At the Heart of it All

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Eating Disorders
Association of Canada
Association des Troubles
Alimentaires du Canada

ABSTRACTS

Thursday, September 29th

Paper Presentations I

Early Identification of Eating Disorders: A Mixed Methods Pilot Study

Ahmed Boachie, Karin Jasper, and Laura Rogers

Introduction: Background, Purpose, and Rationale. Children and adolescents with early onset eating disorders, who receive prompt treatment, show better outcomes particularly with family-based treatment. Parents may notice subtle changes in their children and their eating habits before there are any medical consequences that allow a family doctor to formulate an eating disorder diagnosis and may take their child to the doctor many times before getting a diagnosis. The purpose of this pilot study was 1) to learn whether parents would identify common early warning signs prior to seeking help for their children; 2) to learn what barriers and facilitators parents found to getting help once they sought it; and 3) to learn family physicians' current awareness of early warning signs of eating disorders and the extent to which they manage eating disorders in their own practices.

Methods. Parents whose children attended our program were invited to participate in focus groups to discuss their experiences and to make suggestions on how to improve early identification. Each group was audio taped and written notes were simultaneously taken by a research assistant. The audiotapes were then transcribed and content was coded and categorized. Physicians who had referred patients to our program were contacted by phone and invited to consider completing a survey with multiple choice questions requiring about 5 minutes of their time. Survey responses were compiled.

Results/Discussion. There was considerable overlap in the changes parents identified in their children leading up to their seeking help, including changes in mood, physical symptoms, social interactions, and eating patterns. Most but not all parents reported barriers to getting help including self-imposed barriers and difficulties getting an accurate diagnosis. Physicians were effective in recognizing classic eating disorder symptoms but most did not recognize the non-specific symptoms characteristic of early onset. All physicians who completed the survey endorsed as either likely or very likely that they would use measures that could facilitate early identification.

Conclusion. Parents should be seen as key informants in early identification of eating disorders. Family physicians, with appropriate supports, are in a unique position to identify eating disorders early. Working together, family physicians and parents can change the course of eating disorders.

Learning Objectives:

Participants will be able to:

1. Explain the rationale for developing strategies for early identification of eating disorders,
2. Identify commonly observed early warning signs of eating disorders,
3. Recognize the roles that parents and family physicians can play in early identification.

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Treatment Outcomes for Adolescents in an Intensive Day Treatment Program for Eating Disorders

Jennifer S. Coelho, MacKenzie Robertson, Katie Coopersmith, Pei-Yoong Lam & Jadine Cairns

Background and Objectives. Day treatment programs for youth with eating disorders provide support for individuals who are medically stable, but require more intensive support than outpatient modalities are able to offer. The goals of our day treatment program are to decrease youth eating disorder pathology, support youth to get back into their life, and empower parents and caregivers in their involvement in their child's recovery. With these goals in mind, the youth and their caregivers who began treatment were invited to complete self-report questionnaires at admission and discharge.

Methods. Youth measures assessed eating pathology (Youth Eating Disorder Examination-Questionnaire, YEDE-Q) and patient-identified functional goals (Canadian Occupational Therapy Measure, COPM), and caregiver questionnaires assessed self-reported accommodation of their child's eating disorder symptoms (Accommodation and Enabling Scale for of Eating Disorders, AESED). Additionally, patient demographic data and anthropometric measures (e.g., weight, height) were collected as part of routine care.

Results. A total of 37 youth have participated in the outcome study to date, with full data available for a subset of the sample. Preliminary analyses indicate that eating pathology significantly decreased from admission to discharge ($t(26) = 3.44$, $p < .01$) and performance and satisfaction with functional goals (as measured by the COPM) increased from admission to discharge, $t(20) = 4.10$, $p < .01$; $t(20) = 5.23$, $p < .01$. For youth with weight restoration as a treatment goal, weight significantly increased from admission to discharge, $t(36) = 6.42$, $p <.001$. Caregiver accommodation of eating disorder symptoms also decreased over the course of treatment; however, this decrease did not reach statistical significance, $t(18) = 1.93$, $p = .07$.

Discussion. The current study provides support for the effectiveness of day treatment programs for youth with eating disorders. The role of day treatment programs in the continuum of care for youth with eating disorders will be discussed.

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Keeping Schools Safe: What Proportion of Patients with Eating Disorders Cite School Experiences as a Primary Trigger for ED Onset?

Mark L. Norris, Nicole Hammond, Wendy Spettigue

Introduction. In the last five years Provinces in Canada have adopted public health practices and policies to promote healthy weights that have led to school-wide healthy eating and healthy weight initiatives. To date, there has been little research that has examined the impact (positive or negative) of such initiatives. The objective of this study was to investigate the frequency that school-specific educational experiences were cited at initial Eating Disorder (ED) assessment as being a specific trigger for ED onset.

Methods. A retrospective chart study was completed. Patients between the ages of 8.5 and 15 years were included. Our institution's Research Ethics Board approved the study.

Results. A total of 181 patients were retained. The mean age of all patients was 13.4 years (SD = 1.3 years); 92 of the sample was female. The majority of patients were diagnosed with anorexia nervosa (59). Over half (56.4) were admitted at or immediately after the assessment, suggesting a severe ED. Approximately 11 of the sample noted school-based teaching/ education as a specific trigger for ED onset, of which 2/3 were assessed within the last 5 years, coinciding with the introduction of obesity prevention practices. Other relevant school-related triggers involved peer issues (41), weight-based bullying (22), and issues related to school sports (8).

Discussion. Adverse experiences at school are frequently cited as specific triggers for ED development. Policy makers, educators and clinicians with expertise in both obesity and EDs should work synergistically to ensure that targeted weight-based health promotion results in optimized outcomes for youth and does not inadvertently increase risk for EDs.

Learning Objective 1: Describe how school-wide healthy eating and healthy weight initiatives have been introduced in Canada.
Learning Objective 2: Describe how school and education-related experiences act as triggers for eating disorder onset.
Learning Objective 3: Discuss how policy makers, educators and clinicians with expertise in both obesity and EDs need to work synergistically to ensure that targeted weight-based health promotion results in optimized outcomes for youth without increased risk for adverse events.

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Asceticism, Perfectionism and Overcontrol in Youth with Eating Disorders

Nicole Obeid, Shannon Bedford, Wendy Spettigue, Mark Norris

Background: Certain combinations of personality characteristics have been identified as risk factors for eating disorders. Overcontrol is a composite of both perfectionism and asceticism and is characterized by rigid, self-punishing, and high-striving cognitions and behaviours; however, little is known about the effects of these traits on eating disorders.

Objective: This study investigates asceticism, perfectionism, and overcontrol in a large clinical sample of youth with eating disorders, and will explore diagnostic differences, psychological correlates of these traits, and the predictive value of these personality characteristics on refractory status and length of stay.

Method: The data was obtained from the clinical charts of 278 youth aged 13-18 years who were assessed for an eating disorder at a pediatric tertiary care facility between 2008 and 2015. This secondary data analysis study relied on well-validated self-report measures of eating disorder cognitions and attitudes, depression and anxiety symptoms, in addition to diagnosis determined by a physician during the initial intake assessment process.

Results: Tests for diagnostic differences found that overcontrol, asceticism, and perfectionism were consistently lower in the anorexia nervosa group compared to the bulimia nervosa or eating disorder not otherwise specified group. Correlation analyses revealed moderate to high associations between perfectionism, asceticism, overcontrol and anxiety and depressive symptoms (ranging from r=.302 to r=.883), although regression analyses determined asceticism and perfectionism did not predict refractory status or length of stay as predicted.

Conclusion: Findings of this study indicate diagnostic differences in perfectionism, asceticism and overcontrol in youth with eating disorders. Similarly, results indicate that these traits are related to symptoms of depression and anxiety, and that those with a diagnosis of anorexia nervosa are least likely to report high levels of these personality characteristics. Implications for treatment efforts provide guidance around trying to lift symptoms of overcontrol in order to potentially aid with comorbidities related to the eating disorder. Future studies examining the mechanism by which overcontrol operates within this population are merited.

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Classic Hallucinogen Use is Inversely Related to Disordered Eating and Mental Health Issues: Exploring Mechanisms of Action

Michelle S. Thiessen, Zach Walsh, Adele Lafrance Robinson, & Brian Bird

Prior research has broadly identified substance use as a risk for negative psychosocial outcomes. However, recent evidence suggests that among a representative sample of adults in the USA, hallucinogen use was associated with reduced global psychological distress (Hendricks at al., 2015; Krebs & Johansen, 2013), and among individuals with histories of substance abuse, outcomes were improved when compared to hallucinogen naïve individuals (Hendricks et al., 2014; Walsh et al., 2016). To our knowledge no research has systematically examined the association between hallucinogen use and eating disorders. Although the mechanisms of action remain poorly understood, the use of hallucinogens has been proposed to facilitate emotional regulation (Vollenweider & Kometer, 2010), and recent evidence suggests that emotional dysregulation may account for some differences in disordered eating and eating disorders (Lafrance Robinson et al., 2013). In the present study, we examine hallucinogen use, dietary restraint, and emotional dysregulation among a community sample of 927 adult respondents to an online survey. Logistic regression analyses indicated that lifetime classic hallucinogen use was associated with lower levels of emotional dysregulation (F(925, 1) = 6.73, p < .01) and decreased likelihood of dietary restraint (Exp(B)=.62, 95 CI: .47-.80). Although the association between hallucinogen use and dietary restraint remained after accounting for emotional dysregulation (Exp(B)=.65, 95 CI: .50-.86), the Sobel test indicated that the association was partially mediated (z’ = -2.42, p = .02). These findings provide preliminary evidence of an inverse relationship between hallucinogen use and disordered eating, and suggest that emotional regulation may play a role in this association. These findings add to increasing evidence of the potential of psychedelic medicines to address behavioral disorders. Given the insufficiency of treatments for eating disorders, findings such as these suggest value for further study of the potential of psychedelic interventions and they are in line with a recent issue published by the Canadian Medical Association highlighting a re-emerging therapeutic paradigm worthy of consideration.

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Deep Brain Stimulation for Anorexia Nervosa- One year outcome in 16 subjects

Blake Woodside, Andres Lozano, Nir Lipsman, Eileen Lam

Background: Anorexia Nervosa is a serious medical illness with high rates of chronicity and mortality. Few treatments are available for those who do not respond to traditional approaches. We have been investigating the utility of Subgenual Cingulate Deep Brain Stimulation(DBS) in chronic, treatment-resistant Anorexia Nervosa.

Objectives: To present clinical, psychometric and imaging data on subjects at one-year follow up post surgery.

Methods: This study was approved by the Research ethics board at the University Health Network. Subjects were assessed independently by two psychiatrists before enrollment in the study. Subjects underwent pre-surgical clinical, psychometric, and imaging assessment. Imaging was performed by Positron Emission Tomography. Post implantation, subjects were assessed at 1,3,6 and 12 months in a fashion identical to the pre-surgical assessment.

Results: Data is available on 16 subjects. The average age of the sample is 34 years, with an average duration of 17 years. BMI is significantly improved at 12 months(p=0.001). At 12 months, 9/16(56) of subjects had a BMI of>17, and 6(38) had a BMI of >18.5. Rates of bingeing and purging declined by 67 and 56 respectively, with 38 of bingers and 44 of purgers abstinent. There were wide-ranging improvements in depression, anxiety, obsessionality, some areas of ED psychopathology, emotional regulation, and quality of life(all p<.01). One subject withdrew from the study at 6 months, and a second opted to have her stimulator turned off at 9 months. There have been few adverse events. Analysis of imaging data is ongoing.

Discussion: DBS appears to be acceptable to a sub-group of those suffering from the more severe, chronic form of Anorexia Nervosa. The procedure is tolerated well and there are few adverse effects reported. Subject report improvements across a wide range of clinical and psychometric variables. It would be valuable to conduct a blinded study to confirm that these findings are not the result of a complex placebo effect.

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“Reexamining the role of exercise in relationship to Eating Disorders; Symptom and Treatment?”

Danika Quesnel, Marianne Clark, Cristina Caperchione

Background: Excessive exercise is a symptom often displayed by those with eating disorders (EDs). Recently, exercise prescription has been explored to help manage this symptom and improve overall prognosis. However, exercise is generally abstained from in treatment. There continues to exist controversy surrounding exercise's role in relationship to EDs and no formal protocol exists to guide management efforts. To facilitate formal management of exercise in EDs and to further understand the potential of exercise prescription in treatment, it is necessary to gain an in-depth understating of the perspectives of those currently working in this area about the role of exercise in relationship to the management of treatment of EDs.

Objective: The purpose of this study is to explore the perceptions and beliefs of ED health professionals concerning exercise as a supportive treatment to EDs. More specifically, this paper will examine how these health professionals describe the existing beliefs and perspectives about the role of exercise that currently shape their practice.

Methods: Purposeful sampling was used to select a panel (n=13) of international ED health professionals from both clinical and research backgrounds. Participants were selected based on their explicit interest (research or personal) in exercise prescription in EDs, their total time working in the field and their level of education. Explorative semi-structured interviews were conducted to capture participants' insights into the role of exercise in treatment and management of EDs. Interviews sought to elicit in-depth and rich detail about the controversy surrounding exercise in EDs and about the current role it holds in treatment. Interviews were transcribed verbatim and data was analyzed using thematic analysis supported by NVivo.

Results: Results suggest that despite the lack of established guidelines and the counter-intuitive nature of utilizing exercise as a supportive treatment for EDs, various forms of exercise are beginning to be more readily incorporated into public and private treatment settings. This emerging incorporation and management of exercise in ED treatment suggests the overall perceptions about exercise are shifting away from previously held positions that advocated abstinence. Data further suggest that researchers who explore exercise prescription in EDs and clinical health professionals who work closely with ED patients hold distinctly different views about exercise prescription in EDs. Clinical experts tended to view the role of exercise in treatment as "taboo" and approached the topic with extreme caution. Conversely, those participants identified as researchers reported confidence in this treatment approach and advocated for more comprehensive research focusing on the integration of exercise in ED treatment. This paper will articulate these tensions in greater detail and outline potential strategies for narrowing the gap between the two perspectives.

Conclusion: The utilization of exercise in the treatment of EDs is emerging as an important issue for those working in the area of EDs in both a research and clinical context. More comprehensive research and knowledge translation efforts that explicitly focus on this approach are necessary for negotiating these tensions and advancing our understanding of this complex issue.

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A Pilot Study of Cardiac Abnormalities in Anorexia Nervosa Patients based on Electrocardiogram, Echocardiogram, and Cardiac Magnetic Resonance Imaging

Karen Chu, Ilan Buffo, Margo Lane, Louis Ludwig, Davinder S. Jassal, Daryl Schantz

Background: Anorexia nervosa (AN) is a medical condition where restriction of energy intake leads to a lower body weight than is minimally expected for age, gender, and developmental trajectory. It has a higher mortality compared to other psychiatric diseases and is associated with numerous cardiac complications including sinus bradycardia, decreased heart rate variability, repolarization abnormalities, hypotension, orthostatic tachycardia, decreased myocardial mass, myocardial dysfunction, and pericardial effusions. Cardiac involvement in anorexia nervosa is usually diagnosed with electrocardiograms (ECGs) to identify electrical abnormalities and transthoracic echocardiography (TTE) to evaluate for structure and functional abnormalities. However, TTE is limited by patient windows and does not allow for assessment of changes to the myocardium, including edema or scarring (known as tissue characterization). Cardiac magnetic resonance imaging (CMR) is a modality that overcomes the limitations of poor acoustic windows and tissue penetration allowing for a more accurate assessment of ventricular volumes, function, measurement of myocardial mass; it also provides information on tissue characterization.

Objective: Our objective is to characterize baseline CMR findings in adolescent and young adult patients who have been diagnosed with severe anorexia nervosa, including detecting the presence of abnormal cardiac mass, left ventricular function, pericardial effusion.

Design/Method: We conducted a pilot study to assess the frequency and severity of abnormal cardiac findings in severe anorexia nervosa patients during CMR imaging. We recruited 16 patients from the Health Sciences Centre Child and Adolescent and Adult Eating Disorders Services with a weight at diagnosis < 80 of expected body weight. Subjects underwent CMR protocoled to assess cardiac anatomy and functional assessment. Our results will be compared to published normal values. Results were analyzed using descriptive statistics.

Results: Sixteen patients (all female) were scanned with a mean age of 17 (13-22) years (mean height 166 (155-211) cm, weight 55.3 (44.2-81.4 kg), body surface area 1.59 (1.35-2.18) m2). There was a significant decrease in left ventricular volumes, mass, and ejection fraction. Right ventricular volumes mass and ejection fractions were also decreased, except for end-systolic volume, when compared with published normal values.

Conclusion: We found significant changes to cardiac parameters in adolescents and young adults with severe AN when evaluated by CMR. Our study is the first study to document decreased right ventricular mass in patients with severe AN.

Table 2. Cardiac MRI findings in our study population compared with a reference values

Parameter	Study population Mean+/-STD(range)	Adult reference values (females) Mean+/-STD(range)	p value
LV ejection fraction	55.7+/-5.6 (47.6-67)	69+/-6(57-81)	<0.001
RV ejection fraction	53.9+/-4.8 (41-67.8)	63+/-5(53-73)	<0.001
LV mass/BSA	45.8+/-5.0(37.1-52.5)	54.6+/-12(31-79)	<0.001
RV mass/BSA	17.3+/-3.9(5.8-23.5)	20+/-3.5(13-27)	0.022
LV EDV/BSA	65.6+8.0/-(54.5-84.2)	78+/-12(54-102)	<0.001
RV EDV/BSA	65.2+/-10.3(39.8-78.8)	84+/-17(50-118)	<0.001
LV ESV/BSA	29.2+/-6.1(20.1-44.1)	24+/-6(13-36)	0.007
RV ESV/BSA	29.8+/-6.3(21.1-42.5)	32+/-10(12-52)	0.316
LV Stroke volume/BSA	36.4+/-4.4(36.6-44.4)	54+/-9(36-72)	<0.001
RV stroke volume/BSA	35.3+/-8.4(16.4-51.0)	53+/-9(35-71)	<0.001

Abbr: BSA: body surface area, EDV/ESV: end diastolic/systolic volume, LV: left ventricular, RV: right ventricular

Thursday, September 29th

Workshop Session I

Longer Term Outcomes and Length of Stay in a Day Hospital Program for Children and Adolescents

Ahmed Boachie, Karin Jasper

Background: Day treatment provides an intermediate level of care between weekly outpatient service and inpatient or residential treatment. It is far more intense than the former and much less expensive than the latter. Adolescents who need day treatment often have complex presentations that include co-morbid depression, anxiety, OCD, ADHD, trauma, or cluster B traits and many also live in challenging situations with cultural or immigration issues, parent mental health disorders, abuse, or other issues. These likely play a role in the rate and length of recovery required. This workshop will describe the adaptation of family-based treatment principles to a day hospital program that aims to bring patients with these complex presentations to remission.

Case Presentations: Two cases will be presented that will illustrate the importance of not rushing patients to discharge. Length of stay should not always be the priority measure to evaluate success in outcomes.

Research Study. A qualitative research study of longer term outcomes of our day treatment program will be described. This is the first study of its kind. Purpose: to learn about the longer-term outcomes of those who attended our program as adolescents between the ages of 13 and 18.

Method: Semi-structured qualitative interviews were conducted via telephone with patients who had been out of day treatment for between three and thirteen years. An independent psychologist with training in qualitative research analyzed interview transcripts using a Grounded Theory approach.

Results: In spite of having had complex eating disorders, most participants reported maintaining adequate weight, recovering and maintaining menstruation, and attending college or university. Themes related to positive impacts of the program included self-knowledge and confidence, better relationships, and improved mood. Length of stay of the participants ranged between 3 and 15 months.

Interactive Component: Participants are invited to join the case study discussions throughout and there will be time for Q & A in the last fifteen minutes of the workshop.

Discussion: Day hospital is an intensive treatment suited to the needs of adolescents who are acutely ill but medically stable. For parents who have never seen their children doing well, single family or multifamily therapies may fail while day treatment can provide the intensity and length of treatment required to reach remission. It is the ideal setting in which to identify co-morbid conditions that may be treated there or may require transfer to other facilities. It can also be a step down from inpatient service for those who need continued intensive treatment at the same time saving health care dollars. Successful outcomes in day hospital may help minimize use of the limited residential treatment available.

Learning Objectives:

Participants will be able to:

1. Describe how family based treatment principles can be adapted to day treatment.
2. Describe the strengths of continuity of service in treatment of eating disorders, that mirrors the way that families function.
3. Evaluate the benefits of longer length of stay for those with more complex conditions.

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“Culturally sensitive body image programs: What is missing and how can we address the gap?”

Courtney R. Petruik, Gina Dimitropoulos, Manual (Les) Jerome

Workshop Purpose. The goals of this workshop are to:

1) Increase participant knowledge on how to better understand body image issues that affect Aboriginal Communities (First Nations, Metis, Inuit). Discussion will focus on the current research and clinical practices and implications of status quo.
2) Participants will generate new strategies for working collaboratively to identify culturally sensitive approaches to working with Aboriginal populations.

Workshop Delivery: The workshop will be delivered in a group discussion format. After a preliminary presentation lasting approximately 30 minutes, participants will divide up into smaller groups of 5-8 members to generate culturally sensitive strategies to work collaboratively with Indigenous communities who are affected by dominate images of feminine beauty.

Workshop Description: Traditionally, body image scholars have not focused their attention toward aboriginal females because it was assumed that females of First Nations, Inuit, or Metis descent do not struggle with body image concerns in the same way that Caucasian or “western” females do (McHugh, Coppola & Sabisto, 2014). The dearth in literature is likely due to the assumption that aboriginal women do not identify with the mainstream media’s thin ideal because this ideal is usually featured mainly as a white woman (McClure, Poole, & Anderson-Fye, 2012). However, despite the lack of focus on aboriginal females in body image literature, some articles have emerged with contrary findings. With the colonization of aboriginal populations in Canada, aboriginal women may face difficulty in identifying with their aboriginal roots and the westernized culture despite cultural demands from both. The tensions these women experience with the divide in cultures may translate to strain in self-identification and ultimately in their body satisfaction and acceptance. Women and female youth who identify as aboriginal have not been given sufficient opportunity to discuss their perceptions of body image in relation to mainstream ideals of beauty. Cross-cultural differences are often noted in body image literature, but specific studies conducted with aboriginal women and female youth are minimal or absent (Smolak, 2004). In this workshop, we will discuss the implications of this gap in literature and draw on strengths and weaknesses of current body image prevention, intervention, and treatment programs in terms of how they may align with the unique challenges faced by aboriginal women and youth. At the end of the workshop, the groups will present their finished products. After the workshop, the presenters will compile the session discussions into a “Future Directions” document that will be shared amongst interested participants (emails will be gathered at the beginning of the workshop).

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You can’t do this without an OT: Normalizing occupational performance in adolescents with eating disorders to support recovery

Cheryl Fiske, Leora Pinhas

Background. Adolescents struggling with eating disorders typically spend a great amount of time engaged in maladaptive behaviors that maintain symptoms and further promote the disorder. Associated behaviors often consume the occupational roles that once held normal, functional meaning and purpose for that individual. This means that less time is spent doing age appropriate occupations and potential difficulties when attempts are made to resume roles that support development, recovery, and wellbeing. Despite the support adolescents receive from interdisciplinary treatment teams, their families, and social networks, many continue to struggle with this process. Occupational performance issues are observed in the adolescent’s productive and leisure roles and in their ability to manage self-care while treatment is simultaneously focused on building family and social relationships, improving self-esteem and emotional regulation, and navigating the complexities of a world filled with potential and opportunity. If the opportunity to develop foundational, age appropriate life skills is unattended and the meaning and purpose of occupation remains rooted in eating disorder symptomatology, these individuals experience difficulty in trying to normalize occupational performance in adulthood. Occupational health and occupational therapists should therefore be considered essential to the recovery process and prevention of relapse in the treatment of adolescents with eating disorders.

Objectives. Workshop participants will have the opportunity to:

1) Define the role specific scope of occupational therapy practice in the treatment of adolescents with eating disorders;
2) Discuss the importance of examining functional engagement and performance from an occupation focused lens and how this supports recovery and relapse prevention;
3) Review and discuss a case study outlining the practical application of occupational therapy and the assessment, treatment, and intervention modalities utilized.

Design/Method. Presenters will engage participants in an interactive 90 minute workshop including a formal presentation and review of a case study. The opportunity for questions and answers will also be included.

Results/Discussion/Conclusion. This workshop will focus on the importance of engaging adolescents in opportunities to develop foundational, age appropriate life skills to normalize occupational performance in the context of recovery and relapse prevention. Discussion on the practical application of occupational therapy assessment, treatment, and intervention modalities will help to inform this process. Implications for occupational therapy practice in the treatment of adolescents with eating disorders will also be discussed.

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Moving from Weight to Wellness: A Community-Based Treatment for BED

Ann McConkey, and Danna McDonald

Objective: This workshop introduces and describes a community-based, weight-neutral, outpatient treatment program for Binge Eating Disorder. We take an evidence-based approach to treatment, promote body acceptance, and do not promote weight loss. These principles are the heart of our work.

Based on a review of literature, and in our experience providing treatment, we discuss that a weight-neutral approach leads to positive outcomes for clients with BED.

Method: We describe our experience providing treatment in the program, as well the positive changes we have seen in clients’ attitudes and food-related behaviours, coping skills and overall wellness. We use a group-based, weight-neutral, wellness-focused approach to provide treatment.

Results: We are excited to share our program experience. Our holistic focus is a paradigm shift away from diet culture and a focus on weight as a measure of wellbeing. Although research is still pending, our experience is that clients report increased self-worth and self-compassion, as well as increased quality of life.

Program evaluation is currently underway, and will include both quantitative and qualitative research, with expected results in 2017.

Discussion: Our program utilizes a number of evidence-based treatment approaches in our program, including Cognitive-Behavioural Therapy, Dialectical Behaviour Therapy, Self-Compassion, Mindfulness, via a feminist lens.

We take a weight-neutral perspective that promotes acceptance of all shapes and sizes in bodies, encourages intuitive eating, and recognizes the role that a weight-loss focus has in the development of disordered eating. In their article review, Tylka et al (2014) propose that weight bias should be addressed for several reasons: when clients are accepting of their body shape and size, they are more likely to practice wellness behaviours such as intuitive eating and healthy movement. Conversely, when the focus is on weight loss, an increase in negative outcomes is shown, such as weight cycling, binge eating, and lower levels of physical activity. In a review of 24 articles, Schaefer and Magnuson (2014) found that interventions that encourage intuitive eating decrease behaviours such as dietary restraint and binge eating, as well as depression and anxiety, and increase self-esteem, and positive body image.

Cognitive-behavioural therapy remains an efficacious treatment choice for eating disorders. Kelly et al (2012) suggest that the development of positive cognitive-emotional coping strategies should be part of treatment for BED. They note that binge eating behaviour may occur more frequently in people who engage in more impulsive coping strategies, and developing cognitive-emotional coping strategies can reduce binge eating episodes.

Preliminary research on the use of DBT in BED treatment is also promising. As discussed by Klein et al (2012), group based DBT treatment seems to have benefits for participants including reducing incidence of binge-eating episodes.

Webb and Forman (2012) discussed the impact of self-compassion on binge eating behaviour in college age women. They noted that lower levels of self-compassion often correlate to emotional intolerance and increased severity of binge-eating symptoms.

The workshop will include a power-point presentation, as well as an experiential exercise.

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Meal support: a novel, individualized approach

Sara Wolfe, Shawn Carter, Cheryl Fiske and Leora Pinhas

Background. Supporting patients during eating opportunities is an essential component of treatment. Traditional approaches to meal support involve strict adherence to a prescribed meal plan and symptom interruption.

A philosophical approach that discourages perfectionistic approaches to nutritional care and encourages opportunities for symptom engagement to build ‘real world’ distress tolerance skills will be explored. This presentation will demonstrate how individualizing symptom management plans allows for constructive conflict which fosters genuine interactions that enhance confidence and cohesion within the care dynamic. Creating nutritional and behavioural care plans that are individually relevant and transferrable to patients’ home environment is presented as essential for relapse prevention.

Objectives. To provide participants with opportunities to:

(1) Gain knowledge of how to provide effective meal support and the philosophy that governs individualizing meal support as a cornerstone of Eating Disorder treatment and relapse prevention;
(2) Learn novel strategies or approaches to meal support they or their programs provide; and
(3) Apply these new strategies or approaches during interactive activities/role-plays.

Design/Method. Presenters will provide an interactive 90 minute workshop which incorporates a formal presentation, group discussion, modelling and opportunities to practice skills discussed.

Results/Discussion/Conclusions. The intent of this workshop is to allow participants to gain an understanding of this novel approach to meal support and provide practical strategies that can be transferred to their respective therapeutic environments.

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Family Therapy Interventions with Eating Disorders: A Pinwheel of Models Applied to a Single Clinical Case Vignette

Gina Dimitropoulos, Monica Sesma-Vazquez, and Shelly Russell-Mayhew

Family therapy is considered a key component of a comprehensive treatment plan for individuals with an eating disorder. Multiple studies have shown that family therapy can be more effective than individual therapy, particularly with adolescent clients with anorexia and bulimia nervosa whose illness is not chronic. For example, family based treatment and systemic family therapies have revealed similar and positive outcomes but the former contributes to fewer hospital admissions. This workshop aims to present a brief overview of various family therapy models including family based treatment, contemporary systemic therapies, multi-family therapy, emotionally-focused family therapy, and other approaches currently in use for treating families with a member diagnosed with an eating disorder. We will provide an outline of the different models of family therapy and varying corresponding foundations and techniques, and then invite participants to identify differences and commonalities in each model. Participants will discern the implications and benefits of exploring and including different family therapy approaches with eating disorders. To get to the heart of the matter, we will provide a clinical example of a family we will call the “Smith” case vignette. We will facilitate discussions and explorations about how family based, structural, brief, solution focused, narrative, and collaborative therapists would work with the “Smith” family. Using an interactive group format, we will discuss and explore a pinwheel of possibilities (see Figure 1) for family therapy with eating disorders using the same vignette. Interactive group discussion might include the applications of an array of techniques and interventions for working with young people across the lifespan and their families.

Participants will be encouraged to share their own wisdom and expertise about how they would work with the “Smith” family given the pinwheel of options available for consideration. Ample time will be provided for participants to share their clinical experiences and insight about how they work with or wish to work with families with eating disorders.

Participant learning objectives:

1. Participants will appreciate the work of different family therapy models with a clinical example of a family with a member diagnosed with an eating disorder.
2. Participants will identify differences and commonalities in different techniques and interventions across a variety of contemporary family therapy models.
3. Participants will discuss and reflect on the implications and benefits of each approach.

Figure 1. Pinwheel of family therapy approaches with eating disorders.

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Residential Treatment for Adolescents with Eating Disorders-Two years later

Leora Pinhas, Sheila Bjarnason, Raluca Morariu

Background: The first publically funded residential treatment program in Canada for adolescents with eating disorders opened its doors on October 1/2014. Two years after its opening, the program has developed and implemented a new model of care that operationalizes residential treatment. The various aspects of the new model, "Recovery High School" will be described and the theoretical underpinnings discussed. Patient presentation and qualitative and quantitative pilot outcome data will be reported.

Learning Objectives:

1. To discuss the theoretical underpinnings of the residential model: family centred care, recovery model, and brain biology.
2. To describe the model, and how it was operationalized and implemented.
3. To explore early qualitative and quantitative data describing presentation and early outcomes for patients admitted in the first 2 years.

Method: Presenters will engage participants in an interactive 90 minute workshop that will include a formal, frank presentation of the program's development and the bumps along the way. There will be opportunity throughout the workshop to explore the active ingredients of the model with the treatment team. Participants will be asked to consider what is minimally necessary to provide effective specialized care to this patient population.

Discussion/Conclusion: This program opened its doors with little in the way of an evidence based model of treatment as no similar program for adolescents existed in Canada and very little clinical and research literature was available from other countries. The clinical team has spent the last two years developing a treatment model based on clinical experience, trial and error, and creative use of the existing and parallel literature. A new model of care was designed and implemented that provides structure, support and intensive psychiatric treatment to adolescents with chronic, severe and previously unremitting eating disorders. Encouraging data is emerging and while still a work-in-progress, it serves as a starting point for innovation in intensive services for a population that has previously gone unaddressed in clinical services provided in Canada.

Workshop Session II

Understanding ARFID… What do we know? What have we learned?
Mark L. Norris, Wendy Spettigue

Background: Avoidant Restrictive Food Intake Disorder, or ARFID for short, was introduced as a new DSM-5 eating disorder diagnosis in 2013. Prior to its introduction, those struggling with ARFID-like features were described in different ways (i.e. food avoidance emotional disorder) and little formative research was completed to help guide clinical decision-making. Since it's introduction, different teams have sought to study ARFID using various research designs.

Objectives of the proposed workshop include:

1) To provide attendees with a review of what is currently known about ARIFD by reviewing diagnostic criteria set in DSM-5, and summarizing published literature across different ages.
2) To describe what we know of clinical expression across ages, and use case-based examples (with adolescent patients) to illustrate some of the many challenges providers can face.
3) To share findings from our own recently completed program of research that examines treatment options including family-based therapy and the augmented use of olanzapine.

Method: The workshop will use a combination of didactic and case based teaching. Attendees will have ample time to ask questions and participate throughout the entire workshop.

Discussion: Over the duration of the workshop, information will be presented that will allow attendees an understanding of how challenges (and realities) faced by the DSM-5 working group for Eating Disorders resulted in ARFID's inclusion as a stand alone diagnosis. We will explore shared findings among different studies that have allowed us to substantively increase our descriptive understanding of ARFID, and promote discussion regarding questions and controversies that have arisen since the diagnosis was first launched. Although we will focus our talk on adolescence, mention will be made of research in infants and children, and what has currently been described in adult patients. We will draw heavily upon our own clinical experience and use real case examples to highlight challenges that we have faced and overcome in clinical domains. It is expected that all attendees will leave with an improved overall understanding of ARFID and be able to differentiate key factors that help guide diagnosis and treatment decision-making.

The authors have no relevant disclosures.

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LEAP-ing Into Awareness
Lauren Jennings, Ali Eberhardt

Background: Exercise is not always addressed in the same was as other eating disorder symptoms. The way in which we provide information and education regarding exercise is not always consistent and is sometimes overlooked in eating disorder treatment programs.

In our experience working with patients in a tertiary eating disorders program, exercise is extremely difficult to reduce or change. Increased support is often desired but not always the top priority and strategies to overcome compulsive exercise are not always openly discussed.

The presenters adapted a CBT-based inpatient program called “Loughborough Eating-disorders Activity Programme” or LEAP to a pilot 8 week outpatient group. The overarching aim of this education group was the promotion of healthy (i.e., non-compulsive/non-eating disorder related) attitudes, beliefs, and behaviors toward both structured exercise and physical activity in general. The aim of the treatment program was not to make patients stop exercising, but rather to educate them about what constitutes healthy/ non-compulsive exercise and equip them with the knowledge and skills that will enable them to regain control of their exercise in a healthy balanced lifestyle.

Objectives: The purpose of this workshop is to explore exercise as a symptom of an eating disorder and to describe the benefits of directly addressing exercise in treatment.

After completing this workshop:

- Participants will be able to describe the benefit of exploring exercise as an eating disorder symptom
- Participants will be able to understand the LEAP program as a treatment modality to discuss and promote healthy attitudes, beliefs & behaviors around exercise and address compulsive exercise as a symptom of an eating disorder
- Participants will discuss how to adapt the LEAP inpatient program to an outpatient setting

Delivery: Presenters will discuss their experiences facilitating LEAP. Specifically, they will review how they adapted the modules to the outpatient setting and provide qualitative observations of patient experiences & engagement. Finally, they will provide quantitative evaluation data collected from LEAP participants throughout the year long pilot program.

Participants will have an opportunity to reflect upon how they address exercise as a symptom within their treatment approach and be able to adapt what they learn to their own setting.

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What Makes it Hard to be Collaborative (even when we want to be)? Mindfulness and compassion in clinical practice

Josie Geller, Suja Srikameswaran

Background. How does it feel when we are not on the same page as our client? What is going on when despite our best intentions, we feel frustrated, impatient, or disconnected? What gets in the way of being collaborative and compassionate when the going gets tough? A collaborative stance is at the heart of empirically supported therapies in the eating disorders and motivational techniques highlighting a non-judgmental attitude and emphasizing client choice are key features of these interventions. Unfortunately, research has shown that despite therapist, support provider and client preferences for a collaborative approach, it is common for us to drift from this stance, and for clinicians and support providers to be more directive than they wish.

Objectives. The purpose of this workshop is to help clinicians identify barriers to maintaining a collaborative stance and to explore ways that mindfulness and compassion can help in overcoming these barriers.

Participants will learn:

1) The determinants of a collaborative stance and review factors that contribute to discrepancies between intentions and actions
2) Strategies to overcome barriers to maintaining a collaborative stance as clinicians
3) Strategies to help support providers of adults with eating disorders maintain a collaborative stance with their loved one

Delivery. This workshop will be useful for clinicians in their own practice and in working with support providers of adults with eating disorders. It will begin with a review of recent studies on collaborative and directive stance and factors that are associated with barriers to use of an optimal stance. Participants will have an opportunity to reflect upon their practice and learn strategies, including use of mindfulness and compassion that assist in maintaining a collaborative stance in situations where it is most needed.

Conflict of Interest/ Ethics. There are no conflicts of interests to report in this research. This research was funded by the Social Sciences and Humanities Research Council and was conducted under the University of British Columbia Providence Health Care Research Ethics Board regulations.

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Family Based Treatment for Transition Age Youth (FBT-TAY) with Anorexia Nervosa: An Interactive Workshop for Engaging Young Adults and their Carers in a Developmentally, Age Appropriate Model

Gina Dimitropoulos, Victoria Freeman, Elyssa Greenbaum, Marla Engelberg, Carly McMorris

Background: Family Based Treatment (FBT) is considered the most effective intervention for adolescents with anorexia nervosa (AN) (Lock and Grange, 2012). FBT is a three-phase, adolescent focused intervention that emphasizes the caregiver's role in re-nourishment, symptom reduction, and treatment adherence of the youth. In the second phase of treatment, efforts to return independence around issues of eating and exercise are addressed, with an emphasis on helping parents transition the adolescent back to a more typical developmental trajectory. In the third phase, the family reflects on their progress and concludes therapy.

While FBT is the gold-standard treatment for adolescents with AN, in the initial evaluation of FBT with older adolescents (16-19), outcomes were not superior to individual treatments (Russell, et al., 1987), suggesting that this treatment modality is better suited to younger teenagers. The FBT model used with adolescents with AN was not designed to prepare families for the developmentally appropriate shift to more autonomous decision-making and functioning in the affected individual as he or she matures into adulthood. Older teenagers and young adults and their families may also see family treatment as a less suitable alternative given their greater independence, as the principles rest upon utilizing parents to make decisions in treatment.

The purpose of this workshop is to provide an overview of an adapted FBT for transition age youth (FBT-TAY) (for ages 16-24) with AN, that can be utilized in both pediatric and adult eating disorder tertiary care programs and community organizations. This adapted version builds on the principles of FBT for adolescents, but teaches family members developmentally appropriate ways to support emerging adults.

Learning objectives: 1) To provide participants with a step by step description of how the tenets and principles of FBT have been adapted to support the developmental stage of the young adult with AN while also acknowledging the need for carer support; 2) To increase participants' knowledge of the interventions required of clinicians implementing the three phases of FBT-TAY including: in phase 1, promoting a therapeutic alliance and engaging young adults and their carers in treatment with the intent to ameliorate symptoms; in phase 2, incrementally shifting responsibility from carers to the young adult for eating and symptom reduction; and in the final phase of FBT, working with young adults and their carers to identify multiple life transitions that may arise as they progress into adulthood. To achieve these two objectives, we will provide several clinical examples to illustrate the application of the key tenets and interventions of the adapted FBT model.

Interactive Component: Through interactive discussions and structured activities, participants will work together to apply FBT-TAY to case-examples from their own clinical practice. In break-out sessions, participants will generate strategies for engaging transition age youth who are often ambivalent about treatment and involving their carers in FBT-TAY. In addition to providing 15 minutes at the end of the workshop for questions, the participants will have ample opportunities to consult with the presenters on how to apply this treatment model in various settings.

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Eating disorders post-bariatric surgery: What eating disorder professionals need to know

Jessica Van Exan, Susan Wnuk, Holly Axt, Sanjeev Sockalingam

Background: Bariatric surgery has been shown to be the most effective long-term intervention for severe obesity and obesity-related illnesses like Type II diabetes; thus, increasing numbers of individuals in Canada have undergone surgery in recent years. When eating disorders develop post-bariatric surgery, eating disorder professionals face unique challenges in assessing and adapting specialized treatments for this population. Assessment and diagnosis of eating disorders post-bariatric surgery can be complicated in terms of differentiating eating disorder symptoms from surgical limitations. For example, restricting certain foods and reducing portion sizes is often recommended post-bariatric surgery and may mimic eating disorder pathology. While there are some differences in symptom presentation, eating disorders that develop after bariatric surgery also share some common features with classic eating disorder pathology, such as an overevaluation of weight and shape. In terms of treatment for eating disorders post-bariatric surgery, the limitations to eating imposed by the surgery itself can make it difficult to implement the dietary changes necessary to improve eating disorder pathology.

Objective: This workshop will focus on providing clinically applicable information relevant to eating disorder professionals. Participants will increase their knowledge of bariatric surgery, including types of surgery, eligibility criteria for bariatric surgery and mental health issues common in individuals pursuing bariatric surgery. Also, a brief review of common medical comorbidities pre-surgery and some post-op medical complications that may impact eating disorder treatment will be reviewed. Individuals will develop an understanding of how to assess and treat individuals with eating disorders occurring post-bariatric surgery. The role of the dietitian and nutrition management will be discussed with a focus on how to collaborate with the patient and make adaptations in terms of meal planning (e.g., food substitutions and time allowed for meals). Psychopharmacological considerations will also be addressed in terms of the impact of malabsorption post-bariatric surgery.

Design: The presenters include professionals working in both eating disorder and bariatric programs and bring forth research and clinical experience in obesity and bariatric surgery as well as eating disorders. In addition to didactic teaching, this workshop will be interactive and common myths and misunderstandings about bariatric surgery will be identified and dispelled as part of interactive learning. Learning will also be enhanced through case examples and small group discussions.

Discussion: This workshop will provide opportunity to engage in discussion and receive feedback from facilitators.

Educational Learning Objectives:

1) Review bariatric surgery and the relevant literature on eating disorders in pre- and post-bariatric surgery patients.
2) Identify disordered eating post-bariatric surgery including factors involved in differential diagnosis of eating disturbance relevant to clinical practice.
3) Discuss treatment of eating disorders post-bariatric surgery with a focus on nutrition, psychological and psychopharmacological considerations.

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Peer Support and Eating Disorders

Shaleen Jones, Stacey Huget

Only a fraction of those with eating disorders receive specialized treatment in Canada. This is for a variety of reasons, including stigma, readiness and motivation challenges, and access to care.

There is increasing recognition for peer support as an important component in the continuum of care for those experiencing mental illnesses. The Mental Health Commission of Canada recognizes the role of peer support in reducing stigma, symptoms and hospital admission rates, while fostering healthier coping strategies, increasing self-confidence and building social support networks.

Peer support can serve as a stepping stone for those in need of treatment – reducing stigma, encouraging them to access support, and readying them to fully participate in treatment. For those who have completed treatment, peer support can help them stay well, and avoid relapse and further readmissions.

What form can peer support take for those with eating disorders? What training and support would those providing peer support need? How can we ensure standards are met? How can we evaluate the effectiveness of peer support?

This workshop will discuss various ways peer support can be delivered to people living with eating disorders based on the experiences implementing and evaluating peer support programs from two provinces. Challenges and lessons learned will also be discussed.

Outcomes

1. Participants will learn about ways in which peer support for eating disorders can be implemented (group, one-on-one, online), and the infrastructure needed including organizational readiness, training, screening, and ongoing support.
2. Participants will learn about challenges in implementing peer support, and ways these challenges can be addressed.
3. Participants will learn about the potential benefits of peer support including increased interest in seeking help, increased motivation/readiness, and decreased isolation.

The workshop will be delivered by leads from two organizations delivering peer support, with time for questions and discussion.

Friday, September 30th

Paper Presentations II

Dance/Movement Therapy in a multidisciplinary adolescent ED inpatient program: evaluation of its integration and preliminary outcomes.

Louis Picard, Elysa Côté-Séguin, Guadalupe Puentez-Neuman, Danielle Taddeo, Olivier Jamoulle, Jean-Yves Frappier, Andrea De Almeida, Chantal Stheneur

Background. A duality opposing emotions and cognition may act as a contributing factor to eating disorders (ED). Research and clinical data show that verbal therapy may not always be the best way to integrate body sensations into cognitive experience.

Dance/Movement Therapy (DMT) is the therapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual. It focuses on movement expression that emerges in the therapeutic relationship. The core component of dance – body movement – provides the mode of intervention and the mean of assessment. One of the main aims of this treatment is to integrate body and mind. Research has demonstrated this effect in different mental health problems.

Therefore, many researchers and clinicians had elaborated an application of DMT for adult ED patients. They observed changes in many aspects of their patient's movement experience: gaining trust in body wisdom concerning hunger and satiety, better recognition of affect and meaning of behaviours, development of a capacity to symbolize and play, reduction of anxiety, and integration of body image and internal sensations.

Objectives. The aims of this study are (1) to evaluate the integration of this emergent intervention into the multidisciplinary ED inpatient program of a University Hospital, through observations of team members and feedback of patients' experience, and (2) to evaluate the effect of DMT groups on adolescent patients' levels of self-esteem and anxiety.

Method. Staff members were asked to give their opinion on the integration of DMT to the program during program staff meetings. All comments concerning the participant's reaction toward DMT and the adjustment of DMT to patient's needs were noted by research team members. Two groups of patients were recruited as they participate in weekly DMT group sessions (study group: n=17) (mean of DMT sessions = 4,29; max=6, min=3)or not (control group: n=4). Both groups included inpatient female adolescents (age range: 11-17 y.o., mean=14.42 y.o.). Control group was recruited while DMT sessions were not available. Study group was asked to complete questionnaires before and after their participation. Control group was tested at the entrance in the study and retested between 23 to 28 days later. Study and control group both completed the Rosenberg Self-Esteem Scale and the State-Trait Anxiety Inventory for Children (STAIC). T-tests were performed to compare groups.

Results. Main observations from the staff indicated that patients reported appreciating this treatment modality. They expressed it helps them focus on pleasure and movement instead of their body dissatisfactions or concerns with nutrition. Therapist observed changes in the pattern of movement in many patients, mainly an increased level of energy and the use of greater range of movements. A non statistically significant lower level of anxiety (state) was shown in the DMT group.

Conclusion. Preliminary results indicate that participation in DMT may be integrated with benefit into an adolescent inpatient treatment. It seems helpful in dealing with anxiety as this DMT experience shows a great potential of distraction from ED cognitions. It helps to rediscover pleasant sensations within a suffering body. More research is needed to evaluate the impact of DMT on mental health of ED patients.

Conflict of interest. The DMT project has been founded by the Hospital Foundation. They also funded this research.

Ethics. This study had been approved by the Hospital Research Ethics Board.

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Preliminary findings of a DBT-informed Multi-family Therapy Group

Gisele Marcoux-Louie, Lana Bentley, Gina Dimitropoulos

Conflict of Interest Statement: Nothing to declare.

Ethics: As this was purely program evaluation data, no ethics review was required.

Background. Families are a vital resource and play an important role in promoting recovery of their children with eating disorders. Multi-family Therapy (MFT) has been internationally recognized as an intervention that provides families with the necessary educational information and skills to support the amelioration of eating symptoms in their adolescent child. However, traditional models of MFT do not provide families and young people with skills to manage intense emotions that may arise during the weight gain process and the cessation of symptoms. To address this issue, we integrated Dialectical Behavioural Therapy principles into Multi-Family Therapy.

Objectives. The objective of this oral presentation is to provide preliminary data on adolescent patients and their families participating in MFT that incorporates Dialectical Behavior Therapy (DBT) skills to assist with intense emotions that arise for young people normalizing their eating, gaining weight and stopping purging symptoms.

Multi-family Therapy Group-Skills (MFTG-S) provides programming for families where the primary issue for the client is dysregulation and impulsive behavior. MFTG-S teaches DBT skills such as mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills over the span of four months. Group leaders adopt the stance of a “skills trainer” and engage families in a variety of DBT inspired interventions including diary cards, behavior analysis, and mindfulness practice.

Methods. The Family Assessment Measure : General Scale (FAM-III) was disseminated at three different time points (initial, upon completion of the 4-day intensive and the final day of follow-up).The FAM-III is a 50- item self-rating scale that consists of assessing family functioning in seven clinical parameters and two validity scales. For each item, statements are rated on 4-point likert scale ranging from strongly agree (0) to strongly disagree (3). Higher scores suggest a greater disturbance in the area of functioning. A mixed between analysis of variance was conducted to assess changes overtime in the young person and their family members on the FAM-III.

Results. The sample consisted of 11 female clients, average age 16.4 years, with varying DSM-IV diagnoses (4 BN, 4 AN-R, 2 AN-B/P, 1 EDNOS) and their family members (8 fathers, 10 mothers and 6 siblings). Preliminary findings suggest that there were statistically significant improvements in Task Accomplishment (p=.013), Communication (p=.008) and the Overall Rating (p=.032). We also observed changes in categorical functioning whereby fathers reported problematic functioning across more clinical scales at baseline (Task Accomplishment, Communication, Involvement, Control, and Values & Norms) and mothers reported more at endpoint (Task Accomplishment, Role Performance, Affective Expression, Control, Values & Norms).

Conclusions. Preliminary results suggest that a new MFT-skills based intervention may lead to changes in some areas of family functioning including Task Accomplishment & Communication. The limitations of this evaluation will be discussed including measurement issues and difficulties engaging fathers in research. Potential clinical and research implications will be discussed. Future research is required on a larger sample size with the inclusion of a control or comparison group.

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Translating Research into Clinical Practice in Tertiary Care: Mapping the Patient Journey according to the BC Clinical Practice Guidelines

Josie Geller, Julia Raudzus & Patty Yoon

Background: The Clinical Practice Guidelines for the BC Eating Disorders Continuum of Service were developed to support the delivery of evidence-based care in BC. In consultation with provincial and international expert groups, the guidelines were created in accordance with four key principles central to patient-centered care: relationships matter, care across the developmental spectrum, management of medical factors, and matching level of care to patient.

A cornerstone of the BC Clinical Practice Guidelines is the Short Treatment Allocation Tool for Eating Disorders (STATED). The STATED recommends assigning level of care according to patients' disposition along three continua; medical acuity, life interference and engagement/readiness. The STATED ensures treatment is matched to patient needs and utilizes provincial treatment resources in a cost-effective manner.

Objective: The purpose of this project was to translate the BC Guidelines into clinical practice in a tertiary care setting. Specifically, this project sought to use the STATED dimensions to create a patient journey map that allows for clear communication, consistent decision making and that maximizes patient and family autonomy.

Methods: Consultation and feedback was sought from key stakeholder groups: a Patient and Family Advisory Committee, comprised of patient and family members who have accessed tertiary care, current patients, and a tertiary care interdisciplinary team, with representation from nursing, psychiatry, psychology, dietetics, social work, and occupational therapy. All stakeholder groups attended presentations on the Clinical Practice Guidelines and the STATED and provided feedback on the current state and areas for improvement at PATSED.

Results: A Patient Journey Map that incorporates the BC Clinical guidelines and stakeholder feedback was created. In it, STATED dimensions required for decision making in the course of tertiary care services (e.g., at intake and admission to inpatient, residential and outpatient services) were identified. For instance, life interference information triages patients at intake, medical acuity information determines the need for hospitalization, and engagement/readiness information allocates patients to one of several intensive treatment options. The patient journey map underwent several rounds of feedback and revision until it was approved by all stakeholder groups (see Figure). Tools for assessing each of the STATED dimensions were created to facilitate communication, consistency and patient autonomy.

Discussion: This project is the first to apply the BC Clinical Practice Guidelines to a tertiary care setting. The STATED ensures treatment is matched to patient needs and delivers provincial treatment resources in a cost-effective manner. Evaluation is planned to determine the impact of the new Patient Journey on access to care, clinical outcome and patient satisfaction.

Conflict of Interest: The BC Clinical Practice Guidelines were funded by the BC Ministry of Health. There are no conflicts of interests to report in this research.

Ethics: This research was conducted under the University of British Columbia Providence Health Care Research Ethics Board regulations.

Mapping the Patient Journey according to the BC Clinical Practice Guidelines

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Parental Involvement Matters: Improving Access to Nutrition Care

Tara Slemko, Gisele Marcoux-Louie, Lana Bentley

Conflict of Interest Statement: Nothing to declare.

Ethics: As this was purely program evaluation data, no ethics review was required.

Background: Meal times are commonly overwhelming and stressful for families who have a child with an eating disorder. This often affects their confidence in providing meal support. Dietitians are essential to empowering parents in making food decisions. In our program, adolescent patients complete a nutrition assessment early in the treatment process. Due to limited resources there was an average delay of 70 days to access follow-up appointments with a dietitian. This was unacceptable and highlighted a need for change.

Objectives/Rationale: In order to provide timely access to nutrition care and education, a parent Nutrition Information Session was developed. Prior to the implementation of the session, no group based nutrition interventions were offered for parents in the program. It encourages parents to adopt a ‘parents in charge’ approach. The objectives of the oral presentation are: 1) Briefly outline key content from the group, 2) Share learnings from parent and staff feedback that informed the changes that occurred over time.

Design/Methods: Since its inception in February 2014, the information session has undergone a few revisions, including shifts in content, structure and length. The information session is one hour in length, is offered once per month and is included as part of the adolescent patient’s assessment schedule. An anonymized evaluation is completed by parent participants upon conclusion of the session.

Results/Discussion: A total of 134 parents have provided feedback on group logistics and content for the Nutrition Information sessions. Initial evaluation results indicated that changes were needed, and the session was revised in July 2015. Overall, 83% of parents report being satisfied with the information session and their understanding of our program’s nutrition philosophy. The majority of participants (77.4%) also reported feeling more confident providing meal support for their child.

Conclusions: Being faced with an obstacle of treatment delays, meant employing a different method in order to deliver important nutrition messages and connect with parents of adolescent patients. Offering a group information session was a helpful way to standardize information delivery, reduce access delays and provide vital information to parents. The unanticipated observed clinical benefits included increased parent engagement, parent validation and improved treatment delivery. At the heart of it all is the belief that a family that eats together, heals together. Parental involvement matters.

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Transitional Age Young Adults: Navigating the need for interdependence in the treatment of eating disorders

Madalyn Marcus, Courtney Watson, Kelty Berardi, Jessica Van Exan, & Ahmed Boachie

Background and Objectives: Young adults (18-25) are faced with numerous life transitions while simultaneously navigating the apparent divergence between an increased need for autonomy with a need for interdependence requiring some degree of family supports (Arcelus, Bouman, & Morgan, 2008). This is further complicated if young adults are part of the mental health care system where at age 18 they are placed into adult services which often do not take into account the unique needs of these transitional age young adults. For people with eating disorders, the evidenced based treatment recommendations regarding family involvement differ greatly depending on the age of the individual, with family involvement being a pivotal component of care for children and adolescents and yet not required in individual-based therapy approaches for adults.

Design/Method: The Young Adult Eating Disorder Program was therefore developed in an effort to address the unique, and often complex, developmental needs of this age group. Currently, individual CBT-E is offered to young adults and family involvement is incorporated into treatment on an individualized basis. Specifically, young adults attend the initial assessment with a designated support person(s) (e.g., family, friend) and the young adults are encouraged to continue to utilize their support person throughout the duration of treatment.

Results/ Discussion: Preliminary results suggests that the young adults who participated in our program experienced statistically significant changes in their eating disorder symptoms (EDE-Q Total Score (t(12 =4.05, p = 0.002) and EDI-Eating Disorder Risk Composite Score (t(8)=2.84, p = 0.025)).The current paper will expand beyond this preliminary data to explore if the degree of involvement of a support person (e.g., number of sessions attended by a support person) is associated with clinical outcomes for transitional age young adults (18-25) who have received outpatient CBT-E for eating disorder treatment. in the treatment of eating disorders

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Adolescent and young women's opinions of eating disorder prevention messages

Jennifer S. Mills, Nicole Witton, Ron Manley, Shasha Tse

Background: Previous research has demonstrated the effectiveness of eating disorder (ED) prevention programs in schools. However, effect sizes are often small and there is agreement among researchers that programs could be improved by studying participants' opinions of prevention messages, in order to understand which ones they believe work best and why.

Objectives: This study examined young women's opinions of five common ED prevention themes (i.e., media literacy, psychoeducation) in terms of persuasiveness (relevance, believability, emotional impact), and impact on behavioural intentions. The purpose was to inform ED prevention programs so as to improve their efficiency and impact.

Method: Evidence-based ED prevention themes identified by Durkin et al. (2005) were shown in video format and were rated by 173 clinical (i.e., with an eating disorder) and non-clinical (i.e., with no current or past eating disorder) female adolescents and young adults.

Results: The five prevention themes selected for study were seen as equally and moderately persuasive. Younger participants found the messages to be less persuasive than did older participants. Controlling for age, clinical participants found the messages to be less persuasive than did non-clinical participants. Clinical participants reported no change in their behavioural intentions after watching the videos, whereas non-clinical participants reported a lower intention to diet and a lower intention to make body comparisons after viewing the messages.

Discussion/Conclusions: Younger adolescents and women who already engage in disordered eating may be relatively harder to reach with ED prevention programs and further research is needed to improve their impact among those vulnerable groups. Presenter ratings (e.g., credibility, attractiveness) were predictive of message persuasiveness, suggesting the importance of the source of the information presented.

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Hashtag Goals: Eating Disorder Recovery on Instagram

Andrea LaMarre, Carla Rice

Background: Eating disorder recovery remains poorly understood despite over 30 years of study. Treatment programs often use symptom remission and weight gain as criteria for discharge, but do not always instruct clients what they should expect as they continue to pursue recovery. In spite (or perhaps because) of lacking a consensus clinical and research definition for recovery, people who have experienced eating disorders are making sense of their own recoveries, in part by engaging in dialogue about and representation of recovery online. One popular venue for posting about recovery is Instagram, a social media site designed for image sharing. Instagram users post photos with captions and hashtags (categorizers using a # sign).

Objectives: In this study, we sought to better understand eating disorder recovery from the perspective of those who represent their experiences online. Our aim was to explore the representational field of recovery; by investigating these representations, we sought to understand: (1) what recovery looks like, online and (2) how the version of recovery presented online might impact diverse people seeking to recover (i.e., people with different ethnicities, genders, socioeconomic statuses, sexualities, body sizes, etc.).

Design/Method: We gathered data in December 2015, selecting images and captions posted using the hashtag #EDRecovery. Following an initial scan for co-occurrence of hashtags, we selected 4 additional commonly-used hashtags for analysis: #EatingDisorderRecovery, #AnorexiaRecovery, #BulimiaRecovery, and #RecoveryWarrior. We then searched Instagram using these hashtags on 3 days in December (a Friday, a Saturday, and a Tuesday, in the morning, afternoon, and evening) and archived the first 100 posts to each hashtag at each data selection point for a total of 1500 images with associated captions. We used thematic analysis to analyze this corpus of data, identifying and categorizing the content of the images and exploring how users described their images. We used a feminist theory lens to identify how dominant constructions of ethnicity, socioeconomic status, sexuality, body size, etc. were endorsed and/or contested by users in their imagery.

Results: We found that users primarily posted images of food; users also posted images of thin and/or toned bodies, and inspirational quotes. While on the surface this is unsurprising, given that eating disorders are marked by distressing relationships with food and bodies, these images and their captions are also subtly marked by trappings of social location, most notably class, that inform the version of recovery that is proliferated in the social media sphere.

Discussion: People with eating disorders and in recovery may seek role models for their recoveries. Documenting recovery online may be a way for those in recovery to chart their progress, interact with similar others, and to hold themselves accountable. However, recoveries presented on Instagram resemble stereotypical perspectives on who gets eating disorders and, thus, who might recover: images overwhelmingly document recovery using markers of middle-to-upper class, white, young women. The manicured version of recovery documented online may not be available to all, limiting the possibility of this medium for being representative of diverse recoveries.

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Exploring Eating Disorders Programs, Services and Supports through a Knowledge Exchange Network in British Columbia

Sarah Bell, Julia Raudzus, Pamela Joshi, Charlene King, Aazadeh Madani

Abstract Objectives:

1. To raise awareness at national, provincial, regional and local levels about the BC Provincial Eating Disorders Network
2. To share network planning and priorities with a broad range of partners and stakeholders for collaboration and knowledge exchange

Background: In British Columbia (BC), eating disorders services and supports are provided within a networked system of mental health and substance use treatment and care. The Provincial Eating Disorders Network has provided an opportunity to bring together regional and provincial health authorities, BC government, non-government organizations, research and education to engage in provincial dialogue and action in eating disorders services and supports.

Methods: The Provincial Eating Disorders Network is one of four Provincial Specialized Mental Health and Substance Use Knowledge Exchange Networks stewarded and facilitated by the Provincial Health Services Authority. The network has been meeting since 2009 and has evolved over time through building relationships and partnerships across the province (Figure 1).The network also relies upon the BC Centres for Excellence in Eating Disorders - Web Portal as an online knowledge exchange mechanism.

Results: Network processes include supporting awareness, exploring partnerships, and strategically linking across organizations and ministries to explore eating disorders system planning, models of care, guidelines, professional development opportunities, and outcome measurement. In 2015, through a collaborative visioning process, the network identified the following priorities for action in 2016-17:

1. To select, identify and share a collectively agreed upon set of eating disorders supports and resources across programs, services and levels of care
2. To collaborate and share learning when addressing clinical service delivery issues across levels of care
3. To act as a reference group to inform the development of eating disorders guidelines across different settings
4. To diversify the network membership and perspective to include strategic partners across sectors such as the First Nations Health Authority, Indigenous Service Providers, Cross Cultural Organizations, National Organizations, etc.
5. To advocate for values based approaches and resourcing for eating disorders services and supports

Conclusions: The Provincial Eating Disorders Network has been a stable component of provincial knowledge exchange infrastructure over time. This network based knowledge exchange approach has provided a forum to identify opportunities to strengthen eating disorders services and supports. By taking action in priority areas, the network will build upon existing relationships, connections and collaboration. Ultimately, the network aims to shift services towards becoming more adaptive and proactive to respond to the needs of children, youth, and adults with eating disorders.

Figure 1. Provincial Eating Disorders Network Social Network Mapping of Existing Collaborations and Partnerships across BC