both been positively associated to caregiving experience and levels of expressed emotion

(Kyriacou et al., 2008a, 2008b; Sepulveda et al.2012). Objectives: The aim of this study was to examine the association between mothers' and fathers' illness perception and psychological distress with their caregiving experience and level of expressed emotion in the context of caring for their adolescent presenting with anorexia nervosa. Design/methods: Participants of the study were fifty mothers and 38 fathers of adolescents suffering from anorexia nervosa, hospitalized for the first time. All participants answered questionnaires evaluating different concepts: the Family Questionnaire (Wiedemann et al., 2002) evaluated two dimensions of expressed emotion (emotional overinvolvement (EOI) and critical comments (CC)), the Experience of Caregiving Inventory (Szmukler et al., 1996) measured negative aspects of caregiving, the Anorectic Behaviour Observation Scale (Vandereycken, 1992) evaluated the perception of the illness and the General Health Questionnaire – 28 (Goldberg & Hillier, 1979) measured the level of psychological distress of parents. We hypothesized that illness perception and psychological distress would have a mediation effects on the association between negative aspects of caregiving and both dimensions of expressed emotion. The mediation effects were tested according to the approach of Preacher and Hayes (2004), which consists in testing the presence of a direct and indirect effect of a mediating variable. Results/discussion: A mediation effect of psychological distress on the association between negative aspects of caregiving and emotional over-involvement was observed for both parents. Mediating effects of illness perception on the link between negative aspects of caregiving and critical comments were also observed for mothers and fathers. Results show that caregiving experience has a direct effect on the dimensions of EE. However, it also can have an indirect effect on EOI through psychological distress and on CC through illness perception. Conclusion: A better knowledge of the mediation effects of variables related to the caregiving experience and expressed emotion is important because it represents interesting therapeutic targets for intervention. Therefor, reducing parents' negative aspects of caregiving as well as psychological distress and qualifying illness perception, could contribute to lower their level of EE and in turn be beneficial to their child.

C7. **The Role of Sex and Gender in Pediatric Eating Disorders: Symptom Presentation and Treatment Outcome in Male and Female Youth**

Jennifer S Coelho, PhD, BC Children's Hospital, Vancouver BC (Presenting)
Janet Suen, BSc, BC Children's Hospital, Vancouver BC
Alex Burns, MRCP, BC Children's Hospital, Vancouver BC
Pei-Yoong Lam, FRACP, FRCPC, BC Children's Hospital, Vancouver BC
Sheila Marshall, PhD, University of British Columbia, Vancouver BC
Josie Geller, PhD, St. Paul's Hospital, Vancouver BC

Learning Objectives:

1. Identify assessment tools that are relevant for male youth with eating disorders.
2. Describe sex differences in the presentation of male and female youth with eating disorders.
3. Examine strategies for treating pediatric eating disorders across the gender spectrum.

Abstract:

Background: Research on eating disorders includes samples that are predominantly biological females, as the majority of individuals presenting for treatment are female. The distribution among early-onset eating disorders show fewer imbalances across males and females, suggesting potential barriers to accessing treatment for older males. There is a paucity of research regarding the clinical presentation and treatment outcome of male youth with eating disorders. Objectives: The current study was designed to compare biological male youth presenting for treatment at a specialized eating disorders program with a group of biological female youth (matched for age, symptom presentation, and treatment intensity). Assessments included measurement of eating disorder concerns that may be particularly relevant to males (i.e., muscularity, exercise). Methods: All male youth between the ages of 8 and 25 who presented for treatment at one of two specialized eating disorder treatment centres were

invited to participate, with a sample of female youth matched to the clinical presentation of males. Participants completed self-report questionnaires at admission, discharge, and 3-month follow-up to assess changes in psychological parameters. Measures included assessment of eating pathology, body attitudes, and exercise. Physical indicators of recovery (i.e., body weight, hormones) were also tracked. Parents/caregivers of participants were invited to complete questionnaires assessing family functioning and parental-efficacy. Results/Discussion: Thirty-eight matched youth (male = 19, female = 19), diagnosed with Anorexia Nervosa (n = 24), Bulimia Nervosa (n = 1), Avoidant/Restrictive Food Intake Disorder (n = 7), and Other Specified Eating/Feeding disorder (n = 6) have been recruited. The mean age of participants is currently 14.84 years (*SD* = 2.84). Discharge and follow-up data is available for a portion of this sample. Analyses excluded participants with an ARFID diagnosis, given differences in presence of body image concerns and few participants with an ARFID diagnosis. Preliminary analyses on admission and discharge data reveal a significant decrease in eating pathology [$F(1, 17) = 11.68$, $p < .005$] and excessive exercise [$F(1, 18) = 13.99$, $p < 0.001$] over the treatment course; however, no interaction with gender emerged for these measures. An interaction was detected on the Male Body Attitudes Scale, $F(1, 18) = 4.83$, $p < .05$, suggesting males (but not females) report a decrease in unhealthy attitudes relating to muscularity, height, and body image over the treatment course. We have a target of 25 pairs and expect to complete data collection by Summer 2018. Conclusion: Preliminary results suggest some gender effects in treatment response, with differential treatment responses emerging for male body attitudes. The importance of eating disorder assessment measures that are relevant across the gender spectrum will be discussed. Increased knowledge regarding the clinical presentation of male youth with eating disorders will support clinicians in considering the role of gender in eating disorder treatment.

C8. **Understanding Avoidant Restrictive Food Intake Disorder in Children and Youth: A Canadian Surveillance Study**

Debra Katzman, MD, FRCPC, The Hospital for Sick Children, Toronto ON (Presenting)
Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Wendy Spettigue, MD, FRCPC, University of Ottawa, Ottawa ON
Holly Agostino, MD, McGill University, Montreal QC
Jennifer Couturier, MD, FRCPC, McMaster University, Hamilton ON
Anna Dominic, MD, FRCPC, Memorial University, St. John's NL
Sheri Findlay, MD, FRCPC, McMaster University, Hamilton ON
Pei-Yoong Lam, MD, FRACP, University of British Columbia, Vancouver BC
Margo Lane, MD, FRCPC, University of Manitoba, Winnipeg MB
Cathleen Steinegger, MD, University of Toronto, Toronto ON
Danielle Taddeo, MD, Universite de Montreal, Montreal QC
Ellie Vyver, MD, FRCPC, University of Calgary, Calgary AB

Learning Objectives:

1. Describe the frequency by which children and youth meeting criteria for ARFID present in a National Canadian community sample.
2. Describe clinical characteristics of patients with ARFID in a Canadian community sample of children and adolescents.

Abstract:

Background: Avoidant/Restrictive Food Intake Disorder (ARFID) is a new eating disorder introduced in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5). The incidence of ARFID ranges from 6 to 14% in tertiary care paediatric eating disorder centres; however, there are no data on the incidence of ARFID in community-based pediatric samples. Methods: A questionnaire was developed based on a review of the relevant literature and consultation with content experts. The questionnaire

was administered on a monthly basis to 1300 Canadian pediatricians in accordance with the standard Canadian Paediatric Surveillance Program (CPSP) methodology using a two-tiered reporting process to ascertain and investigate cases between 2016-2018. A case was defined as any child or adolescent between 5 – 18 years old, seen in the previous month who met the diagnostic criteria for ARFID as outlined in the DSM-5. Results: 180 cases of ARFID were identified. 110 (61.1%) were females. The average age was 13.00 years (SD = 3.16). Cases were from Western Canada (44; 24.4%), Central Canada (128; 71.1%), and Atlantic Canada (8; 4.4%). The majority (78.7%) of cases were White. The average length of illness prior to diagnosis was 34.1 months (SD = 40.5). The most common abnormal eating behaviours reported were: 160 (88.9%) eating, but not eating enough; 148 (82.2%) avoided food; 129 (71.7%) had a loss of appetite or little or no desire to eat; and 129 (71.7%) were not initiating eating or seeking out food as expected. The three most common presenting clinical signs included: marked interference with psychosocial functioning [116 (64.4%)], significant weight loss [104 (57.8%)], and failure to achieve expected weight gain [103 (57.2%)]. The most common psychiatric comorbidities included anxiety [87 (48.3%)], attention-deficit/hyperactivity disorder [24 (13.3%)], depression [19 (10.6%)], autism spectrum disorder [16 (8.9%)], and obsessive-compulsive disorder [13 (7.2%)]. Hospitalization occurred in [71 (39%)] cases. The majority of children [151 (83.9%)] were being medical monitoring as an outpatient. Conclusion: This is the first study that examines the frequency of presentation of ARFID in children and adolescents in a community sample in Canada. The majority of patients with ARFID were female; however, a higher percentage of males with ARFID were reported than has been reported in older adolescents and adults with AN and BN. A significant period of time elapses between the onset of symptoms and receiving a diagnosis of ARFID. The majority of children and adolescents were in treatment, most commonly outpatient medical monitoring. Improvements in the identification of ARFID are necessary to accelerate access to appropriate treatment. These results will advance the knowledge of Canadian clinicians and relevant stakeholders to facilitate early diagnosis and management of ARFID that may lead to policy, educational, and public health initiatives.

C9. **A Tertiary-Care/Primary-Care Partnership Aimed at Improving Care for People with Eating Disorders**

Lea Thaler, PhD, Douglas University Institute, Montreal QC (Presenting)
Shiri Freiwald, MA, Douglas University Institute, Montreal QC
Chloe Paquin Hodge, PsyD, Douglas University Institute, Montreal QC
Émilie Fletcher, BA, Douglas University Institute, Montreal QC
Danaelle Cottier, BA, Douglas University Institute, Montreal QC
Esther Kahan, BSc, Douglas University Institute, Montreal QC
Erika Rossi, BA, Douglas University Institute, Montreal QC
Myra Piat, PhD, McGill University, Montreal QC
Shalini Lal, PhD, Université de Montréal, Montreal QC
Mimi Israel, MD, Douglas University Institute, Montreal QC
Howard Steiger, PhD, Douglas University Institute, Montreal QC

Learning Objectives:

1. Describe the implementation of an evidence-based knowledge exchange program for the treatment of EDs.
2. Summarize the impact of knowledge exchange trainings on clinician confidence in treating EDs and on patient outcomes.
3. Review the importance of disseminating knowledge of ED treatment from specialized to non-specialized clinicians within the Canadian health-care system.

Abstract:

Background: Studies from across Canada highlight that people with Eating Disorders (EDs) are too often unable to access informed treatment, or wait for such access for unacceptably long periods of time. The

Douglas Mental Health University Institute Eating Disorders Program (EDP), housed at the Montreal West Island Integrated University Health and Social Services Centre, is the main, and one of the only specialized ED treatment program for adults with Anorexia- or Bulimia-spectrum EDs in the Province of Quebec, In 2009, the EDP mounted a specific response to the reality of limited capacity for ED treatment in community mental-health programs in Quebec by offering ED-focused knowledge exchange (ED-KE) with selected community mental-health teams throughout the province. Methods: Ethical approval was obtained from the Research Ethics Board of the Douglas University Institute and from the ethical review boards of participating sites. Between 2009 and 2016, a total of 71 trainings were attended by 765 clinicians from 21 different institutions. Clinician satisfaction with trainings and attitudes towards treating patients with EDs were assessed. A subset of the clinicians (n=87 at 12 sites) received direct case supervision with a specialist ED therapist. These clinicians followed a total of 338 patients in their sectors. Outcomes in a subset of patients were also assessed using the Eating Disorder Examination-Self-Report Questionnaire Version (EDE-Q; (Fairburn & Beglin, 1994), and the Center for Epidemiologic Studies Depression Scale (CES-D; (Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977). Results: The majority of clinicians (95.1%) reported being satisfied or very satisfied with the KE program and indicated that the trainings enhanced their confidence and felt ability to treat patients with EDs. Patients treated by trained clinicians showed clinically significant improvements from pre- to post-treatment on eating (EDE-Q Total score: t (36) = 4.00, *p*=.000) and depressive symptoms (CES-D: t(35) = 3.23, *p*=.003)., and patients reported being satisfied with the treatment received. Discussion/Conclusion: The KE program described was effective in establishing ongoing partnerships between staff working at a specialized ED program and in various community mental-health teams. Furthermore, the resulting partnerships have enabled the community settings to offer previously unavailable services for people with EDs, with the result that people with EDs have been able to access effective, informed ED treatment in their communities.

C10. **What Does it Take to Make Patient-Directed Care a Reality?**

Andrea LaMarre, PhD, University of Guelph, Guelph ON (Presenting)
Leora Pinhas, MD, FRCPC, University of Toronto, Toronto ON
Raluca A Morariu, BSc, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Patients and Staff of the Ontario Shores Centre for Mental Health Sciences Adolescent Eating Disorders Unit 2016-2017, Whitby ON

Learning Objectives:

1. Review the experience-based co-design model for program evaluation of eating disorders program.
2. Describe patient-centered, recovery-model oriented care and its challenges and benefits.
3. Review methods of integrating recovery model and patient involvement into eating disorder treatment programs.

Abstract:

Background: The rhetoric of patient-centered care is common in mental health service delivery, including eating disorders care. However, such rhetoric is not always backed up with action. In order to make patient-oriented care a reality, there is a need for accountability. Particularly in eating disorders treatment, there is a call for more and better metrics for program outcomes that include patients' voices in determining the type and direction of care they desire and require. Objectives: In this qualitative program evaluation, we sought to determine: 1. The key positive and negative touchpoints of an adolescent eating disorders program based on recovery model principles from the perspective of patients and staff; 2. How and why patient engagement is critical to the success of the treatment model, and 3. The extent to which the ideals of patient engagement are being met. Design/Method: We undertook a modified Experience Based Co-Design (Larkin, Boden & Newton, 2015) study. The model is designed to involve patients and staff in identifying areas of improvement and successes of the

treatment. Following ethics board approval, we sent out a call for participants to all staff, patients, and parents on the unit. We interviewed 11 staff members, 8 patients, and 2 primary caregivers about their experiences. Results/Discussion: Patients found great value in participating in the design of their treatment. They identified moments in which they had their voices heard in ways that would impact their own care and the care of future patients. Patients and caregivers felt confident in the team's ability to meet their various needs and appreciated the flexibility and transparency of the program. They saw room for improvement in striking the balance between support and autonomy, as well as in transitions from treatment to home. Staff saw patient involvement in their care as important in actualizing recovery model principles and patient-oriented care. They identified a need for more resources and continued training around how to support eating disorder patients with different needs, as well as the recovery model "in action." They noted that when engaging with patients, active listening skills and an orientation toward patients' expertise in their own care fostered empathy and would be beneficial across program models. Conclusion: Involving patients in treatment and in evaluations of treatment models can help us to improve eating disorders treatment; by doing so we might then be able to move toward an evidence base founded not only on standardized quantitative questionnaires but deep inquiry into lived experiences of patients. This evidence base can help to inform dynamic eating disorder treatment delivery that better meets patients' needs.

C11. **Current Practices in Assigning Patients to Level of Care using the Short Treatment Allocation Tool for Eating Disorders (STATED)**

Josie Geller, PhD, St. Paul's Hospital, Vancouver BC (Presenting)
Emily Seale, BSc, Children's Hospital of Eastern Ontario Research Institute, Ottawa ON
Leanna Isserlin, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Megumi Iyar, BA, St. Paul's Hospital, Vancouver BC
Jennifer Coelho, PhD, BC Children's Hospital, Vancouver BC
Suja Srikameswaran, PhD, St. Paul's Hospital, Vancouver BC
Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON

Learning Objectives:

1. Identify the three *STATED* dimensions used to assign patients to each of five levels of care.
2. Describe the extent to which *STATED* principles are currently in use.
3. Describe which *STATED* dimension is least consistently used.

Abstract:

Background: There is little consensus or consistency in how patients with eating disorders (ED) are assigned to the most helpful and cost-effective level of care. The Short Treatment Allocation Tool for Eating Disorders (*STATED*) is a new evidence-based algorithm developed to ensure current empirical evidence is used in matching patients to treatment to promote best resource utilization in British Columbia. The *STATED* uses three patient dimensions: medical stability, symptom severity, and readiness in assigning patients to one of five levels of care. Objectives: The objectives of the present study were to: 1) determine the extent to which current practices are in alignment with *STATED* recommendations, and 2) compare the consistency with which *STATED* dimensions are used in clinical practice. Methods: Participants were 179 healthcare professionals belonging to international ED-specific organizations providing care for youth and/or adults with EDs. Over a period of three months, they were recruited online and invited to participate in a brief survey. Ratings were made on the extent to which each patient dimension (medical stability, symptom severity, and readiness) was considered suited to each of the five levels of care. Results: Twenty-four McNemar tests were conducted testing a priori hypotheses based on *STATED* recommendations. For example, the *STATED* recommends inpatient hospitalization for high medical acuity, and recovery-focused treatment (as opposed to treatment focusing on engagement or quality of life) for those with higher readiness. Of the 24 analyses

conducted, 22 were statistically significant (all *p*'s < .001), in the direction of *STATED* recommendations. A coding scheme was developed to test the extent to which current practice ratings were inconsistent with the *STATED*. The mean proportion of inconsistent responses across levels of care for each dimension was as follows: medical stability (9%), symptom severity (40%) adult readiness (58%), and family readiness (66%). Conclusions: This research serves as a first step in understanding the extent to which evidence based practice is used to assign patients to level of care. The greatest inconsistencies involved the use of readiness information, and the lowest involved the use of medical stability information.

C13. **A Longitudinal, Epigenome-Wide Study of DNA Methylation in Anorexia Nervosa: Results in Actively Ill, Partially Weight Restored, Long-Term Remitted, and Non-Eating-Disordered Women**

Howard Steiger, PhD, Douglas University Institute, Verdun QC (Presenting)
Linda Booij, PhD, McGill University, Montreal QC
Lea Thaler, PhD, Douglas University Institute, Verdun QC
Esther Kahan, BSc, Douglas University Institute, Verdun QC
Kevin McGregor, MSc, McGill University, Montreal QC
Aurelie Labbe, PhD, HEC Montreal, Montreal QC
Ridha Joober, MD, Douglas University Institute, Verdun QC
Mimi Israël, MD, Douglas University Institute, Verdun QC
Moshe Szyf, PhD, McGill University, Montreal QC
Luis B Agellon, PhD, McGill University, Montreal QC
Emilie Fletcher, BA, Douglas University Institute, Verdun QC
Lise Gauvin, PhD, Centre de recherche du Centre Hospitalier, Montreal QC
Annie St-Hilaire, PhD, Douglas University Institute, Verdun QC
Erika Rossi, BA, Douglas University Institute, Verdun QC

Learning Objectives:

1. Describe what DNA methylation is.
2. Describe research examining DNA methylation in patients with EDs at various stages of illness activity.
3. Describe research and findings regarding DNA methylation in ill, partially recovered, and recovered women with AN compared to non-ED controls.

Abstract:

Background: Research in people with Anorexia Nervosa (AN) has suggested that DNA methylation levels may vary in function of illness activity, staging and nutritional status. Objectives: This ongoing study examines genome-wide methylation profiles and plasma levels of micronutrients acting in DNA methylation in women with and without AN. Methods: Preliminary analyses have implicated 78 women with active AN (AN-Active), 21 showing stable remission of AN (AN-Remitted), and 36 with no eating-disorder history (NED). Results: Compared to AN-Remitted or NED individuals, AN-Active individuals showed many differentially methylated sites (False Discovery Rate Q < .01), corresponding to genes relevant to dietary functions, metabolic and nutritional status, and general immune function. Chronicity of Illness correlated (at Q < .01) with generally reduced methylation levels at sites mapping onto genes regulating glutamate and serotonin activity, epigenetic age, immune function, brain white-matter integrity and olfaction. Findings on nutrient levels show significant elevations of plasma methionine and betaine in AN-Active women, and normalization of methionine levels with improved clinical status. Conclusions: Our findings point to the encouraging possibility of reversible epigenetic alterations in AN, and suggest that an adequate pathophysiological model will need to account for psychiatric, metabolic and auto-immune components.

C14. **Preliminary Evidence for the Off-Label Treatment of Bulimia Nervosa with Psychostimulants: Six Case Reports**

Aaron Keshen, MD, FRCPC, Nova Scotia Health Authority, Halifax NS
Thomas Helson, BSc, Nova Scotia Health Authority, Halifax NS
Laura Dixon, BSc, Nova Scotia Health Authority, Halifax NS (Presenting)

Learning Objectives:

1. Describe published literature on treatment of bulimia using stimulant medications.
2. Describe potential risks and benefits of off-label treatment of bulimia patients with stimulants.
3. Describe a case series on the treatment of bulimia patients with stimulant medication.

Abstract:

Psychostimulants have been assessed in bulimia nervosa (BN) patients with comorbid attention deficit/hyperactivity disorder (ADHD) but few studies have examined the impact of psychostimulants on BN patients without comorbid ADHD. The aim of this study is to examine psychostimulants as a potential treatment for BN and to assess the concern of weight loss, given the medication's appetite suppressing effects. This retrospective study describes six case reports of outpatients who were prescribed a psychostimulant specifically for their BN. The number of binge/purge days per months and body mass index (BMI) were assessed. All patients demonstrated reductions in the number of binge/purge days per month and one patient experienced total remission of bulimic symptoms. Minor fluctuations in weight were observed but no clinically significant reductions in weight were noted. These findings support the need for clinical trials to examine the efficacy and safety of this potential treatment.

C15. **Pharmacogenetics: Can it Explain the Lack of Evidence for the Use of Medications in Eating Disorders?**

Leora Pinhas, MD, FRCPC, University of Toronto, Toronto ON (Presenting)
Deanna Herbert, BSc, Centre for Addiction and Mental Health, Toronto ON
Anashe Shahmirian, MSc, Centre for Addiction and Mental Health, Toronto ON
Patty Ibrahim, _____, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Nicole King, PMP, Centre for Addiction and Mental Health, Toronto ON
James L Kennedy, MD, FRCPC, University of Toronto, Toronto ON

Learning Objectives:

1. Review problems in the literature on the use of medication in persons with EDs.
2. Describe the potential role of psychopharmacologic testing for psychotropics.
3. Review how pharmacogenetic testing impacts prescribing practices in the treatment of adolescents in a tertiary eating disorder program.

Abstract:

Background: While there continues to be a rise in the diagnosis of eating disorders within society, aside from the use of antidepressants to address the symptoms of binging/purging in bulimia nervosa (BN) and binge eating disorder (BED) there is little to support the use of medications in the treatment of people with Eating Disorders (EDs). This leaves few options for clinicians. The guidance offered through the introduction of pharmacogenetic testing may be the game changer for both clinicians and researchers. Objectives: 1. To review problems in the literature on the use of medication in persons with Eds; 2. To describe the potential role of psychopharmacologic testing for psychotropics; 3. To report on how the results of pharmacogenetic testing impact prescribing practices in the treatment of adolescents in a tertiary eating disorder program. Method: A retrospective chart review was completed on consecutive patients admitted to a tertiary Eating Disorder program over a period of 3 years. Descriptive data was collected and included demographics, primary and concurrent diagnoses. This study is unfunded and there is no conflict of interest to declare. It has REB approval as part of an outcome larger outcome study. Results: 54 consecutive patients were reviewed. The majority were female (98%). The most common diagnosis was anorexia nervosa (AN) (83% AN, 9% BN, 9% ARFID) Of

the patients reviewed, 36 (67%) agreed to pharmacogenetic testing. Out of 36 patients 16 (44%) had subsequent changes to their treatment plans. Treatment changes occurred when reports demonstrated: 1.) a patient's genotype may impact drug mechanism of action resulting in reduced efficacy of a planned or current medication, 2.) the use of a current or planned medication may increase risk of side effects, 3.) the serum level may be too high/low, requiring a change in dosing protocol. Obtaining results from pharmacogenetic testing was able to adequately reassure 2 patients to allow for a recommended medication trial. Discussion: Previous literature suggests that there is limited evidence to support the use of medication in the routine treatment of patients with Eating Disorders. However, the majority of the studies had small sample sizes and/or short trial periods. The frequency of significant pharmacogenetic variances in predicted responses to psychotropic medications found in this study, confirm previous studies may have lacked sufficient statistical power to control for pharmacogenetic variances. Potential future directions for the clinical and research applications of pharmacogenetic testing will be discussed.

C16. **Visual Scanning Behaviour: A Potential Biological Marker for Diagnosis (and Recovery) in Eating Disorders?**

Leora Pinhas, MD, FRCPC, University of Toronto, Toronto ON (Presenting)
Raluca A Morariu, BSc, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Andrea Byrne, PhD, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Jonathan Chung, MSc, University of Toronto, Toronto ON
Moshe Eizenman, PhD, University of Toronto, Toronto ON

Learning Objectives:

1. Describe what visual scanning is and how it is used in research.
2. Review research demonstrating differences in visual scanning behaviour in patients with AN versus normal controls.
3. Discuss how visual scanning behaviour could be used as a marker for diagnosis and recovery in patients with AN.

Abstract:

Background: Visual scanning behavior (VSB), a direct measure of eye movement, has previously been shown to be useful in distinguishing patients with anorexia nervosa (AN) from normal controls on the basis of their VSB patterns when viewing social images and body shape images. This pilot study aim is to expand upon these results. Objectives: (1) To compare VSB when viewing body shape images in patients with active AN and in recovery; (2) To explore VSB patterns in relation to food images in patients with AN compared to normal controls. Method: The study was limited to adolescent girls aged 12-18 with and without AN. Four competing images were presented simultaneously on a computer. These included images of bodies (fat or thin) and images of food (high or low calorie), alongside social and neutral images. To control for the potential confound of hunger, participants viewing food images were randomly assigned to view the images on either an empty or full stomach. Primary outcome was relative fixation time (RFT) spent on image type. Descriptive analyses including chi-square analyses were performed. Results: A total of 22 subjects, including 13 controls and 9 patients (PANs), viewed food images. For hungry controls, RFT was highest for food images 83% of the time and RFTs for controls who were not hungry had no specific pattern, with 57% having food images with the highest RFT (p=n.s.). By contrast, for PANs on an empty stomach, RFT was highest for social or neutral images and lowest for food images 100% of the time, while for 100% of PANs who had eaten recently, food images had the highest RFT (p-0.04). A total of 20 patients, 14 with active illness (PAN) and 6 in recovery (PAN-R), viewed body images. For PANs, the RFT was highest for thin body images 100% of the time, with fat body images having the second highest RFT 85% of the time. The mean RFT for thin images was 3X longer than for social images. PANs spent 75% of their time focused on body images (p=0.003). In

PAN-Rs, social images had the highest RFT 67% of the time and social images (p=0.001) either had the highest or second highest RFT 100% of the time (p=0.001). PAN-Rs spent only half of their time looking at body images. Discussion: The current study presents preliminary pilot data suggesting people with AN demonstrate an attentional bias toward fat and thin images that was no longer present after recovery. In contrast with controls. They also tended to look away from food when hungry and towards food when they had recently eaten. VSB may have potential to be an easy to use biological marker for both illness and recovery in AN.

C17. **Preliminary Findings on Patient Treatment Expectations at a Canadian Outpatient Eating Disorders Program**

Pauline Leung, MSc, Queen's University, Kingston ON
Brad A MacNeil, PhD, George Mason University, Fairfax VA USA (Presenting)

Learning Objectives:

1. Describe literature on patients' treatment expectations for attending outpatient care for an eating disorder.
2. Identify and discuss the complex interactions between patient expectations and the ego-syntonic nature of the illness.
3. Discuss Canadian patients' expectations for treatment and clinical and research implications moving forward.

Abstract:

Background: Research has established that for a variety of presenting problems, patients' expectations of treatment services are intricately linked with treatment outcome. Indeed, patient expectations were revealed to be relevant predictors for outcome in the treatment of various psychiatric conditions including major depressive disorder (Rutherford, Wager, & Roose, 2010), anxiety disorders (Borkovec, Newman, Pincus, & Lytle, 2002; Fromm, 2001) and posttraumatic stress disorder (Gray, Elhai, & Frueh, 2004). This work cumulatively suggests that any treatment service would benefit from consideration of patient expectations in therapy. However, to date, investigation of patient expectations in the context of eating disorder treatment is a line of research that remains untouched. Eating disorders potentially present a complex influence of patient expectations given the ego-syntonic nature of the illness, as this results in patients wavering between feeling highly motivated and unmotivated about participating in treatment (Kaplan & Garfinkel, 1999)—which may, in turn, result in the wavering of expectations about said treatment. Objectives: The current qualitative study aims to serve as a first step towards acknowledging the importance of patient expectations in the treatment of eating disorders among Canadian adults. We describe patients' self-reported expectations and hopes for treatment at intake assessment and provide a preliminary window into how these expectations may relate to symptoms and motivation for treatment. Design/Methods: Data from 31 Canadian adults meeting *DSM-5* criteria of an eating disorder were assessed at intake at a tertiary level outpatient eating disorders program in Southeastern Ontario. Participants were asked to self-report their expectations and hopes for treatment. Participants responses were then coded by research assistants. Additionally, participants were asked about whether they previously received treatment, and their reaction towards and willingness to participate in group therapy as the main focus of their care (i.e., the program's primary modality of treatment). Finally, participants completed psychometric measures of eating disorder symptoms (Eating Disorders Inventory – 3rd Edition), and depressive and anxiety symptoms (Beck Depression and Anxiety Inventories). Results: In coding patients' responses, six overarching categories emerged: normalizing eating and improve other domains of life (e.g., mood and coping skills) (10%), symptom interruption or management (35%), developing healthier body image and food attitudes (16%), and relapse prevention (7%). Sixteen percent of participants self-reported no expectations for treatment, and finally, 16% indicated that they did not want help with the illness. Within each category,

different proportions of individuals had previously undergone treatment, and moreover, each category presented with different trends regarding reaction to group therapy (i.e., positive, negative, or neutral). Finally, clinically descriptors for eating disorder symptoms, as well as depressive and anxiety symptoms are described. Conclusions: This preliminary study provides a first look at patient expectations for eating disorder treatment in a Canadian adult sample. It highlights the need to acknowledge the importance of such expectations, and serves as a starting point for future research on this topic.

C18. **Self-Efficacy as a Predictor of Treatment Outcome in an Outpatient Eating Disorder Program**

Aaron Keshen, MD, FRCPC, Nova Scotia Health Authority, Halifax NS (Presenting)
Thomas Helson, BSc, Nova Scotia Health Authority, Halifax NS
Joel Town, PhD, Dalhousie University, Halifax NS
Karly Warren, BSc, University of Calgary, Calgary AB

Learning Objectives:

1. Describe the current understanding of self-efficacy in eating disorder treatment.
2. Review the potential role of self-efficacy as a predictor of eating disorder treatment outcome.
3. Review the potential importance of future research aimed at enhancing self-efficacy in eating disorder treatment.

Abstract:
This prospective pilot study examined the relationship between self-efficacy and treatment outcome in an adult outpatient eating disorder program. Data from 59 eating disorder outpatients were collected, including measures of self-efficacy, eating disorder symptom severity, negative emotions (depression, anxiety, and stress), body mass index, and duration of illness. Hierarchical regression was used to examine the impact of baseline self-efficacy, and early treatment changes in self-efficacy (i.e., baseline to 6 weeks), on end-of-treatment (EoT) eating disorder symptom severity and treatment dropout. This study received institutional research ethics board approval and all participants provided written informed consent. Early change in self-efficacy during the course of treatment was found to predict EoT symptom severity when controlling for confounding variables. Furthermore, baseline self-efficacy was found to predict treatment dropout, but not end-of-treatment symptom severity. This is the first study (using a validated scale) to show that self-efficacy, and early changes in self-efficacy, may be an important predictor of treatment outcome for eating disorder outpatients. Implications and suggestions for future research are discussed.

C19. **A Comparison of Motivation-Oriented Versus Psychoeducation-Oriented Day Hospital Treatment for Eating Disorders**

Jennifer S Mills, PhD, York University, Toronto ON (Presenting)
Gillian Kirsh, PhD, North York General Hospital, North York ON (Presenting)

Learning Objectives:

1. Describe how adjunctive treatments can be integrated with hospital treatment for eating disorders.
2. Review how research design can impact a clinical trial.
3. Describe and evaluate motivation-oriented treatments for eating disorders.

Abstract:
Background: A major clinical research priority is to understand how to maximize motivation and engagement in treatment among hospital patients with eating disorders (EDs). Research on the efficacy of motivational interviewing (MI), a psychosocial intervention aimed at overcoming ambivalence toward behaviour change, for eating disorders has been demonstrated in the literature. However, in almost all randomized controlled trials on motivation-oriented treatment for eating disorders MI is offered as a brief prelude to intensive treatment (i.e., 1-2 sessions prior to starting intensive treatment) and less is known about how motivation-oriented psychosocial interventions can be successfully implemented

throughout the course of hospital treatment and not just at the beginning. This randomized controlled trial compares two psychosocial adjunctive treatments offered during standard hospital-based day treatment: one that focuses on patients' motivation to recover (motivation) and the other than focuses on teaching patients about eating disorders and their associated risks (psychoeducation). Objectives: 1. To evaluate changes in ED symptomatology in adult patients undergoing day hospital treatment and compare them between treatment groups (motivation-oriented vs. psychoeducation-oriented); 2. To determine treatment satisfaction ratings in patients undergoing day hospital treatment and compare them between treatment groups; 3. To evaluate the acceptability of patient-centered and motivation-oriented eating disorder treatment among patients and staff. Design/Method: We have two groups in the study: patients at the Adult Eating Disorders Program at the North York General Hospital are randomly assigned to either motivation-oriented or psychoeducation-oriented adjunctive treatment. Adjunctive treatment includes a self-help manual and contact with an individual staff therapist at scheduled points throughout treatment and as needed. Staff therapists self-selected their group based on therapeutic allegiance (2 MI, 1 psychoeducation) and received clinical training. Questionnaires administered at the start of treatment include measures of clinical impairment, self-esteem, mood, eating pathology, and personality. In addition to the standard package of questionnaires patients complete in the program, study participants complete questionnaires assessing motivation, confidence, and readiness for change measures, satisfaction with treatment, and usage of the self-help manual. We will compare means on all measures between groups from pre-, mid- and end-of-treatment. An institutional ethics review board and the hospital research ethics board both approved this study. Results/Discussion: As of January 2018, 24 patients had consented to participate in the study; nine were currently enrolled in treatment, eight had completed treatment, and seven had dropped out of treatment. By September 2018 we will have enough data (35+ patients) to analyze between-group differences in our outcome measures of interest and to examine and discuss treatment acceptability among patients and staff.

C20. **Concurrent Anorexia Nervosa (AN) and Non-Tuberculosis Mycobacterium (NTM) in a Canadian Male Receiving Outpatient Treatment for an Eating Disorder**

Brad A MacNeil, PhD, George Mason University, Fairfax VA USA (Presenting)
Chloe Hudson, MSc, Queen's University, Kingston ON
Pallavi Nadkarni, MD, Queen's University, Kingston, ON

Learning Objectives:

1. Review background data on eating disorders in men.
2. Describe how non-tuberculosis mycobacterium (NTM) may be contracted.
3. Describe a case report of a male with anorexia nervosa (AN) and *Mycobacterium kansasii* attending an adult eating disorders program.
4. Describe and discuss how AN may contribute to immunosuppression and further vulnerability for NTM illness.

Abstract:

Background: Cases of nontuberculosis mycobacterium (NTM), a chronic lung infection resembling tuberculosis, are on the rise across North America. Although NTM infections can occur in healthy individuals, the most common strain, *Mycobacterium kansasii,* occurs more often in individuals with suppressed immune systems. Few reports are available on NTM in individuals with anorexia nervosa (AN), which is a severe condition associated with suppressed immune function secondary to weight loss. Although two cases of NTM have been described in the literature in men who experienced weight loss (Suzuki et al., 2005; Wong et al., 2008), it is not clear whether the men met full threshold criteria for AN, and neither man was engaged in treatment for an eating disorder and *Mycobacterium kansasii* concurrently. Objectives: We describe a 31-year-old man who presented in July 2016 for specialized

assessment and outpatient treatment of his longstanding struggles with nutritional restriction and low weight status. The patient's clinical presentation and implications for outpatient care will be discussed. Design/Methods: The patient was referred by his primary care physician. He was followed by the eating disorder outpatient team from July 2016 through March 2017. He provided written consent for the case study, which received ethics approval through the University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board. Results: Psychiatric clinical interview with accompanying psychometric questionnaires indicated that the patient met *Diagnostic and Statistical Manual 5th edition* (*DSM-5*) criteria for AN and comorbid obsessive compulsive disorder. The patient took part in both individual cognitive behavior therapy (CBT) and a 16-session CBT group. Following successful completion of this group, he attended a 16-session exposure with response prevention group for body satisfaction aimed at addressing symptoms of body dissatisfaction. The patient was being treated with antibiotic medications for his *Mycobacterium kansasii* infection at this time, and he missed four sessions of this group due to negative side effects of the medications. He also attended adjunct nutritional counseling and ongoing medical and psychiatric follow-up throughout his time in treatment. The patient's satisfaction with life score increased over the course of treatment. He also experienced a reduction in depressive symptoms, anxiety symptoms, cognitive rigidity, and attention to detail." The patient's self-reported eating disorder symptoms (i.e, drive for thinness, bulimia, and body dissatisfaction) did not change over the course of treatment. His weight increased over the course of treatment (e.g., pre-treatment 62.3 kg and post-treatment 68.3 kg), and was maintained despite the concurrent NTM infection. Conclusions: This is the first case report to describe the specialized outpatient assessment and treatment of a male with a formal diagnosis of AN and *Mycobacterium kansasii* in North America attending an adult eating disorders program. The patient's history of eating disorder symptoms likely contributed to immunosuppression, which may have placed him at greater risk for the development or exacerbation of symptoms of the NTM.

C21. **Treatment for "Transition Age" Youth: Effectiveness of a Residential Program for Eating Disorders**

Kim D Williams, MA, BC Children's Hospital, Vancouver BC (Presenting)
Caitlin O'Reilly, PhD, BC Children's Hospital, Vancouver BC
Jennifer Coelho, PhD, BC Children's Hospital, Vancouver BC (Presenting)

Learning Objectives:

1. Review the role of residential treatment in the continuum of care for eating disorders.
2. Describe the effectiveness of residential treatment.
3. Compare outcomes of youth with EDs in residential care to those of other treatment facilities for youth and young adults.

Abstract:

Background: A Canadian, publicly funded 14-bed residential eating disorder treatment facility specifically designed for youth and young adults, aged 16-24, has been established. Objectives: Despite a growing number of residential programs to treat eating disorders, there are few publications on the outcome data associated with this treatment modality. This paper builds on what is known in the literature by providing information regarding the population accessing residential eating disorders treatment, basic outcome information, and resident perceptions and experiences with residential treatment. Design/Method: A retrospective chart review was conducted to investigate outcomes in youth who were admitted to a residential treatment setting for eating disorders. Charts were available for 193 youth, 184 of whom were discharged during the study period. In addition, a retrospective thematic analysis of 39 routine exit interviews was conducted with residents at discharge. Results/Discussion: This paper will identify information regarding the population accessing residential eating disorders treatment including demographic information, eating disorder diagnosis, and previous treatment history. Analysis of weight changes demonstrated that all residents gained weight over the

course of treatment; however, those who were underweight (BMI < 20) at admission gained more weight than did those who started treatment at a BMI ≥20 (interaction between time and weight classification: $F$ (1,131) = 101.4, $p$ < .001). A small portion of residents (5.2%) were offered a step-out from the program to reflect on their treatment readiness. Step-outs were a predictor of early treatment termination (p< .001). Residents reported that they continued to have eating disorder thoughts and behaviors at discharge, suggesting that residential treatment is a step in the process of eating disorder recovery. The majority of residents (66.3%) were discharged to follow-up with treatment in their community. The current study provides support for the effectiveness of residential treatment programs for youth with eating disorders. The role of residential treatment in the continuum of care will be discussed.

C22. **Multi-Family Group Therapy for Adolescents with Eating Disorders**

Ahmed Boachie, MD, FRCPC, Southlake Regional Health Centre, Newmarket ON (Presenting)
Karin Jasper, PhD, Southlake Regional Health Centre, Newmarket ON (Presenting)

Learning Objectives:

1. Identify the unique benefits of MFGT for eating disorders.
2. Describe the potential benefits of MFGT for families at different points in the recovery process.
3. Recognize the potential of MFGT as a stand-alone treatment.

Abstract:

Background: Multifamily Group Therapy (MFGT) is an outpatient therapy that can minimize eating disorder (ED) pathology while also minimizing disruptions to schooling, peer relations, and family relationships, thereby protecting patients' developmental processes. It brings families who are coping with an eating disorder together to learn from and support each other, while also providing the expertise of professionals using a Maudsley model. Families benefit from seeing adolescents at different stages in their recovery, creating an environment of hope for change. All group members benefit from the stimulation of new perspectives. Parents have described MFGT as fast-forwarding their progress and strengthening their determination towards family wellness. Patients feel hope that they may recover and gain an appreciation for why their parents must take charge of re-feeding. Siblings have a unique opportunity for support with their experience of living in a family with an eating disorder. MFGT may also reduce waitlist times. Objectives: The objectives of this study are to 1. Compare the outcomes of MFGT with treatment as usual (TAU), i.e. individual family based treatment for eating disorders; and 2. Learn more about the benefits of MFGT for families at different stages of recovery. Design/Methods: This is a naturalistic study. Over a five-year period, 28 sets of parents and adolescents attended MFGT at a specialized eating disorder treatment centre. Some were new to treatment while others had participated in numerous treatments. Demographic, medical, and clinical information was collected. In addition, adolescents completed the Children's Depression Inventory, Multidimensional Anxiety Scale, and the Eating Disorder Inventory-3 while parents completed the Parents vs Anorexia scale, the Eating Disorders Symptom Impact Scale and the Accommodating and Enabling Scale for Eating Disorders. Attrition rates were recorded and costs were compared to regular outpatient treatment. Results/Discussion: We are currently analyzing the results of this study. Our hypotheses are (1) that parents' increases in self-efficacy and decreases in accommodating and enabling behaviours will be associated with improvements in their childrens' mental and physical health, as is the case with TAU; and (2) that MFGT has unique benefits for families at different stages of recovery. Conclusion: In addition to reducing wait list times in the short term, MFGT can lead to less need for intensive services such as Day Treatment and Inpatient Programs which are costly to operate as well as being more disruptive to family well-being. Those few families who do not make significant gains through MFGT are likely to seek continued treatment because their understanding of the illness is increased, as is their appreciation of how to support their child.

C23. **Targeting Cognitive Inefficiencies in an Adolescent Residential Treatment Program**

Andrea M Byrne, PhD, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenting)
Tina Slaunwhite, RPN, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenting)
Raluca A Morariu, BSc, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Leora Pinhas, MD, FRCPC, University of Toronto, Toronto ON

Learning Objectives:

1. Describe cognitive deficits associated with EDs, namely impaired cognitive flexibility and central coherence.
2. Describe research that addresses these cognitive deficits using Cognitive Remediation Therapy (CRT).
3. Describe the experience of a residential treatment program in using CRT.
4. Describe ways in which program evaluation can inform both research and treatment.

Abstract:

Background: Research suggests many adolescents with eating disorders (ED) show cognitive inefficiencies related to executive function, most notably impaired cognitive flexibility and central coherence. This has led to efforts to directly address these difficulties through adjunct treatment with Cognitive Remediation Therapy (CRT). The purpose of this research was to examine executive functioning in our population both in relation to eating disorders symptomology and recovery, with the goal of informing the development of a comprehensive program to better meet the individual needs of patients. Objectives: (1) Describe the CRT group designed for a residential adolescent ED program, (2) Compare outcomes among adolescents who participated in the CRT group and those who received treatment as usual (TAU), and (3) Discuss how these findings can inform both research and intervention. Design/Method: Twenty-six adolescents at a specialized inpatient eating disorders residential treatment program were assessed at program entry and at discharge. As part of clinical care, participants and their parents completed a battery of measures at admission and discharge, including standardized measures of ED symptoms and executive functioning. Also included were measures of mood and anxiety. Results/Discussion: At program entry, participants self-reported significant difficulties with aspects of executive functioning, most notably in the area of set-shifting, suggesting impaired cognitive flexibility. Differences between parent and self-report measures were evident. Change over time was also examined, with participants who received CRT showing a greater degree of improvement in cognitive flexibility at discharge (intake $M = 62.80$, $SD = 6.81$, discharge $M = 52.60$, $SD = 9.89$, $t(9) = 2.97$, $p < .016$ [two-tailed]). Conclusion: The identification and remediation of cognitive inefficiencies may represent an important step toward facilitating recovery. We present preliminary data from an adolescent inpatient eating disorders unit, examining symptom severity in the context of executive functioning. Implications for future research and clinical practice are discussed.

C24. **Intensive Treatment for Pediatric Eating Disorders: A Systematic Review of Inpatient, Residential and Day Treatment Outcomes**

Leanna Isserlin, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)
Jennifer Couturier, MD, FRCPC, McMaster University, Hamilton, ON
Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Wendy Spettigue, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Natasha Snelgrove, MD, FRCPC, McMaster University, Hamilton ON
Cheryl Webb, MSW, McMaster University, Hamilton ON
Neera Bhatnagar, MLIS, McMaster University, Hamilton ON

Learning Objectives:

1. Describe the available evidence for the use and outcomes of inpatient, residential and day treatment levels of care for children and adolescents with eating disorders.

2. Describe the available evidence for the use of inpatient treatment for the purpose of medical stabilization versus weight restoration.

Abstract:
Background: Clinicians are regularly faced with making decisions regarding treatment setting and discharge criteria for patients with eating disorders. However, there remains minimal evidence to guide these treatment decisions as they relate to inpatient, residential and day treatment. Objectives: The aim of this systematic review was to examine the literature on outcomes for the highest intensity treatment settings for pediatric eating disorders, including inpatient, residential and day treatment programs. Methods: A database search (including psycinfo, embase, medline, cinahl, Cochrane central and Cochrane SR) was conducted for studies published up until 2017 using the search terms "eating disorders" and "inpatient" or "residential" or "day treatment" or "partial hospitalization". Inclusion criteria were: 1) meta-analyses, systematic reviews, randomized controlled trials, open trials, case series, and case reports, 2) involving children and adolescents (under age 18 years) with eating disorders, 3) focusing on treatment (psychological or pharmacologic, 4) reporting on patient outcomes related to recovery from an eating disorder (eg. weight, binge/purge symptom frequency, psychological symptoms). Two reviewers screened each study for inclusion and disputes were resolved by a third reviewer. Results: Two-hundred-and-fifty-two articles were reviewed and sixty-nine were included. The majority of studies reported on treatment in the inpatient setting and described various forms of multimodal treatment with the most common outcome measure being weight. Only three randomized controlled trials (RCTs) were found, all of which compared inpatient treatment for the purposes of medical stabilization only, followed by discharge to either outpatient family-based treatment (FBT) or day treatment, versus inpatient treatment to the point of full weight restoration. The outcomes of these RCTs suggest that a short inpatient admission followed by outpatient FBT or day treatment is as effective in ensuring full weight restoration and weight maintenance as is a longer inpatient admission. Studies examining day treatment and residential settings were more likely to report on improvement in the core psychological symptoms of eating disorders. Almost all studies included family therapy and/or the involvement of families in the provision of care in the inpatient, residential or day treatment setting. Conclusions: There is a need for further studies examining specifically which components of multimodal treatment for children and adolescents with eating disorders are most effective, what are the optimal lengths of intensive treatment or discharge criteria associated with the best outcomes, and which patient and family characteristics suggest a patient is best suited for various treatment settings.

C25. **Evaluating the Unique Associations Between Personality Psychopathology and Heterogeneous Eating Pathology Symptoms**

Shauna Solomon-Krakus, MSc, University of Toronto Scarborough, Scarborough ON (Presenting)

Learning Objectives:
1. Describe and discuss associations between personality psychopathology and heterogeneous eating disorder symptoms.
2. Describe unique personality characteristics associated with restricting, with purging and with binge eating found in a large community sample.
3. Review how personality traits and symptom profiles affect treatment recommendations and delivery.

Abstract:
Background: There are mixed findings regarding the associations between personality psychopathology and eating pathology. The common practice to examine categorical eating disorder diagnoses and normal-range personality traits could explain these inconsistencies. Objectives: This study examined whether associations between dimensional eating pathology symptoms (restriction, purging, binge eating) and pathological personality facets could produce

more consistent findings. This study also aimed to examine whether unique associations between heterogenous eating pathology symptoms and pathological personality facets would arise. Method: Participants were 570 community adults (247 women) recruited through Mechanical Turk. The Personality Inventory for DSM-5 (PID-5) measured pathological personality facets. Indicators from two eating pathology scales (EAT-26 and EDE-Q) were used to measure latent and dimensional eating pathology symptoms as opposed to categorical diagnostic constructs. Structural equation modeling was used to test the associations. Results: Unique associations were found; higher rigid perfectionism, lower perseveration, and higher deceitfulness were uniquely associated with restriction whereas lower attention seeking and higher perceptual dysregulation were uniquely associated with purging. Higher impulsivity and higher anxiousness were uniquely associated with binge eating. Discussion and Conclusion: Based on these findings, there are unique associations between heterogeneous eating pathology symptoms and pathological personality facets. Researchers are encouraged to examine dimensional and heterogeneous eating pathology symptoms when exploring associations with personality. Findings may also inform individualized care aimed to treat eating pathology symptoms and comorbid personality psychopathology.

C26. **The Effects of Active Social Media Engagement on Eating Disorder Risk Factors in Young Women**

Jacqueline V Hogue, MA, York University, Toronto ON (Presenting)
Jennifer S Mills, PhD, York University, Toronto ON

Learning Objectives:

1. Describe risk factors that can result in increased body dissatisfaction and lowered self-esteem.
2. Describe how social media use may result in body dissatisfaction and lowered self-esteem among young women.

Abstract:

Background: Social media use is immensely popular among young adults; 88% of 18-to-29-year-olds use Facebook and 59% use Instagram (Greenwood et al., 2016). Social media is especially popular with young women, among whom body distress is very common (Grogan, 2016; Rodin, Silberstein, & Striegel-Moore, 1985). Therefore, it is important to understand how social media use impacts young women's well-being and which individuals are vulnerable to any adverse effects. This study experimentally examined how engaging with female peers on social media affects young women in terms of risk factors for disordered eating. Objectives: Our first aim was to examine the causal effects of interacting with Facebook and Instagram photos of potential comparison targets (i.e., attractive acquaintances versus relatives) on young women's body image. Our second aim was to expand the sociocultural model of eating disorders in terms of the roles of both social media and social comparison, and to determine whether trait body concerns (i.e., trait appearance investment) moderate the effects of social media on women's body image concerns (Fardouly & Vartanian, 2015). Design/Method: Participants were 112 young women (aged 17-27 years) randomly assigned to an experimental condition in which they were asked to browse and leave a comment on the Instagram and Facebook profiles of either 1) someone they identified as an attractive peer acquaintance, or 2) a non-peer family member they did not identify as more attractive than themselves. The authors' institutional ethics review board approved this study. Results/Discussion: Consistent with research on upward social comparisons, women who engaged with an attractive acquaintance on social media subsequently had worse state self-esteem and body image than did those who had engaged with a family member. Self-evaluative salience of appearance investment moderated the relationship between social media engagement and subsequent self-esteem and body image. Taken together, these findings reveal that active social media engagement with upward comparison targets is causally related to eating disorder risk factors in young women, and that young women for whom weight and shape are especially important are more susceptible to such effects. Conclusion: The findings expand and modernize the sociocultural model of eating disorders.

Social comparison processes are triggered by appearance-based social media engagement, resulting in worsened self-evaluation. Young women whose sense of self-worth is highly appearance-based are especially susceptible to such effects. This is the first study to demonstrate that social media use is causally related to established risk factors for eating disorders in young women. These results can inform eating disorder prevention initiatives aimed at protecting young women from risky social media activities.

C27. **Development of an Assessment Guide for a Proposed Eating Disorder: Orthorexia Nervosa**

Gavin McAtee, MEd, University of Lethbridge, Lethbridge AB (Presenting)
Brenda Leung, PhD, University of Lethbridge, Lethbridge AB

Learning Objectives:

1. Describe and discuss orthorexia nervosa and the proposed diagnostic criteria.
2. Describe how to differentiate between patients at-risk of orthorexia nervosa versus other similar disordered eating behaviours.
3. Review strategies to enable mental health professionals to better detect clients at risk of orthorexia nervosa.

Abstract:

Background: Orthorexia nervosa describes individuals whose restrictive dietary practices and mental preoccupation with healthy food consumption have led to physical, emotional, and psychological symptoms. Although the field of eating disorders has been working towards constructing new methods to screen for orthorexia, there remains limited information available outlining any specific assessment procedures, questionnaires, or clinical measures that could be used by health practitioners who suspect that a patient might be at-risk of orthorexia nervosa. Objectives: To create an assessment guide for psychologists, social workers, psychiatrists, and other mental health practitioners with the purpose of assessing whether a client is displaying behavioural and psychological characteristics that would indicate if they are at-risk of orthorexia nervosa. In addition, to create a psychoeducational resource to be given to clients at-risk of orthorexia nervosa. Methods: Four literature reviews were conducted to obtain the information needed to create the assessment guide. These reviews were on orthorexia nervosa; the assessment process for eating disorders; instruments for eating disorder evaluation and data gathering; and semi-structured clinical interview for orthorexia. The literature for the reviews was gathered from the PsycINFO, Academic Search Complete, Medline, Ovid, and EBSCOHost databases. The terms researched included orthorexia nervosa; anorexia nervosa; bulimia nervosa; eating disorders; weight disorders; weight control methods/techniques; body image; body weight; body shape; DSM-V; feeding disorders; assessment/screening of eating disorders. Results: An assessment guide for orthorexia was designed using a three-stage decision tree model. The guide instructs practitioners to use clinical judgement and criterions to sequentially assess for a risk for orthorexia. Stage one includes an intake interview and a screener for eating disorders. Stage two includes three self-report questionnaires designed to screen for orthorexia nervosa and alternative eating disorders. Stage three requires the clinician to conduct a semistructured interview with the client. The results of the interview will then be reported to the client and any third-party members using a formal assessment report. Conclusion: A assessment guide was created containing details regarding the background of orthorexia nervosa, the measurement tools available in the literature, and guidance for assessment using a decision tree model.

C28. **Clinical Evidence in the Initial Inpatient Management of Adolescents Admitted with Severe Anorexia Nervosa**

Stéphanie Proulx-Cabana, MD, Sainte-Justine University Hospital Center, Montreal QC (Presenting)
Danielle Taddeo, MD, Sainte-Justine University Hospital Center, Montreal QC
Olivier Jamoulle, MD, Sainte-Justine University Hospital Center, Montreal QC

Rola Ghaddar, MD, Sainte-Justine University Hospital Center, Montreal QC
Jean-Yves Frappier, MD, Sainte-Justine University Hospital Center, Montreal QC
Chantal Stheneur, MD, PhD, Sainte-Justine University Hospital Center, Montreal QC
Learning Objectives:
1. Describe the risks and complications associated with severe malnutrition due to anorexia nervosa.
2. Describe the available evidence regarding initial management of adolescents admitted with severe anorexia nervosa.
3. Describe treatment gaps in evidence-based medicine for youth with anorexia nervosa.
Abstract:
Background: Anorexia nervosa is the third most frequent chronic disease during adolescence and has the highest mortality rate of all psychiatric disorders. The inadequate refeeding of severely malnourished patients further increases the risk of serious medical complications and death. Although there are a few guidelines addressing the management of patients with severe anorexia nervosa, there is a lack of evidence and/or clear consensus on the best practices in terms of specific refeeding protocol, supplementation and surveillance of clinical complications. Objectives: Elaboration of an inpatient admission protocol for adolescent patients admitted for severe anorexia nervosa based on a review of available evidence and expert consensus in the literature. Method: A search of PubMed was done in July 2017, by using the keywords severe anorexia nervosa or eating disorders and management guidelines and adolescent. From the guidelines obtained, we further searched on Google Scholar other guidelines or articles cited as references. After reviewing available guidelines, we conducted a secondary search for articles, including RCT, reviews and sometimes case reports, on PubMed, using anorexia nervosa or eating disorders and each of the following key word: refeeding protocol, refeeding syndrome, hypophosphatemia, hypoglycemia, cardiac monitoring and cardiac complications. Discussion: We considered patients as severe if they met any of these predisposing factors for high risk of refeeding syndrome: Percent mean body mass index (%mBMI) <70%, BMI <0.4th centile, oral intake <500 kcal/day for ≥3-4 days, 15% weight lost or more in the last 3 months or abnormal electrolytes before beginning refeeding. Baseline blood test including CBC, electrolytes, calcium, phosphate, magnesium, creatinine, urea, ALT, TSH and baseline EKG were performed at admission. We suggested selective blood tests during the first three days of refeeding targeting the earliest indicators of refeeding syndrome (electrolytes and phosphate). Although higher initial caloric intake during refeeding of patients with anorexia nervosa is supported by evidence, no clear consensus exists in favor of oral meal plan or continuous nasogastric tube feeding. We decided to propose continuous nasogastric tube feeding in patients with BMI <12 (<0,1th centile) instead of meal plans. No clear evidence for glucose monitoring is available but some experts recommend bedside blood glucose to monitor hypoglycemia (<2.5 mmol/L) before breakfast and 2 hour post-prandial for 72 hours. Due to the absence of evidence of a clear cut-off of sinusal bradycardia to consider mandatory monitoring, we considered a bradycardia <30 BPM as significative. Since no harm was documented with phosphate supplementation in adolescents, we recommend to consider systematic phosphate supplementation at 1 mmol/kg/day for 7 days at admission or if phosphate drops below 1 mmol/L. Conclusion: The development of standardized protocols is necessary in order to improve the quality and standardization of care in medical institutions caring for adolescents with anorexia nervosa. We provide an example of inpatient admission protocol for adolescents with severe anorexia nervosa based on current evidence. Opportunity to produce Canadian consensus guidelines for managing these patients should be seized.

C29. **Implementing Dialectical Behaviour Therapy on a Pediatric Eating Disorders Unit**
Cheryl Webb, MSW, McMaster University, Hamilton ON (Presenting)

Liah Rahman, BA, Hamilton Health Sciences, Hamilton ON
Jennifer Couturier, MD, FRCPC, McMaster University, Hamilton ON (Presenting)
Zechen Ma, BSc, McMaster University, Hamilton ON

Learning Objectives:

1. Describe an intensive pediatric Eating Disorders program and ways in which DBT was implemented into treatment.
2. Describe the experiences and feedback of front line staff involved in the implementation of DBT into the intensive treatment program for adolescents with severe EDs.
3. Describe challenges associated with incorporating DBT into treatment programming.

Abstract:

Background: Eating disorder programs are faced with the challenge of how to approach treatment of children who have not responded to evidence-based outpatient treatment and require more intensive service. Dialectical Behaviour Therapy (DBT) has demonstrated initial success with mild-moderate outpatients with bulimia or binge eating disorder and with a mixed group of adults. DBT for adolescents holds promise to meet the clinical need of providing treatment to multidiagnostic patients. An Ontario based tertiary care centre for pediatric eating disorders implemented DBT as a treatment model for patients on a combined day hospital and inpatient unit. Objectives: To evaluate the experiences of frontline staff implementing DBT on a combined pediatric eating disorders inpatient and day hospital unit. To identify challenges associated with delivering DBT to a complex patient population of adolescents with eating disorders and whether staff felt DBT was an acceptable model of care. Methods & Design: Fundamental qualitative analysis guided sampling and data collection. Audio-recorded and transcribed semi-structured interviews from eleven Registered Nurses, one Child Life Specialist, and one Child and Youth Worker (N=13) were coded and analyzed using thematic content analysis to expose central themes. Results: Four major themes emerged and were explored: DBT as a valuable treatment model; improvement of team cohesion; frontline staff feeling more effective in their role; and a need for both ongoing education and staff coaching. Frontline staff positively endorse DBT as a treatment model, but note the challenge committing to DBT skills practice and group co-facilitation among their competing roles and priorities. Staff expressed difficulty supporting patients at various degrees of wellness and challenged by perceived patient ambivalence or commitment to toward recovery. Staff endorse a desire for more training in DBT and suggest that this be staged throughout and after implementation to increases confidence in utilizing the therapy with patients. Conclusions: Implementation themes align with previous research examining the adoption of DBT and provide further insight into clinical programs seeking to implement DBT for pediatric eating disorders in an intensive hospital setting. Overall, DBT is deemed an acceptable and beneficial treatment model for adolescents with eating disorders by frontline staff. Implementing DBT produced positive benefits of team cohesion and communication. Staff highlighted challenges of skill retention for part time staff, continuing education needs, and the special needs of malnourished patients that warrant further investigation.

C30. **What Evidence Exists for Medication Use in Children and Adolescents with Eating Disorders? A Systematic Review of the Literature**

Jennifer Couturier, MD, FRCPC, McMaster University, Hamilton ON (Presenting)
Wendy Spettigue, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Leanna Isserlin, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Natasha Snelgrove, MD, FRCPC, McMaster University, Hamilton ON
Amanda Ritsma, MD, McMaster University, Hamilton ON
Melissa Kimber, PhD, McMaster University, Hamilton ON
Neera Bhatnagar, MLIS, McMaster University, Hamilton ON

Learning Objectives:
1. Describe the available evidence for the use of antipsychotics in children and adolescents with eating disorders.
2. Describe the available evidence for the use of SSRIs in children and adolescents with eating disorders.
3. Describe the evidence base for other psychotropic medications in the treatment of children and adolescents with eating disorders including mood stabilizers, and SNRIs.

Abstract:
Background: Psychotropic medications are often used for children and adolescents with eating disorders in clinical practice without sufficient evidence to guide treatment decisions. Objectives: The goal of the current study was to systematically review the literature pertaining to the efficacy of psychotropic medication for this population. Methods: The following databases were searched up until 2017 using the search terms "eating disorders" and "SSRIs" or "SNRIs" or "antipsychotics" or "mood stabilizers": psycinfo, embase, medline, cinahl, Cochrane central and Cochrane SR. Inclusion criteria were: 1) meta-analyses, systematic reviews, randomized controlled trials, open trials, case series, and case reports, 2) involving children and adolescents (under age 18 years) with eating disorders, 3) focusing on psychotropic medications, 4) reporting on patient outcomes (weight, binge/purge frequency, psychological symptoms). Two reviewers agreed upon each article for inclusion with a third resolving disputes. Results/Discussion: The following number of articles were reviewed: SSRIs 866, SNRIs 176, Antipsychotics 195, and mood stabilizers 380. With respect to articles pertaining to SSRIs, there were 14 studies included (four open trials, ten case reports). Regarding articles pertaining to antipsychotics, there were 25 studies included (two RCTs, four open trials, 19 case reports). Regarding mood stabilizers five case reports were found. There were no studies pertaining to SNRIs. Only one prior systematic review focused on medication in this population could be located. The results of these studies indicate that olanzapine is generally effective for children and adolescents with Anorexia Nervosa in terms of weight gain and improvement in psychological symptoms. The evidence base for SSRIs, is weaker, with some studies reporting improvements in Bulimia Nervosa and Avoidant/Restrictive Food Intake Disorder. Evidence for the efficacy of other psychotropic medications in this population is extremely limited.

C31. **Caregiving Experience and Expressed Emotion Among Parents of Adolescents Suffering from Anorexia Nervosa Following Illness Onset**

Soline Blondin, PhD, Université de Montréal, Montreal QC (Presenting)
Dominique Meilleur, PhD, Université de Montréal, Montreal QC (Presenting)
Danielle Taddeo, MD, CHU Sainte-Justine mère-enfant, Montreal QC
Jean-Yves Frappier, MD, CHU Sainte-Justine mère-enfant, Montreal QC

Learning Objectives:
1. Describe the relationship between parents' experience of caregiving and expressed emotion during the early stage of anorexia nervosa and of their adolescent being hospitalized.
2. Review which specific aspects of the caregiving experience are most related to the dimensions of expressed emotion of mothers and fathers of adolescents hospitalized for anorexia nervosa at the beginning of the illness.

Abstract:
Background: Treatment guidelines for anorexia nervosa encourage family members' implication while this may increase caregivers' burden (Anastasiadou et al., 2014; Le Grange et al., 2010). At the same time, the reaction of close others has been identified as a potential maintaining factor of the disorder through the concept of expressed emotion (EE) (Treasure & Schmidt, 2013). No study has examined the association between the experience of caregiving and the dimensions of expressed emotion at an early stage of the illness in caregivers of hospitalized adolescents. Objectives: The aim of this study was to

better understand the relationship between parents' experience of caregiving and expressed emotion during the early stage of their child's illness. More specifically, this study examined which aspects of caregiving contributed to mothers' and fathers' levels of expressed emotion at the first hospitalization of their child. Design/methods: Fifty mothers and 38 fathers of adolescents suffering from anorexia nervosa and hospitalized for the first time, participated in the study. The participants completed the Experience of Caregiving Inventory (Szmukler et al., 1996), which measured the negative and positive aspects of caregiving experience, and the Family Questionnaire (Wiedemann et al., 2002) that evaluated the two dimensions of Expressed Emotion (EE): emotional over-involvement (EOI) and critical comments (CC). Based on the literature, the first hypothesis was that the negative aspects of caregiving would be positively related to the dimensions of EE for both parents. The second hypothesis was that, among the aspects of caregiving, difficult behaviours and negative symptoms would be the strongest contributors to the variance of the dimensions of EE. Correlations between aspects of caregiving and the dimensions of EE were calculated and regression models were used to measure which aspects of caregiving experience contributed the most to the dimensions of EE. Results and discussion: Results show that caregiving experience is significantly correlated to dimensions of expressed emotion for both parents, although differences were observed between mothers and fathers. Among the negative aspects of caregiving, for both parents, sense of loss contributed most to emotional over-involvement, while difficult behaviours contributed most to critical comments. Among mothers dependency was secondly associated with EOI and need for back up with CC. For fathers positive experiences were associated with EOI and a positive relationship with their child was negatively associated with CC. Conclusion: The sense of loss and the perception of difficult behaviours appear to be interesting targets for clinical intervention for caregivers in order to lower their levels of expressed emotion. Emphasizing positive aspects of caregiving with parents of hospitalized adolescents could be relevant during intervention, especially for fathers.

## Workshops

D1. **Adding Exposure with Response Prevention (ERP) to your Evidence-Based Toolkit for Addressing Ritualistic Behaviours in Eating Disorders**

Brad A MacNeil, PhD, George Mason University, Fairfax VA USA (Presenting)

Learning Objectives:

1. Describe ERP and research regarding the proper timing and delivery of ERP in the treatment of adults with EDs.
2. Review practical skills for the proper timing and delivery of ERP as part of their treatment toolkit.

Abstract:

Background: The need to target patients' engagement in ritualistic behaviour accompanying an eating disorder may be lower priority in hospital-based treatment programs. In fact, current evidence-based treatments for children, adolescents and adults rightfully target normalized eating, symptom interruption, and physical complications of eating disorders during the early phases of care. As a result, evidence-based methods for addressing ritualistic behaviour (e.g., body checking and fixing, social comparison) are currently underutilized as part of routine care. Exposure with response prevention (ERP) is the choice approach for addressing rituals in obsessive compulsive disorder, which shares the highest psychiatric comorbidity with eating disorders. ERP has gained renewed interest within the field and has been adapted in novel formats for addressing fear in anorexia nervosa, symptoms of body dysmorphia and symptoms of bulimia. Therefore, clinicians may benefit from having this evidence-based approach as part of their toolkit for addressing ritualistic behaviour accompanying the eating disorder. Objectives. In this workshop participants will be provided with the theoretical background required to

understand and meaningfully deliver ERP. Participants will learn about behavioural principles involved in ERP, the principles of exposure, use of the "STOP" acronym for response prevention (i.e., where S = stop the ritual altogether, T = trick the ritual, O = obstruct the ritual, and P = postpone the ritual), ERP hierarchy design, and accompanying cognitive restructuring techniques. Interactive Component: The workshop will be interactive with clinical examples provided of ERP hierarchies, in session behavioural experiments, and accompanying cognitive restructuring forms. Participants will receive coaching in the hands on use of ERP and cognitive restructuring worksheets. Lastly, participants will have an opportunity to discuss their program and brainstorm the proper timing for skillfully integrating ERP as an adjunct to core evidence-based treatment (e.g., during *phase 3* family based therapy (FBT), late phases of cognitive behaviour therapy (CBT) for bulimia nervosa). Discussion: Participants will leave with knowledge and practical skills for the proper timing and delivery of ERP as part of their treatment toolkit.

D2. **Emotion-Focused Family-Based Treatment: An Integrative Model to Improve Eating Disorder Outcomes for Treatment Non-Responders**

Gina Dimitropoulos, PhD, University of Calgary, Calgary AB (Presenting)
Adele Lafrance, PhD, Laurentian University, Sudbury ON (Presenting)
Renee Rienecke, PhD, Medical University of South Carolina, Charleston SC (Presenting)

Learning Objectives:

1. Describe the aspects of FBT with which families struggle.
2. Identify the ways in which EFFT can help parents manage these struggles.
3. Outline an integrative treatment proposing to add EFFT sessions as an adjunct to manualized FBT.

Abstract:

Background: Eating disorders (EDs) are serious health conditions that are associated with comorbid psychological symptoms and conditions. They can have a serious impact on quality of life as well as high morbidity and premature mortality. EDs are also among the most challenging mental disorders to treat and even the most effective treatments do not lead to full remission for most patients. For this reason, adaptation to treatments must be explored. Objectives: This workshop will begin with an outline of the methodology for an international study aiming to identify an emotion-focused adjunct to outpatient family-based treatment (FBT). FBT currently has the most empirical support for its use with adolescents with anorexia nervosa (AN) in outpatient settings. However, FBT leads to rates of full remission in approximately 40% of patients. Thus, there is a need for effective forms of treatment for FBT non-responders. Families may struggle with a number of aspects of FBT, including the re-nourishment process in the home environment. While FBT provides a solid framework around physical recovery, there is less focus on managing the difficult emotions that often arise during refeeding. As such, there is a need for a family-based approach that targets both the physical *and* the psychological aspects of recovery. To empower parents to take on their child's recovery, as well as to manage the strong emotions that arise for all members of the family, elements of Emotion-Focused Family Therapy (EFFT) have been integrated into FBT. Method / Content: The workshop will begin with a very brief review of both FBT and EFFT models. Then, presenters will describe an adaptation of FBT that includes adding a series of four sessions of adjunctive EFFT after session four of FBT – a critical juncture in the treatment, as research has shown that gaining approximately four pounds in the first four weeks of FBT best predicts good treatment outcome. These sessions will augment FBT by 1) introducing advanced caregiving skills to parents to manage the often very distressing emotions that arise in their child during refeeding, and 2) supporting parents to manage their own emotions that fuel common recovery-interfering behaviors. Other ways in which the two modalities intersect will also be presented, including ways in which the tensions between the models can be resolved. Demonstrations will be provided and participants will be taught specific skills consistent with the integrative model. A period of time will also be allotted for discussion and Q & A. Conclusion: Although FBT is the most efficacious form of

treatment for adolescents with AN, adaptations are needed in order to help those who struggle with implementing FBT, or who do not respond to treatment. The workshop will present a novel approach integrating FBT with EFFT, which is designed to help parents more effectively manage the psychological aspects of recovery.

D3. **The Clinical Implications for Dietitians of the Changes in DSM-5 Criteria for Eating Disorders**

Susan Osher, MSc, RD, CEDRD, Toronto ON (Presenting)

Learning Objectives:

1. Review the various DSM-5 categories and criteria for eating disorders.
2. Review how to conduct thorough nutrition assessments in order to identify eating disorders.

Abstract:

Background: The DSM-5 widened the criteria for eating disorders, recognizing many more people who are impacted physically, mentally or socially by disturbance of eating or eating-related behaviours. Dietitians in the community are often the first clinicians with the potential to detect eating disorders in clients seeking treatment for other, less urgent conditions. Traditional training for dietitians does not focus on eating disorders: we are trained to provide low calorie diets to overweight people, suggest new foods to picky eaters and applaud healthy eaters who avoid all "unhealthy" foods. By recognizing the signs of disordered eating and using appropriate assessment tools, dietitians can play a pivotal role in early intervention and improved outcomes. Inappropriate nutritional interventions, on the other hand, may have harmful consequences. Objectives: The aim of this workshop is to familiarize dietitians with the DSM-5 criteria for eating disorders including atypical anorexia, ARFID and Binge Eating Disorder. Also, common presentations such as veganism, extreme healthy eating and stress eating will be discussed as potential signs and symptoms of an eating disorder. Content: In the first part of this workshop, the audience will become familiar with the latest diagnostic criteria for eating disorders as outlined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). The participants will be educated about helpful questions, information and tools needed for the assessment of whether a client has an eating disorder or is at risk for developing one. In the second part of the workshop, case studies will be used in smaller groups, providing an opportunity for interactive, hands-on learning for nutrition assessment of clients with eating disorders, or those at risk for developing an eating disorder seeking nutrition counselling. Conclusion: This workshop aims to educate dietitians to differentiate between disordered and normal eating attitudes and behaviour. Participants will leave the workshop with strategies for understanding how to identify and make treatment plans for people with eating disorders.

D4. **Self-Compassion and Barriers to Self-Compassion: Research Update and Applications to Body Image Work in Eating Disorders Treatment**

Suja Srikameswaran, PhD, St. Paul's Hospital, Vancouver BC (Presenting)
Lauren Jennings, MSc, St. Paul's Hospital, Vancouver BC
Josie Geller, PhD, St. Paul's Hospital, Vancouver BC (Presenting)

Learning Objectives:

1. Review research evidence on the role of self-compassion and fear of self-compassion in predicting outcome in ED treatment.
2. Review how to help patients with negative body image and high fear of SC develop self-acceptance and SC skills.
3. Using a vignette, have an opportunity to practice SC skills.

Abstract:

This interactive workshop reviews the latest research on self-compassion (SC) and fear of self-compassion in the delivery of collaborative, patient centered care to individuals with eating disorders.

The presentation will begin with a review of recent evidence on the critical role of barriers to SC, and its implications for treatment. The role of SC and fear of SC will then be applied to one the most challenging aspects of recovery; gaining weight, interrupting eating disorder symptoms, and decreasing negative body image. We will share our experiences teaching SC skills to inpatients in a specialized eating disorders unit, where we found that patients expressed high levels of fear of SC. In our weekly "Body Matters" group aimed at helping patients to understand the impact of negative body image and developing an awareness of factors that may have played a role in the development and maintenance of negative body image, we emphasize the benefits of self acceptance and SC. In our workshop we will share activities and exercises that we use to challenge their beliefs, identify and accept emotions, soften body hatred, and practice acceptance and self-compassion.

D5. **Applying Family Based Treatment (FBT) into Practice: A Capacity Building Model**

Jessica Wournell, BScN, IWK Health Centre, Halifax NS (Presenting)
Herb Orlik, MD, FRCPC, IWK Health Centre, Halifax NS (Presenting)
Kate MacPhee, BSc AHN, IWK Health Centre, Halifax NS (Presenting)
Brynn Kelly, PhD, IWK Health Centre, Halifax NS (Presenting)
Tracy Bourdages, BScN, IWK Health Centre, Halifax NS

Learning Objectives:

1. Describe the principles of FBT and how to get started using FBT.
2. Demonstrate how to use a capacity building model to increase the use of evidence-based treatment in the management of Eating Disorders.
3. Review the importance of consistency in care in providing effective eating disorder treatment.

Abstract:

Background: In 2015, the Health Centre went through a major restructuring of its Eating Disorder Program and had Dr. James Lock visit to initiate training on Family Based Treatment. A two day workshop was provided for clinicians from across the province to gain core skills in the implementation of FBT in their practice. A partnership with an external expert was created to start certifying clinicians implementing FBT in their practice. An FBT Training Clinic was established, which aimed to certify two clinicians at a time with other core learners from different community mental health clinics, specific care clinic and in-patient unit to ensure capacity was being built across the entire Health Centre. This training clinic continues to be at the core of the eating disorder program as this evidence based practice is implemented for all settings, providing consistent family centered care. The training clinic allows new clinicians to learn how to provide FBT in a supportive setting and ensures adherence to the model improving treatment outcomes. The capacity building model is now being expanded through a provincial FBT interest group led by the Eating Disorder Specific Care Clinic, offering consultation to clinicians in rural settings. Design/Method: Workshop - A power-point presentation will be presented outlining FBT, the training clinic and a capacity building model with interactive Q and A. A role play demonstration of the Family Meal – session 2 of the FBT model- with discussion around challenges and strategies to have the parents gain a sense of success in having their child eat more than they planned to. Discussion: Discussion will include an overview of the FBT model, including key elements and resources needed to provide FBT. We will review how we improved consistency of eating disorder treatment on an inpatient and outpatient level throughout the Health Centre and how that had a positive effect on the length of hospital stays and adherence to outpatient follow up. An overview on the development of the FBT Training Clinic and how this training clinic was able to increase capacity of clinicians and their ability to provide quality evidence based treatment to patients and their families suffering from eating disorders. Conclusion: The workshop proposed will give an overview of where the institution was prior to implementing the FBT model into practice, and where it is now after implementing the FBT model for over two years. An overview of the FBT model will be provided, including challenges and triumphs when

using the model. This workshop will aim to highlight outcomes in this institution indicating a decrease in admissions and length of stay and faster, more effective outpatient treatment. The importance of adherence to the model will be reviewed and how this Health Centre developed an FBT training Clinic aiming to support FBT training on its in-patient unit, community mental health clinics and specific care clinics. The evolution of the program will be described indicating an ability to certify several clinicians while also training other learners. The evolution of the capacity building model will be illustrated that now reaches across the province building up clinicians in rural areas on this highly efficient and effective treatment.

D6. **Using Program Evaluation Data, Patient Feedback and Clinical Expertise to Revise a Treatment Program: The TGH Experience**

Marion P Olmsted, PhD, University Health Network, Toronto ON (Presenting)
Kathryn Trottier, PhD, University Health Network, Toronto ON (Presenting)

Learning Objectives:

1. Review the utility of program evaluation data in guiding change in practice.
2. Describe a process for an eating disorder program re-design.

Abstract:

The Eating Disorder Program at TGH was over 30 years old in 2016 and had a well-developed model of care. Staff had the expertise and confidence that comes with years of practice. Patients who returned for repeat admissions knew the routines and expectations of the program. Outcome indicators and levels of patient satisfaction were known and well documented. It was time to escape complacency and ask what we could do to improve long-term outcomes for our patients. We embarked on a full-scale review and re-design process which included an external review of the program, examination of program evaluation data and patient feedback and a facilitated change process to guide staff to envision what could be instead of what is. The purpose of this workshop is to share the information that highlighted a need for change, describe the re-design process and present the new model of care. Program evaluation data related to drop-out rates, outcomes at the end of treatment and relapse rates will be presented, along with patient feedback and the staff perspective. The presenters will describe the re-design process and the core patient care principles that formed the foundation of the re-design. The new model of care will be presented along with iterative adjustments made to date. Participants will be invited to ask questions and to describe their own challenges in recognizing what changes are needed in their programs and in collecting and using program evaluation data to guide them.

D7. **Implementing Dialectical Behaviour Therapy (DBT) within an Intensive Pediatric Eating Disorders Program: Clinical Challenges and Practical Considerations**

Cheryl Webb, MSW, McMaster University, Hamilton ON (Presenting)
Liah Rahman, BA, Hamilton Health Sciences, Hamilton ON
Jennifer Couturier, MD, FRCPC, McMaster University, Hamilton ON (Presenting)
Zechen Ma, BSc, McMaster University, Hamilton ON

Learning Objectives:

1. Describe principles of DBT and examine the role of DBT in the treatment of EDs.
2. Describe an intensive pediatric Eating Disorders program that includes specialized outpatient, inpatient and Day program treatment for adolescents with EDs.
3. Describe challenges and considerations of incorporating DBT into a program for adolescents with severe EDs.

Abstract:

Background: Family Based Treatment (FBT) has strong efficacy for use with young people with eating disorders and has been effectively used for outpatient treatment. However, programs are often faced

with what to do when patients do not improve with FBT, cannot utilize FBT or exhibit significant emotional dysregulation or self harm that interferes with FBT delivery. Dialectical Behaviour Therapy (DBT) is an emerging treatment for patients with eating disorders and holds promise for treating multi-diagnostic patients. An Ontario based tertiary care centre for pediatric eating disorders implemented DBT as a treatment model across outpatient, day hospital, and inpatient programs. Objectives: This session will present an overview of the principles of implementing DBT within an eating disorder program paired with the direct practical experience of clinicians utilizing DBT within such a program. The goal of the presentation is to provide participants with a theoretical framework to implementation DBT as well as the actual experiences of implementing DBT within a clinically busy and established intensive eating disorders program. Design/Methods: Presenters will briefly discuss the issues leading to the decision to develop a DBT informed program and how DBT implementation was staged at each level of care (outpatient, day hospital and inpatient). The clinical challenges of implementing DBT with an FBT-oriented team will be discussed. Key leadership roles and decisions will be discussed with regard to ensuring front line buy in and capacity building. Participants will hear 'real world' challenges of implementing DBT and lessons learned throughout the change process using case examples. Participants are encouraged to bring examples of DBT implementation within their own programs, as one third of the workshop will be devoted to interactive discussion. Results/Discussion: Staff preparation for treatment model change and the planning by program leadership prior to implementation is essential, as it the ongoing role of program leadership for the successful maintenance of DBT. Ongoing accountability mechanisms are necessary in order to maintain the integrity of the treatment model, as well as the various level of training required by frontline nurses, clinicians, and medical staff. These are key challenges for clinicians, pediatricians and programs considering the implementation and sustainability of a DBT program.

D8. **Maximizing Engagement and Motivation for Change in Eating Disorder Treatment: The Importance of Autonomy Support**

Howard Steiger, PhD, Douglas University Institute, Montreal QC (Presenting)
Lea Thaler, PhD, Douglas University Institute, Montreal QC (Presenting)
Chloé Paquin-Hodge, PhD, Douglas University Institute, Montreal QC (Presenting)

Learning Objectives:

1. Describe core concepts that are basic to Self Determination Theory, and understand the concept of Autonomy Support that is inherent to this model.
2. Summarize empirical findings relating concepts of autonomous motivation and autonomy support to clinical outcomes in diverse clinical problems--including eating disorders.
3. Apply autonomy supportive techniques in their own clinical practice, to enhance patient motivation and outcome.

Abstract:

Background: Self-determination theory (SDT) is an empirically derived theory of human motivation that has been applied to diverse clinical problems, including eating disorders (EDs). SDT proposes two types of motivation that impact clinical outcomes -- "autonomous motivation" (i.e., motivation experienced as coming freely from within) and "controlled motivation" (i.e., motivation arising from external sources). SDT also addresses the relational conditions that enhance autonomous motivation, proposing that needs for autonomy, competence, and relatedness are central to individuals' motivation for change and, correspondingly, their response to treatment. Applied to ED treatment, SDT prescribes a relational climate that enhances autonomy support and reduces coerciveness. An accumulating body of literature suggests that autonomous motivation is associated with better outcomes in treatments for Anorexia and Bulimia Nervosa, in both in- and outpatient settings. Design/Method: This workshop will review core SDT concepts, and describe the ways in which these concepts prescribe specific clinical techniques

and therapist stance. The workshop will also review new empirical findings suggesting that therapists' autonomy supportiveness can increase patients' autonomous motivation, and that patients' autonomous motivation is associated with superior clinical outcomes. Various clinical vignettes will illustrate autonomy supportive (rather than coercive) intervention options that are available in complex clinical situations that occur in ED treatment (including refusal of weight gain, suicidality, medical instability, oppositionality, and other situations). Workshop participants will be invited to bring examples from their own clinical practices to enrich a group discussion on choice nodes to which we (as clinicians) can turn to emphasize autonomous or controlled motivation inducements, likely impacts of these choices upon clinical outcomes, and emotional factors that shape clinician choices in problem situations. Time allotment to different portions of the lesson plan: Didactic lecture on theoretical background and empirical support; clinical vignettes and group discussion; discussion around cases provided by participants; and question/answer period and wrap-up discussion.

D9. **ARFID Adjuncts: Tailoring Treatment Beyond the Diagnosis**

Holly Agostino, MD, FRCPC, Montreal Children's Hospital, Montreal QC (Presenting)
Peggy Alcindor, PDt, Montreal Children's Hospital, Montreal QC (Presenting)
Jason Bond, MD, FRCPC, Montreal Children's Hospital, Montreal QC (Presenting)
Danit Nitka, PhD, Montreal Children's Hospital, Montreal QC

Learning Objectives:

1. Describe the heterogeneity of ARFID subtype presentations.
2. Review the nutritional, medical and psychosocial challenges of younger patients with ARFID.
3. Describe and review risk factors (medical and psychological) that may impede early treatment advancement and develop strategies on how best to support families.

Abstract:

Avoidant restrictive food intake disorder (ARFID) is a recently named eating disorder (ED) diagnosis and represents one of the most substantial revisions to the Feeding and Eating Disorders section of the DSM-5. Although the DSM-5 has allowed for improved diagnostic capability, no systematic data on the best approach to treat ARFID patients is yet available. Most academic centers have incorporated these patients into their anorexic family-based treatment (FBT) model. However, although FBT is the gold standard for weight recovery in adolescent anorexia nervosa, this approach alone fails to consider many of the comorbid aspects seen in ARFID patients and does not always address the immediate crisis state of these families. This interactive workshop is aimed at tackling the nuances of treating this diagnosis from a medical, psychological and nutritional point of view. Case examples will be used to illustrate the heterogeneity of ARFID subtype presentations as well as specific medical and nutritional risks that arise with a younger patient population. Current evidence will be reviewed in regard to various psychological treatment options and the use of adjunct medications. Insight from our team's development of an ARFID specific ED program stream will be utilized to stress the need for early identification of psychosocial risk factors that may inhibit treatment progression and the role of ongoing multidisciplinary support (nutritional and psychiatric services) to dampen crisis that may arise in the early phases of treatment.

D10. **After the Workup: A Multidisciplinary Approach to Treating Pediatric Eating Disorder Patients with Somatic Symptoms**

Cathleen Steinegger, MD, The Hospital for Sick Children, Toronto ON (Presenting)
Seena Grewal, MD, FRCPC, The Hospital for Sick Children, Toronto ON (Presenting)
Jaimie Kennedy, BSc, The Hospital for Sick Children, Toronto ON (Presenting)

Learning Objectives:

1. Review the roles multidisciplinary team members can take to support families in shifting their focus from a search for a medical diagnosis to refeeding their child.
2. Describe strategies to address nutrition and refeeding in patients with eating disorders who have complex somatic symptoms using case examples.

Abstract:
Pediatric patients who are ultimately diagnosed with eating disorders may initially present with somatic symptoms, such as abdominal pain, nausea and syncope. Others may have a co-occurring medical condition which alters eating, such as food allergies or diabetes, which contributes to significant anxiety around food. Patients may undergo extensive medical testing before the eating disorder is diagnosed and families may have been given multiple recommendations of how to manage the somatic symptoms prior to meeting the eating disorder team. It can be challenging for families to become involved with mental health treatment as the emphasis switches from a search for a medical explanation to a "non-medical" diagnosis and refeeding of their child. For youth with medical conditions and a comorbid eating disorder, families may need to consider treatment recommendations that appear to be contrary to previous medical recommendations. As the Eating Disorders Program at SickKids sits within a tertiary care pediatric center, we are frequently consulted about patients with who have had an extensive medical workup, but the reason for their poor feeding, weight loss or food aversions is not explained by a medical diagnosis. In this workshop, we will present the strategies our multidisciplinary team uses to support such patients and families to be successful with refeeding in the face of ongoing somatic symptoms that may or may not have a medical diagnosis. After a short didactic presentation, we will use a case examples and small group discussions around how to support families and other medical teams in managing the care of these patients.

D11. **Signalling Matters: Radically Open-Dialectical Behaviour Therapy (RO-DBT) for Disorders of Overcontrol**

Sharon Zister, MSW, RSW, Private Practice, Toronto ON (Presenting)

Learning Objectives:
1. Describe the evidence base for RODBT including its application to Eating Disorder Treatment.
2. Describe a conceptual overview of the primary treatment targets and interventions inherent in the RO-DBT model.

Abstract:
Self-control, the ability to inhibit competing urges, impulses, or behaviors, is highly valued by most societies. However, excessive self-control has been linked to social isolation, aloof interpersonal functioning, maladaptive perfectionism, inhibited expressions, and difficult-to-treat mental health problems, such as anorexia nervosa, obsessive compulsive personality disorder, and refractory depression. Based on 20 years of research, two NIMH-funded randomized controlled trials (RCTs) targeting depression and overcontrolled personality disorders, an open trial with adult anorexia nervosa, and a large ongoing multisite RCT (http://www.reframed.org.uk). The aim of this workshop is to introduce clinicians to the new theory and strategies underlying Radically Open–Dialectical Behavior Therapy (RO-DBT) for disorders of overcontrol.

D12. **Addressing the Gap in Adult Eating Disorder Nutritional Recovery: Transitioning Patients from Intensive Treatment to Home**

Ali Eberhardt, BSc FNH Dietetics, St. Paul's Hospital, Vancouver BC (Presenting)
Nicole O'Byrne, BSc FNH Dietetics, IOC Diploma Sports Nutrition, ISAK Level 1, St. Paul's Hospital, Vancouver BC (Presenting)

Learning Objectives:

1. Describe key components/themes that patients experience as they transition from intensive treatment to the community.
2. Provide strategies for family and friends that may help facilitate a smooth transition from intensive treatment to the community in regard to meal support.

Abstract:
Background: Eating disorder nutritional recovery can be difficult following intensive treatment as refusal, dropout and relapse are common. Adult patients are encouraged to make healthy eating and self-care choices, but increasingly, the involvement of family and other supports are being explored as an important aid for the patient in the transition from treatment to the community. As the symptoms of an eating disorder revolve around the adult patient's relationship with food, meals become a time of high stress and anxiety. This session will explore the common themes adult patients experience around all aspects of meal support and describe a tool dietitians can use to help facilitate a smooth transition from intensive treatment to home. This presentation will review results on this subject from a qualitative research project conducted by the dietitians in the Provincial Adult Tertiary Specialized Eating Disorders Program in Vancouver, BC. From this research a tool was created to help patients communicate needs when transitioning into their home community and enhance knowledge and skills of patients' family and friends who provide meal support. Delivery: In this 90 minute workshop, the speakers will present the background and rationale for development of this tool. They will reflect on how the results of the qualitative study informed the creation of this tool as well as providing highlights of using this new meal support checklist in their practice. A 15-minute question period will be incorporated. Participants will be encouraged to reflect and discuss their own experiences in supporting the skills for nutritional recovery for patients, families and care givers in the transition home from treatment. They will have an opportunity to learn how to incorporate aspects of the checklist into their own practice.

D13. **The Role of Registered Dietitians in Family Based Treatment for Adolescents with Eating Disorders: Lessons Learned from Community to Tertiary Care Settings Across Canada**

Gina Dimitropoulos, PhD, University of Calgary, Calgary AB (Presenting)
Barbara Beach, PhD, BC Children's Hospital, Vancouver BC (Presenting)
Jadine Cairns, MSc, BC Children's Hospital, Vancouver BC (Presenting)
Susan Osher, MSc, RD, CEDRD, Toronto ON (Presenting)
Jennifer Scarborough, MSW, Canadian Mental Health Association, Waterloo-Wellington ON (Presenting)
Tara Slemko, MSc, Alberta Children's Hospital, Calgary AB (Presenting)
Blake Woodside, MD, FRCPC, Toronto General Hospital, Toronto ON (Presenting)

Learning Objectives:
1. Describe the principles of FBT and its different phases.
2. Identify when and how to integrate a registered dietitian in FBT.
3. Review strategies for maintaining parental empowerment when registered dietitians are involved in FBT.

Abstract:
Background: Family Based Treatment (FBT) is designed to support parents to re-nourish their child back to health by making decisions about what to feed their child. FBT consists of three distinct phases aimed at weight restoration and normalized eating by leveraging natural parental authority, historical knowledge of their child, and what works best within each unique family context. Although registered dietitians play a critical role on interdisciplinary teams, their direct involvement in FBT has been discouraged to avoid undermining parental empowerment, problem solving, and decision-making efforts of parents to re-nourish their child. However, parents often request the involvement of registered dietitians and sometimes clearly require additional nutritional guidance. In this context, the

FBT and Nutrition Sections of EDAC have been actively discussing the role of registered dietitians in FBT. Objectives: The aim of this workshop is to bring together FBT therapists and registered dietitians from across Canada to discuss how to integrate registered dietitians in FBT. Method/Content: The first part of the workshop will provide an overview of FBT and its guiding fundamental principles for working with parents and adolescents over the course of three different phases. The second part of this workshop will discuss under what circumstances nutritional support has been used as an adjunct to FBT. We will also examine how and when registered dietitians have been incorporated into the provision of FBT particularly in the first phase of treatment. We will provide clinical examples from different treatment settings (community based agencies, private practice and specialized programs) and across various parts of Canada (i.e., British Columbia, Alberta and Ontario). We will examine how registered dietitians have been integrated in FBT-informed day treatment programs, multi-disciplinary teams using FBT on an outpatient basis and in private practice settings. In the final part of the workshop, we will provide clinical examples of how FBT therapists and registered dietitians may support parents who have challenges preventing them from knowing or believing *how much to feed their child* due to their own history of disordered eating, chronic health or mental health conditions. We will also discuss examples of how registered dietitians can bolster parents with educational information and helpful strategies when the child struggles with the weight gain process. Strategies for incorporating registered dietitians when working with children co-morbid physical conditions that complicate the weight gain process such as diabetes and celiac disease will also be discussed. Using an interactive approach, participants will have the opportunity to discuss successes and challenges in delivering FBT in a collaborative manner between registered dietitians and FBT therapists. Conclusion: This workshop seeks to strengthen collaborations among FBT therapists, registered dietitians and parents to work together when clinically warranted. Participants will leave the workshop with strategies for understanding how and when to initiate dietician involvement in FBT.

D14. **Co-Design in Eating Disorder Treatment: Can We Accept Our Patients as Part of the Crew and Not Just the Passengers?**

Leora Pinhas, MD, FRCPC, University of Toronto, Toronto ON (Presenting)
Sheila Bjarnason, MSW, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Tina Slaunwhite, RPN, Ontario Shores Centre for Mental Health Sciences, Whitby ON
Rebecca Lauwers, BA, McMaster University, Hamilton ON
Stella Ducklow, _____, Ontario Shores Centre for Mental Health Sciences, Whitby ON

Learning Objectives:

1. Describe the concept of Co-Design and the research that supports its use in ED treatment.
2. Review successes in the area of co design and use of peer support specialist in Recovery High School.
3. Describe the obstacles to expanding our use of the patient voice in ED programs.
4. Describe actions that can be undertaken to improve treatment through deliberate incorporation of patients and families at all levels of system change.

Abstract:
Background: Literature on recovery-oriented approaches in adolescent inpatient programs or the treatment of eating disorders (ED) is scant. The Eating Disorder Residential Program (EDRP) was explicitly created to provide an alternative for adolescents who had been treated unsuccessfully by existing settings. As a result, a developmentally appropriate recovery model: Recovery High School was developed as a central part of the treatment model. The program moved to a diagnosis-agnostic treatment that incorporated concepts of transparency, patient and family directed care and co-design present in adult mental health discourse, but relatively rare in adolescent mental health and ED literature. This required the interdisciplinary mental health team to embrace a new way of working with adolescents with EDs. This workshop will focus on exploring what's required from both mental health

clinician and the institution to move from a traditional paternalistic treatment approach to one of collaboration and co-design. As a clinician offering treatment in EDs, how open are you with letting the patient and family take control of the recovery process, where clinicians act as consultants and collaborators? Why do we continue to offer treatments that have poor patient feedback and outcomes? What protection should we be providing to patients who want to report unhelpful or harmful treatment interventions? Is there something about the complexity of this illness, the higher prevalence in girls and women, the high risk for harm that allow us to ignore the feedback and criticisms that patient and families provide? Objectives: In this workshop the facilitators will review the concept of Co-Design and the research that supports its use in ED treatment; highlight "wins" in the area of co design and use of peer support specialist in Recovery High School; and consider the obstacles to expanding our use of the patient voice in ED programs and actions that can be undertaken to improve treatment through deliberate incorporation of patients and families at all levels of system change. Design/Method: This workshop will be interactive and invite a dialogue between clinicians, patients and parents and workshop facilitators. Both in small group exercises and large group discussions, the dialogue will challenge assumptions about what treatments work and for which individuals. We will explore ideas about how to insure the quality and responsiveness of the treatment services in Canada by incorporating the voices of those who have had an ED or who are currently in treatment for an ED into treatment design, implementation and evaluation. Results/Discussion: Recovery High School required significant changes in how the EDRP was organized and in how clinicians approached their work. However, it produced improved outcomes, and greater patient and parent satisfaction. Incorporating patient voice improves both quality and responsiveness of treatment in EDs.

D15. **#Times Up: Putting Reflexivity and Common Humanity Back in Eating Disorder Treatment**

Andrea LaMarre, PhD, University of Guelph, Guelph ON (Presenting)
Leora Pinhas, MD, FRCPC, University of Toronto, Toronto ON (Presenting)
Olivia Detmers, Georgetown ON (Presenting)
Robyn Mercanti, Toronto ON (Presenting)

Learning Objectives:

1. Describe and discuss ways that care and social justice can and should inflect eating disorders treatment.
2. Describe and discuss some of the various "us vs. them" scenarios that arise in eating disorder treatment and propose alternative ways of orienting to self and to patient in treating eating disorders.

Abstract:

Background: At its best, eating disorder treatment is scaffolded by an ethic of care. Evidence points to the need to work in collaborative and transparent ways with patients to build strong therapeutic alliances and provide appropriate, attuned treatment. However, significant barriers typically get in the way of delivering care that is truly guided by this ethic of care: lack of training, implicit biases, power structures that maintain problematic hierarchies, lack of accountability, and assumptions about people who experience eating disorders as lacking agency and humanity may lead to alienating experiences for patients. In order to provide care that is built on principles of recovery focused, trauma-informed, culturally-appropriate, patient-directed, and socially just care, there is a need to engage in reflexivity about who we are in relation to mental health care and eating disorders and to develop strategies for unpacking assumptions about patients, self, and care that may get in the way of delivering good care. Objectives: The objectives of this workshop are: 1. To identify and address the ways that care and social justice can and should inflect eating disorders treatment; and, 2. To break down the various "us vs. them" scenarios that arise in eating disorder treatment and propose alternative ways of orienting to self and to patient in treating eating disorders. Design/Method: In this workshop, we engage in difficult but necessary conversations about how eating disorder treatment is delivered and received. We will outline

principles of patient-oriented, recovery focused, trauma-informed, and socially just care for eating disorders, building on feminist, sociological, and psychological theories and ethics. We will share a series of scenarios built on real-life examples of eating disorder treatment experiences and work through solutions with participants. Participants will engage in experiential, and reflexive writing exercises to situate themselves in relation to this work. Workshop participants will develop strategies for more thoroughly addressing the biases that we each hold. We invite participants to engage in open, honest, and non-defensive unpacking of their own experiences in the world and how these intersect with patients' experiences in care. Results/Discussion: By engaging in reflexive exercises, we can each work to provide better care and/or research on eating disorders. This self-investigation can guide the delivery of care that truly meets patients where they are. Conclusion: Understanding the deep-seated power dynamics and biases that pervade eating disorder treatment is a necessary first step in the consciousness-raising required to bring treatment into the 21st century and improve outcomes.

D16. **The Art of Practicing Evidence-Based Medicine: Some Creative Solutions for When FBT Fails**

Wendy Spettigue, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)
Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)
Clare Roscoe, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)
Leanna Isserlin, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)

Learning Objectives:

1. Describe the evidence for the efficacy of FBT, and treatment guideline recommendations for those adolescents with severe EDs who do not respond to FBT.
2. Describe case examples of adolescents with severe EDs who were helped to recover from their ED by the use of additional treatments that were combined with FBT or used instead of FBT.
3. Discuss and review treatment options for youth with severe EDs who do not respond to FBT or for whom FBT is not indicated.

Abstract:

Introduction: Those of us who treat adolescents with severe, complex eating disorders know that Family Based Therapy (FBT) is the gold standard of treatment, but that FBT is not always successful: sometimes it is contra-indicated, sometimes it fails, and sometimes it helps but is not sufficient on its own. In fact, the research shows that only about 50% of adolescents recover when treated with outpatient manualized FBT (1). As Peterson et al note "…eating disorder treatment outcome studies are generally characterized by significant rates of attrition, relapse, and non-remission." (2) An examination by Lock et al of factors associated with adolescents who dropped out of FBT showed that "The presence of co-morbid psychiatric disorder, being older, and problematic family behaviors led to lower rates of remission." (3) For those adolescents who do not respond to FBT, treatment guidelines suggest a possible role for more intensive treatment, for adjunctive medication, or for adding other therapies, such as DBT, CBT, and MET (2). And sometimes, therapists have to draw on a combination of 'tools in their toolbox' to come up with a creative combination of solutions to help these severely ill adolescents recover from their eating disorders. Methods: This workshop opens up the discussion of how to treat these severely ill youth, and what to do when evidence-based treatments do not have all the answers. Each presenter has many years of experience working on a specialized pediatric eating disorder team. Each presenter will describe a case of an adolescent with a severe, complex eating disorder and multiple comorbidities who did not respond to FBT, but who was eventually able to be helped to recover with the use of creative additions to FBT, including combinations of medications, use of ECT, intensive treatment, additional individual or group therapies, and school-based interventions. Discussion: As Peterson et al note, "although best practices often utilize inpatient, residential, partial, day treatment, and intensive settings, minimal data are available for treatment delivered in settings other than outpatient settings. Additionally, the rigors of the scientific process make the incorporation of novel and experimental

treatments into the evidence base slow." This workshop is not about ignoring the evidence, but rather, about what to do when evidence-based treatments do not provide the answers, but still inform practice. The final 30 minutes of the workshop will be devoted to discussion and questions, during which the audience will be asked to provide their own examples of what helps when FBT is not indicated, or when a young patient is 'stuck' and not responding to FBT.

D17. **The Novel Application of Acceptance and Commitment Therapy (ACT) in an Open Group Format for Patients Awaiting the Initiation of Core Evidence-Based Care**

Brad A MacNeil, PhD, George Mason University, Fairfax VA USA (Presenting)

Learning Objectives:

1. Describe how ACT can be delivered in an open group format.
2. Describe and discuss a flexible model for integrating this treatment into pre-existing programming.

Abstract:

Background: Engaging patients with eating disorders in their recommended care is a well-known challenge in the field. Starting well in treatment is important, with the process of waiting for the initiation of evidence-based care having a potential negative effect on patient motivation and eating disorder symptoms. Eating disorder treatment is also complicated by the unique nature of the illness with aspects viewed as being congruent with an individuals' value system. There is some evidence that patients' initial experiences in treatment are important for their continued participation in care. Therefore, novel treatments that are viewed positively by the patient's themselves may be important to offer during the important initial stages of programming. Acceptance and commitment therapy (ACT) has been argued to be well-suited for patients with eating disorders given its objectives include work aimed at increasing psychological flexibility, values clarification away from the illness, and helping patients decrease avoidance of negative emotional states. Recent work has shown that patients views of ACT delivered in a novel open group format are positive, and that satisfaction with ACT delivered in this format predicts engagement in other aspects of outpatient programming. Objectives. In this workshop participants will be provided with a background of the six components of the ACT model, current literature on the use of this treatment modality for eating disorders, and training in the delivery of ACT in an open group format. Interactive Component: The workshop will be interactive with clinical examples provided of how to offer ACT in a 16 session ongoing open group therapy format that patients can engage in immediately after completing their intake assessment into a hospital-based program. Participants in the workshop will receive worksheets and hands on training in how to deliver ACT concepts in way that is meaningfully adapted for patients with eating disorders. Discussion: Participants will leave with knowledge and practical skills for the delivery of ACT in an open group format and a flexible model for integrating this treatment into pre-existing programming.

D18. **"That Chair Group": Using Group-Based Emotion-Focused Therapy in Eating Disorder Treatment**

Cheryl Aubie, PhD, Nova Scotia Health Authority, Halifax NS (Presenting)
Yvette Scattolon, PhD, Nova Scotia Health Authority, Halifax NS (Presenting)

Learning Objectives:

1. Describe and discuss the use of EFT as a treatment approach to explore and transform emotional pain in individuals with eating disorders.
2. Discuss EFFT can be adapted in a group format for group-based eating disorder treatment programs.

Abstract:

Background: Emotion-focused therapy (EFT) has been demonstrated to be effective in the treatment of emotional pain in individuals with eating disorders. Individuals with eating disorders often experience difficulties with affect regulation and expression. EFT offers specific techniques for expressing and transforming painful emotional experiences, and for dealing with a harsh internal critic as experienced

by many individuals with eating disorders, often referred to as their "eating disorder voice." Because EFT techniques are aimed at gaining mastery over emotional experiences and increasing self-soothing, painful emotions are explored in a manner that aims to decrease the sense of being overwhelmed by affect and the reliance on eating disordered or self-harm behaviors to manage feelings. Traditional EFT is carried out as an individual therapy, however, offering EFT as a group based treatment has been shown to have the additional benefits of offering participants a shared sense of commitment to one another, validation, normalizing of painful experiences and increased motivation to make emotional change. Moreover, vicarious emotional processing within a group allows individuals to experience emotions previously outside of their awareness when demonstrated by another group member. Method/Content: This workshop will begin with a review of the EFT model, including a description of the three main tasks of EFT: two-chair dialogue for internal conflict splits, two-chair enactment of self-interruptive splits and the empty-chair dialogue for resolving emotional injuries with a significant other. The significance of these particular three emotional conflicts in individuals with eating disorders will be discussed along with evidence for why the EFT model is well suited for treatment of eating disorders. The presenters will discuss how EFT has been adapted for group-based treatment in general and specifically at an eating disorder program. The benefits of using EFT, particularly vicarious processing, will be discussed as well as challenges and potential ethical issues. Client readiness factors and suitability for group-based EFT will be discussed. Video clips of sessions will be presented as well as testimonials/evaluations from clients who have participated in the group. Time will also be allotted for discussion and a question & answer period. Conclusion: EFT has been demonstrated to be a powerful adjunctive treatment for individuals with eating disorders because it allows for processing of emotion pain that often serves as triggers for eating disorder symptoms and relapse. Although there is research to support its use as a group-based treatment, EFT does not appear to be widely used in a group format in eating disorder programs. This workshop will discuss how it has been implemented and successfully used in one eating disorder program.

D19. **C-CARE: A Comprehensive Treatment Model for Concurrent Eating Disorders and Substance Use Disorders**

Katherine A Henderson, PhD, Anchor Psychological Services Inc, Ottawa ON (Presenting)
Shari Mayman, PhD, Anchor Psychological Services Inc, Ottawa ON (Presenting)

Learning Objectives:

1. Review the importance of having a treatment model for concurrent eating disorders and substance use.
2. Describe obstacles many clients and clinicians face with concurrent eating disorders and substance use.
3. Describe the four main components of the C-CARE model (see above) through a didactic presentation and through experiential role play of the therapeutic skills/strategies unique to each component.
4. Describe how C-CARE theory and skills can be applied to clinical practice and research programs.

Abstract:

Background: Emotion-focused therapy (EFT) has been demonstrated to be effective in the treatment of emotional pain in individuals with eating disorders. Individuals with eating disorders often experience difficulties with affect regulation and expression. EFT offers specific techniques for expressing and transforming painful emotional experiences, and for dealing with a harsh internal critic as experienced by many individuals with eating disorders, often referred to as their "eating disorder voice." Because EFT techniques are aimed at gaining mastery over emotional experiences and increasing self-soothing, painful emotions are explored in a manner that aims to decrease the sense of being overwhelmed by affect and the reliance on eating disordered or self-harm behaviors to manage feelings. Traditional EFT is carried out as an individual therapy, however, offering EFT as a group based treatment has been

shown to have the additional benefits of offering participants a shared sense of commitment to one another, validation, normalizing of painful experiences and increased motivation to make emotional change. Moreover, vicarious emotional processing within a group allows individuals to experience emotions previously outside of their awareness when demonstrated by another group member. Method/Content: This workshop will begin with a review of the EFT model, including a description of the three main tasks of EFT: two-chair dialogue for internal conflict splits, two-chair enactment of self-interruptive splits and the empty-chair dialogue for resolving emotional injuries with a significant other. The significance of these particular three emotional conflicts in individuals with eating disorders will be discussed along with evidence for why the EFT model is well suited for treatment of eating disorders. The presenters will discuss how EFT has been adapted for group-based treatment in general and specifically at an eating disorder program. The benefits of using EFT, particularly vicarious processing, will be discussed as well as challenges and potential ethical issues. Client readiness factors and suitability for group-based EFT will be discussed. Video clips of sessions will be presented as well as testimonials/evaluations from clients who have participated in the group. Time will also be allotted for discussion and a question & answer period. Conclusion: EFT has been demonstrated to be a powerful adjunctive treatment for individuals with eating disorders because it allows for processing of emotion pain that often serves as triggers for eating disorder symptoms and relapse. Although there is research to support its use as a group-based treatment, EFT does not appear to be widely used in a group format in eating disorder programs. This workshop will discuss how it has been implemented and successfully used in one eating disorder program.

D20.**Meal Support: Philosophies and Strategies**

Emily To, MSc, RD, Looking Glass Residence, Vancouver BC (Presenting)
Jadine Cairns, MSc, RD, BC Children's Hospital, Vancouver BC (Presenting)

Learning Objectives:

1. Describe key components of effective meal support.
2. Describe how application of Dialectical Behaviour Therapy (DBT) and Emotion Focused Family Therapy (EFFT) as philosophical underpinnings of a program can support eating disordered clients to eat.
3. Describe challenges in meal support therapy and their effects on clinicians, and become familiar with systems to help clinicians manage burnout and compassion fatigue.

Abstract:

Background: Meal support is often considered a core part of many eating disorder programs in the process of re-nourishment, symptom cessation, and the establishment of regular and adequate eating routines. However, this process can be very stressful and overwhelming for both patients and clinicians. This can especially be true when meal support is not in line with the philosophy of each unique clinical setting. Ensuring that meal support is consistent with these philosophies can ultimately empower clinicians and motivate patients to translate these skills into their lives. Design/Method: This workshop will start with a formal presentation exploring meal support in clinical settings for youth and adults. It will include practical meal support strategies stemming from DBT and EFFT, as well as indications for their use. Frameworks for integrating at work support systems for clinicians to aid in managing burnout/compassion fatigue will be provided. Results/ Discussion: There will be role-playing components of common "at the table" scenarios to allow participants the chance to utilize techniques discussed through the workshop as well as opportunities to discuss integration into their own clinical practices. The last 30 minutes will be allotted for open discussion and dialogue on the participant's clinical setting for meal support therapy and potential new strategies they may try to improve meal support in a variety of clinical settings.

## Posters

E1. **A Descriptive Analysis of Men with Eating Disorders**

Chloe C Hudson, MSc, Queen's University, Kingston ON
Brad A MacNeil, PhD, George Mason University, Fairfax VA USA (Presenting)

Learning Objectives:

1. We will report the demographic and clinical characteristics of men who have been accepted into an adult outpatient eating disorder program.
2. We will highlight and discuss the potential implications of the factors unique to men with eating disorders.

Abstract:

Background: Eating disorders in men are understudied and poorly understood (Strother, Lemberg, Stanford, & Turberville, 2012). Researchers and treatment providers are largely unaware of the unique demographic and clinical factors of men seeking treatment for eating disorders (Greenberg & Schoen, 2008). Lack of understanding of this population may create a feedback loop wherein men feel misunderstood in treatment settings, leading to a reluctance to engage in evidence-based care and/or poor treatment outcomes. Objectives: The current study will analyze the demographic and clinical characteristics of men seeking treatment at an adult outpatient treatment facility. Design/Methods: Participants include all 34 men who were accepted into an adult outpatient eating disorder treatment program from 2010 – 2017. All males were diagnosed with an eating disorder based on *The Diagnostic and Statistical Manual of Mental Disorders*, fourth edition text-revision (*DSM-IV-TR*) or fifth edition (*DSM-5*). Diagnoses were made by psychiatrists with a speciality in assessing eating disorders. We will review patients' demographic (e.g., age, education level, employment status) and clinical characteristics (e.g., eating disorder symptoms, comorbidities) based on self-reported information. Results/Discussion: The frequency and means of relevant demographic and clinical characteristics will be presented. Results will be compared and contrasted with the characteristics of women with eating disorders, which is well established in the literature. The potential impact of sex differences on treatment and prognosis will be discussed. Conclusions: Males with eating disorders are a poorly understood population. Understanding the demographic and clinical characteristics of men accepted into an outpatient eating disorder treatment program is an important first step to providing better care to this unique population.

E2. **A Preliminary Eye-Tracking Investigation of Attentional Biases and Body Dissatisfaction**

Kaylee Misener, MA, University of British Columbia, Kelowna BC (Presenting)
Stefanie Ciszewski, MA, University of British Columbia, Kelowna BC (Presenting)
Maya Libben, PhD, University of British Columbia, Kelowna BC

Learning Objectives:

1. Understand the implications for cognitive biases present in body dissatisfied individuals.
2. Explain attentional biases to body shape images among individuals with body dissatisfaction.
3. Recognize the avenues for the use of eye-tracking technology in the assessment of attentional biases.

Abstract:

Background: Body dissatisfaction has been reliably supported as one of the primary risk factors for eating disorders (Stice, 2002; Stice, Ng, & Shaw, 2010). There is a large body of literature demonstrating that individuals who are body dissatisfied present with attentional biases that are indicative of harsh evaluation of one's own body (e.g., Glashouwer, Jonker, Thomassen, & de Jong, 2016). The literature is less clear, however, on which attentional biases may be present in the interpretation of other bodies.

Individuals with body dissatisfaction may not only demonstrate attentional biases towards their own bodies but also towards the shape and size of other bodies. One such attentional bias may be disengagement difficulty whereby individuals have difficulty shifting attention away from another body (e.g., fat or thin), even after the stimuli is no longer present. For example, Gao and colleagues (2013) found that participants high in body dissatisfaction demonstrated disengagement difficulty from body stimuli, as determined by reaction time data. To date, no study has examined the relationship between body dissatisfaction and disengagement difficulty from other body-related cues and non-body related cues using eye tracking methodology. Objectives: The objective of the present study was to examine attentional processing of body related stimuli as a function of body dissatisfaction using a modified spatial cueing paradigm. Furthermore, using eye tracking methodology the present study examined attentional bias in the form of disengagement difficulty from control body images, fat body images, and thin body images. Method: Participants included 43 female undergraduates (*M*age = 19.58; *SD* = 1.68) who completed a self-report questionnaire measuring body dissatisfaction (Body Shape Questionnaire-34 [BSQ]; Cooper, Taylor, Cooper, & Fairburn, 1987), and participated in a modified spatial cueing paradigm. Results: A factorial repeated-measures ANOVA revealed a significant interaction between type of image presented and BSQ score for first fixation time (FFT), $F(2, 41) = 4.05$, $p = .025$, partial $\eta 2 = 0.165$. Individuals with high BSQ scores demonstrated disengagement difficulty from images of thin bodies, compared to individuals with low BSQ scores, as evidenced by higher FFTs for letters preceded by images of thin bodies. Individuals with low BSQ scores demonstrated disengagement difficulty from images of fat bodies, compared to individuals with high BSQ scores, as evidenced by higher FFTs for letters preceded by images of fat bodies. Conclusion: Further examination of the relationship between cognitive biases and body dissatisfaction remains an important area of study. Findings from the present study suggest that not only is it important to consider attentional biases towards one's own body but that attentional biases towards others' bodies may be an important avenue to inform prevention and treatment. Future research should investigate the relationship between attentional biases towards others' bodies and eating disorder pathology.

E3. **Correspondences Between Plasma Nutrient Levels and DNA Methylation Patterns in Individuals with Anorexia Nervosa**

Jessica Burdo, BA, McGill University, Montreal QC (Presenting)
Esther Kahan, BSc, Douglas University Institute, Montreal QC
Lea Thaler, PhD, Douglas University Institute, Montreal QC
Xiaoyan Fang, BA, McGill University, Montreal QC
Mimi Israël, MD, Douglas University Institute, Montreal QC
Linda Booij, PhD, McGill University, Montreal QC
Luis B Agellon, PhD, McGill University, Montreal QC
Kevin McGregor, MSc, McGill University, Montreal QC
Aurelie Labbe, PhD, HEC Montreal, Montreal QC
Howard Steiger, PhD, Douglas University Institute, Montreal QC
Keelin Greenlaw, MSc, Concordia University, Montreal QC

Abstract:
Background: Current thinking has it that AN often arises through the activation of latent genetic potentials by environmental exposures. Epigenetic mechanisms provide an avenue for exploring how the environment can modify gene expression on a molecular level. The most commonly studied epigenetic mark, DNA methylation, is an environmentally responsive process that usually results in the silencing of gene expression. Notably, nutrients such as folate, betaine, methionine, B12, and choline are directly implicated in the 1-carbon metabolism pathway that allows for methylation of DNA. Since individuals with AN (by definition) severely restrict their nutrient intake, it is plausible that altered DNA

methylation in the disorder might be attributable directly to nutritional factors. Objectives: To compare plasma levels of micronutrients involved in the methylation pathway between three groups: AN-Active (n=42), AN-Remitted (n=32) and no eating disorder (NED: n=30). To examine the relationships between global and site-specific methylation levels, and plasma levels of micronutrients involved in the methylation pathway within each group. Design/Method: AN-Active participants were recruited from the Eating Disorders Continuum at the Douglas Institute and met full criteria for AN according to DSM-5. AN-Remitted were individuals who once met full criteria for AN, but had been symptom free for at least one year. NED participants had no history of an eating disorder, or psychotropic medication use. Plasma was separated from whole blood and measured for micronutrients levels. Choline, betaine, and methionine were analyzed using mass spectrometry, while folate and B12 were analyzed using the AccuBind® ELISA kit. DNA was obtained from lymphocytes, and processed through the Illumina Infinium® HumanMethylation450 BeadChip Kit. Results/Discussion: Preliminary analyses suggested that, relative to NED controls, AN-Active people had higher levels of B12 (p=.01) and betaine (p=.02), and AN-Remitted participants had higher levels of B12 (p=.03). Contrary to our expectation that micronutrient levels would be depleted in Active AN, we observed no group differences in choline (p= .83), and elevations on Betaine and B12. We further found methionine levels to be negatively correlated with global methylation; a finding that held for AN-Remitted (r=-.50, p=.02) and NED participants (r=-.47, p= .04), but not for AN-Active participants. The latter suggests that a unique relationship between the one-carbon micronutrients and methylation may exist for individuals with active AN. Analyses now-underway examine group-based effects on probe-specific methylation levels, and will help clarify the relationships between micronutrients and methylation levels in AN. Conclusion: Our results suggest that people with AN show elevations on some nutrient levels and do not exhibit the same negative correlation between methionine and global methylation as Remitted and NED-Control individuals, and are consistent with the hypothesis that nutritional factors implicated in DNA methylation may indeed have a role in AN. Such findings might help elucidate mechanisms underlying altered DNA methylation in the AN population, and could pave the way to development of more precise etiological models of the disorder and, eventually, to novel nutritional or pharmacological treatments.

E4. **Determining the Effectiveness of Three Online Expressive Writing Interventions in Reducing Bulimic Symptoms in a Non-Clinical Sample**

Kheana Barbeau, PhD Candidate, University of Ottawa, Ottawa ON (Presenting)
Kayla Boileau, PhD Candidate, University of Ottawa, Ottawa ON
Camille Guertin, PhD Candidate, University of Ottawa, Ottawa ON
Luc Pelletier, PhD, University of Ottawa, Ottawa ON

Abstract:
Background: With increasing incidence rates of eating disorders and sub-clinical symptoms in community samples, online interventions may be the most cost-effective and efficient method of prevention and treatment. Online expressive writing interventions have been shown to improve body image and decrease disordered eating; however, the heterogeneity of these interventions is vast and they often lack a comparator that restructures body image cognitions in different ways. Furthermore, these interventions often do not distinguish between eating disorder symptom severity, which would help to determine whom the intervention works best for. Objectives: The objectives of this study were 1) to compare three commonly used expressive writing interventions that have been shown to decrease negative body image and 2) to examine the relationships between bulimic symptom severity and various constructs. Methodology: Female undergraduate students and community members (*n* = 89) were randomly assigned to a self-compassion (SC) writing condition, a self-esteem (SE) writing condition, or a non-structured expressive (NE) writing condition. They completed measures of self-compassion, self-esteem, body appreciation, body inflexibility and bulimic symptoms at baseline (one week before

starting the writing tasks) and at post-test (one day after the last writing task). They completed writing tasks for seven consecutive days. Research ethics were obtained. Results: A series of mixed-design repeated measures ANCOVAs were conducted to determine the main effects and interactions for each dependent variable. Paired samples t-tests were conducted to examine changes in each dependent variable from pre- to post-test according to bulimic symptom severity (high or low) and condition. There was a marginally significant main effect for time in self-compassion ($p$ = .058): there was a trend for individuals in the SC and NE conditions to increase in self-compassion over time; however, those in the SE condition decreased in self-compassion. There was a significant main effect for time in self-esteem ($p$ = .004): individuals in every condition significantly increased in self-esteem. A planned comparison paired samples t-test revealed that this trend was strongest in the SE condition in individuals with lower bulimic symptoms ($p$ = .009), followed by individuals in the SC condition with higher symptoms ($p$ = .020), and individuals in the NE condition with lower symptoms ($p$ = .054). A main effect of time was approaching significance in body appreciation ($p$ = .065), with every condition showing increases in body appreciation over time. There was also a marginally significant time by condition interaction in body image inflexibility ($p$ = .055), with only the NE condition decreasing over time. This trend was especially strong in those with higher bulimic symptoms, $t(30) = 2.35$, $p$ = .038. A time by symptom interaction was also approaching significance in bulimic symptoms ($p$ = .058): there was a trend for individuals with higher symptoms at baseline to decrease in symptoms over time. Conclusion: Results suggest that expressive writing is beneficial in decreasing eating disorder symptoms, with self-compassionate and non-directed expressive writing interventions being most beneficial for women with higher bulimic symptoms, emphasizing the importance of tailoring online interventions to symptom severity.

E5. **Perceived Helpfulness of Meal Support within an Eating Disorder Day Treatment Program and Considerations for the Implementation of Dinners**

Felicia M Chang, PhD Candidate, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)
Corien Peeters, PhD, Children's Hospital of Eastern Ontario, Ottawa ON
Fiona Meek, MEd, Children's Hospital of Eastern Ontario, Ottawa ON
Wendy Spettigue, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Lisa Cook, MSW, Children's Hospital of Eastern Ontario, Ottawa ON

Learning Objectives:

1. To understand perceived helpfulness of meal support in a DTP.
2. To provide practical considerations for the implementation of dinners in an eating disorder DTP for adolescents.

Abstract:

Background: Meal support is a key component of many eating disorder day treatment programs (e.g., Henderson et al., 2014, Zipfel et al., 2002). This Day Treatment Program (DTP), at a pediatric hospital, operated five days per week and provided meal support for breakfast, lunch and snacks. Patients' perceived helpfulness of meal support and the potential helpfulness of the addition of dinners to the program was assessed. Design/Method: Semi-structured telephone interviews were conducted among 17 adolescents (15 female, 2 male) who participated in a hospital-based eating disorder DTP. Participants were asked to rate how helpful various aspects of the DTP were, including meal support, on a scale from 1(*Not at all helpful*) to 5 (*Extremely helpful*). Participants also responded to questions about how helpful dinners might have been if they were part of the program. Many participants provided additional comments about dinners, beyond the questions they were asked, and these comments were analyzed for key themes. Results/Discussion and Conclusion: Meal support for breakfast, lunch, and snacks was rated as very helpful by former participants of the DTP ($M$ = 4.12, $SD$ = 1.22), and was among the most highly rated components of treatment in terms of helpfulness. Adding dinners to the DTP

appeared acceptable to most participants. Only 4/17 individuals indicated that they would not have participated in the program if it included dinners and none of the participants rated the potential helpfulness of dinners as "not at all helpful." The average potential helpfulness rating for dinners was 3.71 (*SD* = 0.99). Although participants were not asked open-ended questions about the potential helpfulness of dinners, it is of note that some participants indicated that occasional dinners would be helpful, but that having dinners every day would reduce their opportunities to practice eating at home. Weekly multi-family dinners appear to be less acceptable to youth. Almost 50% of participants (*n* = 8) rated the potential helpfulness of multi-family dinner as "not at all helpful," and concerns about eating in front of others and parents' abilities to support their children were reported. These findings provide practical considerations for the implementation of dinners in a DTP (e.g., perhaps dinners should be 3 or 4 times per week rather than 5 days a week).

E6. **Predictors of Outcome in Eating Disorders Treatment: Readiness, Self-Compassion, and Fear of Self-Compassion**

Megumi Iyar, BA, St. Paul's Hospital, Vancouver BC
Yuan (Joanne) Zhou, BA, St. Paul's Hospital, Vancouver BC
Suja Srikameswaran, PhD, St. Paul's Hospital, Vancouver BC
Josie Geller, PhD, St. Paul's Hospital, Vancouver BC (Presenting)

Learning Objectives:

1. Discuss baseline levels of readiness, self-compassion and fear of self-compassion in a residential inpatient treatment setting.
2. Discuss the utility of readiness, self-compassion and fear of compassion in predicting clinical outcome variables (i.e., improvements in eating disorder symptoms, quality of life).
3. Discuss the utility of readiness, self-compassion and fear of compassion in predicting treatment process variables (i.e., early discharge).

Abstract:

Background: Readiness has been shown to be a consistent predictor of clinical outcome in the eating disorders. There is also growing interest in the role of self-compassion in recovery for this population. Objectives: This study examined the relative contribution of readiness, self-compassion and fear of self-compassion in predicting i) clinical outcome variables: improvements in eating disorder symptoms and quality of life and ii) treatment process variables: tube feeding, meal replacement, early discharge. Methods: Participants were recruited from two treatment settings: inpatient treatment focusing on assessment and stabilization, and residential treatment focusing on skill acquisition and full recovery. Inpatients (n = 90) and residential patients (n = 60) completed measures of readiness, self-compassion, fear of compassion, symptom severity and quality of life upon admission and discharge. Results: Consistent with previous research, readiness was a significant predictor of all clinical outcome and treatment process variables in both programs. Readiness to change dietary restriction was associated with eating-related variables (replacement, tube feeding and eating disorder symptom change), and global readiness (a composite of all symptom domains) was associated with early discharge and improved quality of life. A second, new clinical outcome predictor emerged: in residential treatment, fear of self-compassion explained unique variance in symptom change and quality of life after controlling for baseline readiness. Conclusion: These findings replicate the central role of readiness in predicting outcome in two intensive treatment settings, and suggest there may be different utility for symptom specific vs. global readiness scores. The emergence of fear of self-compassion as a predictor of symptom change suggests that this may be a second variable to target in eating disorder treatment.

E7. **SSRI Use in Adolescent Eating Disorders: A Retrospective Chart Review**

Wendy Spettigue, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenting)

Mark L Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON
Nicole Hammond, MA, Children's Hospital of Eastern Ontario, Ottawa ON
Katherine Yelle, MD, Children's Hospital of Eastern Ontario, Ottawa ON
Emily Seale, Children's Hospital of Eastern Ontario, Ottawa ON
Noreen Rahmani, Children's Hospital of Eastern Ontario, Ottawa ON
Nicole Obeid, PhD, Children's Hospital of Eastern Ontario, Ottawa ON
Learning Objectives:
1. Describe the clinical characteristics of youth with EDs who were referred to a specialized pediatric ED team in a tertiary care hospital over a one-year period.
2. Examine the use of SSRIs by clinicians treating this population, including reasons for starting an SSRI, when the SSRI was initiated and at what doses, the most common SSRIs prescribed, and the percentage of patients who were switched to a second or third SSRI.
3. Identify the need for further psychopharmacological research to guide clinicians who treat youth with EDs in Canada.
Abstract:
There is a lack of research to support the use of psychotropic medications in adolescent eating disorders (EDs), yet these medications are widely used. This study is a descriptive review of the psychopharmacological medications prescribed to youth with EDs, with detailed focus on the use of SSRIs in this population. A retrospective chart review of 60 consecutive referrals to a tertiary care pediatric ED program in Ottawa, Canada was conducted. Included patients were assessed between January 1 – December 31, 2014, and received an ED diagnosis at time of assessment. Patient outcomes were tracked for an 18 month period post-assessment. The average age of patients at assessment was 14.0 years old. 70% of patients were diagnosed with AN at assessment, 14% were diagnosed with EDNOS, 10% with ARFID and 3% with BN. Average percentage of treatment goal weight (TGW) at assessment was 82.4%. Psychotropic medications were prescribed to 72% of patients during the course of treatment, of which, 79% were prescribed SSRIs. The initial SSRI was prescribed on average 20.0 weeks after assessment; the average percentage of TGW at the time of initiation of an SSRI was 94.6%. Reasons for starting an SSRI were: Anxiety disorder 41%, Mood disorder 9%, both Mood and Anxiety disorder 41%, Other reasons 9%. Of those treated with SSRIs, 61.8% were treated with one SSRI, 29.4% switched to a second SSRI, and 8.8% switched to a third. The most common SSRI prescribed was fluoxetine (82%) (at a mean maximum dose of 41.0 mg); the other most common SSRIs prescribed were sertraline (29.4%) and escitalopram (29.4%). These results show that SSRIs are widely used by specialists to treat co-morbidities in weight-restored youth with EDs.

E8. **The Impact of Product Health Descriptions and Serving Size Information on Consumption**
Breeanna Streich, BA, Laurentian University, Sudbury ON (Presenting)
Michael Emond, PhD, Laurentian University, Sudbury ON
Learning Objectives:
1. Discuss how modifying serving size information on packaging can influence consumption.
2. Recognize the influence of subtle changes in packaging/marketing on health perceptions.
Abstract:
Background: Research has shown that package labelling, as well as marketing can impact health expectations and consumption levels. For example, studies have shown that consumption increases when a food is presented with a description that focuses on the health benefits of the product and ignores any mention of ingredients that are associated with weight gain (Provencher, Polivy, & Herman, 2009). Objective: The main goal of this study was to investigate the effects of manipulating product health descriptions and serving size information on actual calorie consumption and estimations of calorie consumption. Method: In a 3 (no description vs. healthy description vs. unhealthy description)

by 2 (normal serving size information vs. larger serving size information) factorial design, 150 females over the age of 18 were invited to partake in a "taste test" of an oatmeal cookie product. Results: In terms of consumption, it was found that participants who received the larger serving size information, which was double that of the normal serving size information presented on traditional packaging, consumed significantly less (M=139.92, SD=98.88) than those who received the normal serving size information (M=197.98, SD=145.96). Participants therefore consumed approximately 42% more when they were presented the normal serving size information (140 calories) compared to the larger serving size information (280 calories). When looking at overall accuracy of calorie estimations, it was found that those who received the larger serving size information were significantly more accurate at estimating their actual calorie consumption (M=57.42, SD=73.97) than those who received the normal serving size information (M=94.70, SD=109.68). In addition, participants presented with a healthy product description were significantly more likely to underestimate the amount of calories they consumed during the experiment (M=-52.70, SD=92.25) than those who received no product description (M=-6.72, SD=132.81) or an unhealthy product description (M=7.89, SD=127.14). Thus, product descriptions as well as serving size information can have a significant impact on calorie consumption and an individual's estimation of their perceived calorie consumption. Discussion: The results of this study demonstrate that changing the serving size information displayed on packaging can significantly impact a person's health perceptions of a product, in turn influencing their consumption. Therefore, this is an area of research that should continue to be investigated, as it is important to determine optimal strategies to increase product health awareness ensuring that consumers can make informed choices regarding what they purchase and how much they consume.