

At the Heart of it All

5th Biennial EDAC-ATAC Conference

September 29 & 30, 2016

Fort Garry Hotel | Winnipeg, Manitoba



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Scientific Syllabus

A1. Evidence-Based Practice in the Context of Eating Disorders

Carolyn Becker, PhD, Trinity University, San Antonio TX USA

Learning Objectives:

1. Participants will be able to describe the three legs of the evidence based practice stool.
2. Participants will be able to explain the difference between empirically supported treatment and evidence based practice for eating disorders.
3. Participants will be able to explain how the persons case formulation approach can be used as a tool in delivering evidence-based practice for eating disorders.

A2. Maximizing Engagement and Motivation for Change in Eating Disorder Treatment

Howard Steiger, PhD, Director, Eating Disorders Continuum, Douglas University Institute; Montreal West Island Integrated University Health and Social Service Centre; Professor, Psychiatry Department, McGill University, Verdun QC

Learning Objectives:

1. To discuss the concept of autonomous motivation in ED patients and to examine the impact of motivation and commitment on treatment response.

B1. Binge Eating Disorder

Giorgio A. Tasca, PhD, CPsych, Associate Professor, University of Ottawa, Ottawa ON

Learning Objectives:

1. To highlight the reality of BED awareness and treatment strategies underway in Canada by specifically focusing on clinical trials that have been completed in group settings.

B2. Ask a Simple Question...Is There a Simple Answer? An Update on the Epidemiology of EDs in Canada and Discussion of Next Steps

Mark L. Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON

Gail McVey, PhD, University Health Network, University of Toronto, Toronto ON

Learning Objectives:

1. To review results of a recent study investigating the epidemiology of EDs in Canada.

C1. Early Identification of Eating Disorders: A Mixed Method Pilot Study

Ahmed Boachie, MD, FRCPC, FAED, Southlake Regional Health Centre, Newmarket ON (Presenter)

Karin Jasper, PhD, RP, Southlake Regional Health Centre, Newmarket ON (Presenter)

Laura Rogers, BA, Southlake Regional Health Centre, Newmarket ON

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.

Abstract:

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.

C2. Treatment Outcomes for Adolescents in an Intensive Day Treatment Program for Eating Disorders

Jennifer S. Coelho, PhD, BC Children's Hospital, Vancouver BC (Presenter)

MacKenzie Robertson, BA, BC Children's Hospital, Vancouver BC

Katie Coopersmith, BA, BC Children's Hospital, Vancouver BC

Pei-Yoong Lam, FRACP, FRCPC, BC Children's Hospital, Vancouver BC

Jadine Cairns, MSc, BC Children's Hospital, Vancouver BC (Presenter)

Learning Objectives:

1. Understand the treatment offered in the day program for eating disorders at BC Children's Hospital.
2. Describe treatment outcomes in youth who have been treated in the program.
3. Compare pattern of results with other Canadian day treatment settings for youth with eating disorders.

Abstract:

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.

C3. Keeping Schools Safe: What Proportion of Patients with Eating Disorders Cite School Experiences as a Primary Trigger for ED Onset?

Mark L. Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenter)

Nicole Hammond, MA, Children's Hospital of Eastern Ontario, Ottawa ON

Katie Yelle, BHSc, Children's Hospital of Eastern Ontario, Ottawa ON

Dominique Falardeau, MA, Children's Hospital of Eastern Ontario, Ottawa ON

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

Nicole Obeid, PhD, Children's Hospital of Eastern Ontario, Ottawa ON

Gail McVey, PhD, University Health Network, University of Toronto, Toronto ON

Learning Objectives:

1. Describe how school-wide healthy eating and healthy weight initiatives have been introduced in Canada.
2. Describe how school and education-related experiences act as triggers for eating disorder onset.
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.

Abstract:

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.

C4. Asceticism, Perfectionism and Overcontrol in Youth with Eating Disorders

Nicole Obeid, PhD, Children's Hospital of Eastern Ontario, Ottawa ON (Presenter)

Shannon Bedford, BSc, University of Ottawa, 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

Learning Objectives:

1. To examine asceticism, perfectionism, and overcontrol in a clinical sample of youth with eating disorders.
2. To investigate diagnostic differences of these personality characteristics.
3. To study whether asceticism, perfectionism, and overcontrol predicts length of stay.

Abstract:

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.

C5. Classic Hallucinogen Use is Inversely Related to Disordered Eating and Mental Health Issues: Exploring Mechanisms of Action

Michelle S. Thiessen, BA, University of British Columbia, Kelowna BC

Zachary Walsh, PhD, University of British Columbia, Kelowna BC

Adèle Lafrance, PhD, CPsych, Laurentian University, Sudbury ON (Presenter)

Brian M. Bird, MA, Laurentian University, Sudbury ON

Erin Strahan, PhD, Wilfrid Laurier University, Brantford, ON

Learning Objectives:

Participants will:

1. Identify psychedelics that have been linked to positive mental health outcomes, including disordered eating and eating disorders.
2. Compare theoretical and statistical models related to the therapeutic mechanisms of action of psychedelics in the treatment of anxiety, depressed mood and disordered eating.
3. Discuss the potential role for psychedelics in the development of adjunct-treatment protocols for individuals with eating disorders.

Abstract:

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 et 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 ($\text{Exp}(B) = .62, 95\% \text{ CI: } .47-.80$). Although the association between hallucinogen use and dietary restraint remained after accounting for emotional dysregulation ($\text{Exp}(B) = .65, 95\% \text{ CI: } .50-.86$), 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.

C6. Deep Brain Stimulation for Anorexia Nervosa – One Year Outcome in 16 Subjects

D. Blake Woodside, MD, FRCPC, Toronto General Hospital, Toronto ON (Presenter)

Learning Objectives:

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

Abstract:

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.

C7. Re-examining the Role of Exercise in Relationship to Eating Disorders; Symptom and Treatment?

Danika Quesnel, MSc, University of British Columbia, Kelowna BC (Presenter)

Marianne Clark, PhD, University of British Columbia, Kelowna BC

Cristina M. Caperchione, PhD, University of British Columbia, Kelowna BC

Learning Objectives:

1. To understand the current views and perspectives of eating disorder health professionals concerning exercise in eating disorder treatment.
2. To identify the knowledge and practice gap between researchers and clinicians concerning exercise in the treatment of eating disorders.
3. To discuss potential strategies and preliminary recommendations for incorporating exercise in the treatment of eating disorders.

Abstract:

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 understanding 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.

C8. A Pilot Study of Cardiac Abnormalities in Anorexia Nervosa Patients Based on Electrocardiogram, Echocardiogram, and Cardiac Magnetic Resonance Imaging

Karen Chu, MD, University of Manitoba, Winnipeg MB (Presenter)
 Ilan Buffo, MD, University of Manitoba, Winnipeg MB
 Margo Lane, MD, Child & Adolescent Eating Disorders Service, Winnipeg MB
 Louis Ludwig, MD, Adult Eating Disorders Service Program, Winnipeg MB
 Davinder S. Jassal, MD, University of Manitoba, Winnipeg MB
 Daryl Schantz, MD, University of Manitoba, Winnipeg MB

Learning Objectives:

1. Brief review of the cardiac complications of anorexia nervosa.
2. Describing the use of cardiac magnetic resonance in anorexia nervosa and how it may help us predict cardiac complications.
3. Future next steps.

Abstract:

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 protocol 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.

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

C9. Dance/Movement Therapy in a Multidisciplinary Adolescent ED Inpatient Program: Evaluation of its Integration and Preliminary Outcomes

Louis Picard, PhD, CHU Ste-Justine, Montréal QC (Presenter)

Elysa Côté-Séguin, DPsy (cand), Université de Sherbrooke, Longueuil QC

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Chantal Stheneur, PhD, MD, CHU Ste-Justine, Montréal QC

Learning Objectives:

1. Develop a better understanding of clinical key concepts concerning dance and movement therapy (DMT).
2. Enhance knowledge about empirical evaluation of DMT effects on ED patients.
3. Learn how this new intervention modality integrates to a multidisciplinary ED program.

Abstract:

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.

C10. Preliminary Findings of a DBT-Informed Multi-Family Therapy Group

Gisele Marcoux-Louie, MSc, Alberta Health Services, Calgary AB (Presenter)

Lana Bentley, MSW, RSW, Alberta Health Services, Calgary AB (Presenter)

Gina Dimitropoulos, MSW, PhD, RSW, RMFT, University of Calgary, Calgary AB

Learning Objectives:

1. To share preliminary data on Multi-Family Therapy Group-Skills (MFTG-S).

Abstract:

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.

C11. Translating Research into Clinical Practice in Tertiary Care: Mapping the Patient Journey According to the BC Clinical Practice Guidelines

Josie Geller, PhD, RPsych, St. Paul's Hospital, Vancouver BC (Presenter)

Julia Raudzus, MD, FRCPC, St. Paul's Hospital, Vancouver BC

Patty Yoon, RPN, MA, Providence Health Care, Vancouver BC

Learning Objectives:

1. To provide a rationale for creating a new tool in assigning level of care (e.g., outpatient, intensive residential, inpatient).
2. To describe the Short Treatment Allocation Tool for Eating Disorders (*STATED*) and Patient Journey Map.
3. To describe three clinical applications of the *STATED*.

Abstract:

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.

C12. Parental Involvement Matters: Improving Access to Nutrition Care

Tara Slemko, MSc, RD, Alberta Health Services, Calgary AB (Presenter)

Gisele Marcoux-Louie, MSc, Alberta Health Services, Calgary AB

Lana Bentley, MSW, RSW, Alberta Health Services, Calgary AB

Learning Objectives:

1. Briefly outline key content from the group.
2. Share learnings from parent and staff feedback that informed the changes that occurred over time.

Abstract:

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 137 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.

C13. Transitional Age Young Adults: Navigating the Need for Interdependence in the Treatment of Eating Disorders

Madalyn Marcus, PhD, CPsych, Southlake Regional Health Centre, Newmarket ON (Presenter)

Courtney Watson, PhD, CPsych, Southlake Regional Health Centre, Newmarket ON (Presenter)

Kelty Berardi, PhD, CPsych, Lakeridge Health, Oshawa ON

Jessica Van Exan, PhD, CPsych, Southlake Regional Health Centre, Newmarket ON

Ahmed Boachie, MD, FRCPC, Southlake Regional Health Centre, Newmarket ON

Learning Objectives:

1. Discuss rational and process involved in the development of an eating disorders program for transitional age youth (18-25).

2. Explore impact of involvement of a support person on clinical outcomes for transitional age young adults in an eating disorders program.
3. Understand lessons learned and implications for future directions in transitional age youth with eating disorders.

Abstract:

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.

C14. Adolescent and Young Women's Opinions of Eating Disorder Prevention Messages

Jennifer S. Mills, PhD, York University, Toronto ON (Presenter)

Nicole Vu, PhD, York University, Toronto ON

Ron Manley, PhD, BC Women's and Children's Hospital, Vancouver BC

Shasha Tse, MA, York University, Toronto ON

Learning Objectives:

At the end of this presentation, participants will be able to:

1. Summarize the current state of eating disorder (ED) prevention efforts in Canada.
2. Describe commonly-used ED prevention messages.
3. Explain the factors that predict how adolescent and young women rate those messages.
4. Recommend how to maximize the impact of ED prevention messages.

Abstract:

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.

C15. Hashtag Goals: Eating Disorder Recovery on Instagram

Andrea LaMarre, MSc, PhD(c), University of Guelph, Guelph ON (Presenter)

Carla Rice, PhD, University of Guelph, Guelph ON

Noura Jabbour, University of Guelph, Guelph ON

Inthuya Wamathewan, University of Guelph, Guelph ON

Learning Objectives:

1. Understand how those in eating disorder recovery are using Instagram.
2. Assess the positive, negative, and neutral aspects of Instagram in representing eating disorder recovery.
3. Identify avenues for increasing the diversity and accessibility of representations of recovery available to those with eating disorders and in recovery.

Abstract:

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.

C16. Exploring Eating Disorders Programs, Services and Supports Through a Knowledge Exchange Network in British Columbia

Sarah Bell, MBA, RN, CHE, BC Children's Hospital, Vancouver BC

Julia Raudzus, MD, FRCPC, St. Paul's Hospital, Vancouver BC (Presenter)

Pamela Joshi, MSc, Provincial Health Services Authority, Vancouver BC

Charlene King, MPH, BC Children's Hospital, Vancouver BC

Aazadeh Madani, MA, BC Children's Hospital, Vancouver BC

Learning 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.

Abstract:

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.; and 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.

- D1. Longer Term Outcomes and Length of Stay in a Day Hospital Program for Children and Adolescents
Ahmed Boachie, MD, FRCPC, FAED, Southlake Regional Health Centre, Newmarket ON (Presenter)
Karin Jasper, PhD, RP, Southlake Regional Health Centre, Newmarket ON (Presenter)

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.

Abstract:

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.

- D2. Culturally Sensitive Body Image Programs: What is Missing and How Can We Address the Gap?
Courtney R. Petruik, MA, University of Calgary, Calgary AB (Presenter)
Gina Dimitropoulos, MSW, PhD, RSW, RMFT, University of Calgary, Calgary AB
Manual (Les) Jerome, MSW, University of Calgary, Calgary AB

Learning Objectives:

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.

Abstract:

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).

D3. You Can’t Do This Without an OT: Normalizing Occupational Performance in Adolescents with Eating Disorders to Support Recovery

Cheryl Fiske, MSc (OT), Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

Leora Pinhas, MD, FRCPC, Ontario Shores Centre for Mental Health Sciences, Whitby ON

Learning Objectives:

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.

Abstract:

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. 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.

D4. Moving From Weight to Wellness: A Community-Based Treatment for BED

Ann McConkey, RD, Provincial Eating Disorder Prevention and Recovery Program,
Winnipeg MB (Presenter)

Danna McDonald, MMFT, RSW, Provincial Eating Disorder Prevention and Recovery Program,
Winnipeg MB (Presenter)

Learning Objectives:

Learners will be able to:

1. Describe the structure, philosophies and treatment methods of a unique, community-based treatment program for Binge Eating Disorder.
2. Recognize and address the connection between dieting behaviour and Binge Eating Disorder.
3. Recognize how clinicians, dietitians and physicians can help shift the focus from weight to wellness, and promote recovery from Binge Eating Disorder.

Abstract:

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.

D5. Meal Support: A Novel, Individualized Approach

Shawn Carter, MADS, BCBA, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

Sara Wolfe, BAsC (AHN), RD, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

Learning 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.
3. Apply these new strategies or approaches during interactive activities/role-plays.

Abstract:

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. **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.

D6. Family Therapy Interventions with Eating Disorders: A Pinwheel of Models Applied to a Single Clinical Case Vignette

Gina Dimitropoulos, MSW, PhD, RSW, RMFT, University of Calgary, Calgary AB (Presenter)

Monica Sesma-Vazquez, PhD, University of Calgary, Calgary AB (Presenter)

Shelly Russell-Mayhew, PhD, University of Calgary, Calgary AB (Presenter)

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.

Abstract:

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.

D7. ‘No such thing as an “unmotivated” parent who “doesn’t get it”’: New Clinical and Research Developments in Emotion-focused Family Therapy for Eating Disorders Across the Lifespan

Amanda Stillar, MA Psych, University of Alberta, Edmonton AB

Adèle Lafrance, PhD, CPsych, Laurentian University, Sudbury ON (Presenter)

Joanne Dolhanty, PhD, CPsych, Mount Pleasant Therapy Centre, Toronto ON

Erin Strahan, PhD, Wilfrid Laurier University, Brantford ON

Jennifer Scarborough, MSW, RSW, Canadian Mental Health Association, Kitchener ON

Patricia Nash, MEd – CCC, Eating Disorder Foundation of Newfoundland and Labrador, St. John’s NL

Natasha Files, MSW, RSW, Three Story Clinic, Vancouver BC

Shari Mayman, PhD, CPsych, Anchor Psychological Services, Ottawa ON

Katherine Henderson, PhD, CPsych, Anchor Psychological Services, Ottawa ON

Joanne Gusella, PhD, CPsych, Dalhousie University, Halifax NS

Laura Connors, PhD, CPsych, IWK Health Centre, Halifax NS

Emily S. Orr, PhD, CPsych, Cape Breton Regional Hospital, Sydney NS

Patricia Marchand, MSW, RSW, Hotel Dieu Hospital, Kingston ON

Learning Objectives:

1. Provide an overview of EFFT core tenets and treatment domains as well as outline a theoretical model to conceptualize parental therapy-interfering behaviors.
2. Explain new EFFT outcome and process research; with particular attention paid to increasing

parental self-efficacy, a variable identified as key in improving treatment outcomes.

3. Illustrate via an experiential activity how the philosophies and specific skills of EFFT can be used to engage all caregivers in treatment, even those who present as unwilling to engage in their child's treatment.

Abstract:

Emotion-focused Family Therapy (EFFT) is a model of family therapy whereby parents and caregivers are recruited to be actively involved in supporting their loved one's recovery, regardless of their loved one's age. The primary aim of EFFT is to support and empower parents to adopt a primary role in their loved one's behavioral and emotional recovery, using a skills-based and emotion-focused approach. Within this model, parental therapy-interfering behaviors such as denial, over-control, criticism, and accommodating and enabling behaviors are regarded as efforts to manage strong negative affect in the parent, in particular, fear and self-blame. This means that rather than deeming parents as "unsupportive" or their involvement as "inappropriate", clinicians target the underlying emotions that fuel these processes as a means to minimize their negative impact and in turn enlist parents as powerful and positive agents of change. This workshop will commence with a brief overview of EFFT for those participants new to the model. Facilitators will then present new research developments including a comparison of treatment outcomes of a 2-day EFFT carer workshop for parents of individuals in treatment vs on a wait-list. New process research using structural equation modeling will also highlight emotion-focused mechanisms of change that lead to increases in parental self-efficacy (a variable recently identified as crucial in the treatment of eating disorders), as well as intentions to engage in recovery-focused behaviours on behalf of their loved ones. Lastly, the facilitators will engage the group in an experiential activity where participants will practice the use of an EFFT intervention to re-engage a treatment-refusing parent. This activity will allow participants to personally experience how EFFT philosophies and skills can facilitate change in even the most challenging caregiver presentations.

D8. Understanding ARFID...What Do We Know? What Have We Learned?

Mark L. Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenter)

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

Learning Objectives:

1. To provide attendees with a review of what is currently known about ARFID 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.

Abstract:

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 its introduction, different teams have sought to study ARFID using various research designs. 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.

D9. LEAP-ing Into Awareness

Lauren Jennings, BA, MOT, St. Paul's Hospital, Vancouver BC (Presenter)

Ali Eberhardt, BSc, FNH, RD, St. Paul's Hospital, Vancouver BC (Presenter)

Learning 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:

1. Participants will be able to describe the benefit of exploring exercise as an eating disorder symptom.
2. 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.
3. Participants will discuss how to adapt the LEAP inpatient program to an outpatient setting.

Abstract:

Background: Exercise is not always addressed in the same way 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. **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.

D10. What Makes it Hard to be Collaborative (even when we want to be)? Mindfulness and Compassion in Clinical Practice

Josie Geller, PhD, RPsych, St. Paul's Hospital, Vancouver BC (Presenter)

Suja Srikameswaran, PhD, RPsych, St. Paul's Hospital, Vancouver BC

Learning 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.

Abstract:

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. 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.

- D11. 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, MSW, PhD, RSW, RMFT, University of Calgary, Calgary AB (Presenter)
 Victoria Freeman, MSW, RSW, University Health Network, Toronto General Hospital, Toronto ON (Presenter)
 Elyssa Greenbaum, MSW, RSW, The Hospital for Sick Children, Toronto ON (Presenter)
 Marla J. Engelberg, PhD, CPsych, North York General Hospital - Branson Division, Toronto ON

Learning Objectives:

To achieve these objectives, we will provide several clinical examples to illustrate the application of the key tenets and interventions of the adapted FBT model.

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.

Abstract:

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. 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.

D12. Eating Disorders Post-Bariatric Surgery: What Eating Disorder Professionals Need to Know

Jessica Van Exan, PhD, CPsych, Southlake Regional Health Centre, Newmarket ON (Presenter)

Susan Wnuk, PhD, CPsych, University Health Network, Toronto Western Hospital,
Toronto ON (Presenter)

Holly Axt, RD, Trillium Health Partners - Credit Valley Hospital Site, Mississauga ON (Presenter)

Sanjeev Sockalingam, MD, MHPE, FRCPC, University Health Network, Toronto General Hospital,
Toronto ON (Presenter)

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.

Abstract:

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.

D13. Peer Support and Eating Disorders

Shaleen Jones, CPS, Eating Disorder Nova Scotia, Halifax NS (Presenter)

Stacey Huget, BA, Looking Glass Foundation, Vancouver BC (Presenter)

Learning Objectives:

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.

Abstract:

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 in two provinces. Challenges and lessons learned will also be discussed.

D14. Residential Treatment for Adolescents with Eating Disorders – Two Years Later

Leora Pinhas, MD, FRCPC, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

Sheila Bjarnason, MSW, RSW, Ontario Shores Centre for Mental Health Sciences,
Whitby ON (Presenter)

Raluca A Morariu, BSc, Ontario Shores Centre for Mental Health Sciences, Whitby ON

Stella Ducklow, Ontario Shores Centre for Mental Health Sciences, Whitby ON

Cheryl Fiske, MSc (OT), Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

Shawn Carter, MADS, BCBA, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

Sara Wolfe, BAsc (AHN), RD, Ontario Shores Centre for Mental Health Sciences, Whitby ON (Presenter)

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.

Abstract:

Background: The first publicly 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. **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.

E1. A 12-Month, Open-Label Study of the Safety and Tolerability of Lisdexamfetamine Dimesylate in Adults with Moderate to Severe Binge Eating Disorder

Maria Gasior, MD, PhD, BTG International, Philadelphia PA USA

James Hudson, MD, ScD, McLean Hospital/Harvard Medical School, Belmont MA USA

Javier Quintero, MD, Hospital Universitario Infanta Leonor, Madrid, Spain

M. Celeste Ferreira-Cornwell, PhD, GlaxoSmithKline, Philadelphia PA USA

Jana Radewonuk, MSc, GlaxoSmithKline, Philadelphia PA USA

Susan McElroy, MD, Lindner Center of HOPE, Mason OH USA

Barry K. Herman, MD, MMM, Shire, Lexington MA USA (Presenter)

Abstract:

Background: Lisdexamfetamine dimesylate (LDX) is approved by the US Food and Drug Administration for treating adults with moderate to severe binge eating disorder (BED) based in part on the results of 2 placebo-controlled, double-blind phase 3 studies. **Objectives:** To assess the long-term safety and tolerability of LDX in adults with moderate to severe BED who participated in a phase 3, multicenter, 12-month open-label extension study. **Design/Method:** Eligible adults (18–55 years) with BED who completed 1 of 3 antecedent trials were enrolled in a 52-week open-label extension study (4 weeks of dose optimization [initial dose, 30 mg LDX; target doses, 50 or 70 mg LDX]; 48 weeks of dose maintenance). Safety evaluations included the occurrence of treatment-emergent adverse events (TEAEs), vital sign and weight assessments, and responses on the Columbia-Suicide Severity Rating Scale (C-SSRS). The study was approved by all applicable ethics committees and regulatory agencies before study initiation. **Results/Discussion:** Of 604 enrolled participants, 599 (521 women; 78 men) were included in the safety analysis set (took ≥ 1 study drug dose and had ≥ 1 postdose safety assessment) and 369 completed the study. Mean \pm SD LDX exposure was 284.3 \pm 118.84 days; 344 participants (57.4%)

were treated for ≥ 12 months. A total of 506 (84.5%) participants reported TEAEs (TEAEs leading to discontinuation, 54 [9.0%]; severe TEAEs, 42 [7.0%]; serious TEAEs, 17 [2.8%]). TEAEs reported in $\geq 10\%$ of participants were dry mouth (27.2%), headache (13.2%), insomnia (12.4%), and upper respiratory tract infection (11.4%). Mean \pm SD changes from antecedent study baseline in systolic and diastolic blood pressure, pulse rate, and weight at week 52/early termination (n=597) were 2.19 ± 11.043 and 1.77 ± 7.848 mmHg, 6.58 ± 10.572 bpm, and -7.04 ± 7.534 kg, respectively. On the C-SSRS, there were 2 positive responses for any active suicidal ideations and 4 positive responses for nonsuicidal self-injurious behavior; there were no positive responses for suicidal behavior, actual suicide attempts, or completed suicides. Conclusion: The long-term safety and tolerability of LDX was generally consistent with its known safety profile.

E2. A Double-Blind, Placebo-Controlled, Randomized-Withdrawal Study of Lisdexamfetamine Dimesylate in Adults with Moderate to Severe Binge Eating Disorder

James Hudson, MD, ScD, McLean Hospital/Harvard Medical School, Belmont MA USA

Susan McElroy, MD, Lindner Center of HOPE, Mason OH, and University of Cincinnati College of Medicine, Cincinnati OH USA

M. Celeste Ferreira-Cornwell, PhD, GlaxoSmithKline, Philadelphia PA USA

Jana Radewonuk, MSc, GlaxoSmithKline, Philadelphia PA USA

Maria Gasior, MD, PhD, BTG International, Philadelphia PA USA

Barry K. Herman, MD, MMM, Shire, Lexington MA USA (Presenter)

Abstract:

Background: Lisdexamfetamine dimesylate (LDX) is approved in the United States for adults with moderate to severe binge eating disorder (BED). Objectives: To assess the maintenance of efficacy of LDX, as assessed by time to relapse, in adults with moderate to severe BED. Design/Method: Adults (18–55 years) meeting Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision BED criteria and having moderate to severe BED (≥ 3 binge eating days/week for 14 days before open-label baseline and Clinical Global Impressions–Severity (CGI-S) scores ≥ 4 at screening and open-label baseline) were eligible. Following a 12-week open-label phase (dose optimization: 4 weeks [LDX 50 or 70 mg; dose maintenance: 8 weeks), LDX responders (≤ 1 binge eating day/week for 4 consecutive weeks and CGI-S scores ≤ 2 at week 12) were randomized to placebo or continued LDX during a 26-week, double-blind, randomized-withdrawal phase. Time to relapse (≥ 2 binge eating days/week for 2 consecutive weeks and ≥ 2 -point CGI-S score increases from randomized-withdrawal baseline) was assessed in the full analysis set (FAS) using a stratified log-rank test stratifying for 4-week cessation. Safety and tolerability assessments included treatment-emergent adverse events (TEAEs). The study was conducted in accordance with all applicable ethical requirements and was approved by an ethics committee. Results/Discussion: Of 418 enrolled participants, 275 responded to LDX (per protocol) and were randomized at the end of open-label treatment; 138 participants were randomized to placebo and 137 continued on dose-optimized LDX from the open-label phase. LDX demonstrated superiority over placebo ($P < 0.001$) for time to relapse in the FAS (n=267) during the double-blind, randomized-withdrawal phase. Additionally, the proportions of participants who met relapse criteria were 3.7% (5/136) for LDX and 32.1% (42/131) for placebo. During open-label treatment, 82.2% (338/411) of participants reported TEAEs (serious TEAEs, n=3; TEAEs leading to discontinuation, n=22). TEAEs reported by $>5\%$ of participants during open-label treatment were dry mouth, headache, insomnia, decreased appetite, nausea, anxiety, constipation, hyperhidrosis, feeling jittery, and diarrhea. Mean (SD) changes from open-label baseline in systolic blood pressure (SBP), diastolic blood pressure (DBP), and pulse, respectively, during open-label treatment were 1.14 (9.937) mmHg, 1.79 (7.532) mmHg, and 6.64 (9.948) bpm at week 12/early termination (ET). During the double-blind, randomized-withdrawal phase, 46.3% (62/134) of placebo and 60.3% (82/136) of LDX participants reported TEAEs (serious TEAEs:

placebo [n=0], LDX [n=2]; TEAEs leading to study discontinuation: placebo [n=0], LDX [n=6]). TEAEs reported by ≥5% of participants in either treatment group (placebo; LDX) during the double-blind, randomized-withdrawal phase were nasopharyngitis (6.7%; 9.6%), headache (6.7%; 8.8%), upper respiratory tract infection (3.7%; 8.1%), dry mouth (1.5%; 5.1%), and fatigue (5.2%; 2.9%). Mean (SD) changes from open-label baseline in SBP, DBP, and pulse (placebo vs LDX) during the double-blind, randomized-withdrawal phase were -0.28 (9.643) vs 2.07 (9.960) mmHg, 0.38 (7.883) vs 0.85 (7.232) mmHg, and 1.96 (9.501) vs 6.63 (9.423) bpm at week 38/ET. Conclusion: Following initial LDX response, risk of relapse to binge eating over 6 months was markedly lower with continued LDX than placebo. The safety and tolerability of LDX was consistent with its known profile.

E3. Attentional Processing and Sensitivity to Levels of Intensity in Emotional Facial Expression Recognition in Disordered Eating

Tamara Davidson, MA Cand, Laurentian University, Sudbury ON (Presenter)

Adèle Lafrance, PhD, CPsych, Laurentian University, Sudbury ON

Annie Roy-Charland, PhD, Laurentian University, Sudbury ON

Joel Dickinson, PhD, Laurentian University, Sudbury ON

Abstract:

Background: It is generally accepted that problematic emotional processing is central in anorexia nervosa (AN). Individuals with AN have been found to experience difficulty with emotional facial expression recognition in primary negative emotions of disgust, sadness, fear, and anger. Little has been researched about the relationship between emotional facial recognition, and perceptual and attentional processing of emotional faces in AN and the non-clinical disordered eating population. **Objectives:** The purpose of this study was to explore emotional processing deficits in a non-clinical restrictive disordered eating (DE) population by investigating emotional facial expression recognition accuracy in terms of (1) specific emotion; (2) level of emotion intensity; as well as (3) perceptual and attentional processing through eye-tracking. **Method:** Thirty four female undergraduate students were delineated into high (n=12) and low (n=12) DE groups via the Dieting subscale of the Eating Attitudes Test-26 using method of thirds. Participants viewed 96 images from the Japanese and Caucasian Facial Expressions of Emotion data-base, each featuring one of the six basic emotions (anger, disgust, fear, happiness, sadness, surprise) at four intensity levels, and were then asked to identify the emotion expressed. **Results:** Results revealed a significantly higher accuracy in identifying disgust in participants with high DE compared to the low DE group. Results revealed that the high DE group also had higher accuracy for identifying happiness. In effect, they are significantly better at recognizing happiness at a lower level of intensity (intensity 30%). Furthermore, when analyzing eye-tracking data, it was found that those with high disordered eating spent significantly more time viewing the mouth area of the face at the 30% intensity level than those with low disordered eating. **Discussion and Conclusion:** Contrary to the AN literature, the current study shows an increase in recognition accuracy of the negative emotion of disgust in a high DE group. Disgust has been found to be a pivotal, automatic emotion felt in individuals with AN and high EAT-26 scores, therefore those with non-clinical DE may be better at recognizing disgust because of their familiarity with the emotion. In order to accurately identify happiness, visual scanning and attention to the mouth area is both sufficient and necessary. The high DE group spent more time attending to the necessary area of the face than the low DE group which may explain their proficiency of emotion recognition. Higher proficiency at 30% intensity suggests that those with high DE are more sensitive to subtle facial expressions of happiness than those with low DE.

E4. Avoidant Restrictive Food Intake Disorder: A Single Site Experience with Adolescent Patients

Mark L. Norris, MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa ON (Presenter)

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

Nicole Hammond, MA, Children's Hospital of Eastern Ontario, Ottawa ON
Madeline Gray, BA, Children's Hospital of Eastern Ontario, Ottawa ON
Noreen Rahmani, BSc, Children's Hospital of Eastern Ontario, Ottawa ON

Abstract:

Background: Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating disorder (ED) typified by either significant weight loss (or failure to achieve expected weight gain or growth in children), significant nutritional deficiency, dependence on nutritional supplements, or marked interference with psychosocial functioning. Patients with ARFID lack body image disturbances. The study's aims were to examine characteristics of patients meeting criteria for ARFID in an ED setting and describe treatments employed and outcomes obtained. Method: A retrospective chart review was completed. Forty six patients were identified as meeting criteria for ARFID. The Institution's Research Ethics Board approved the study. Results: Patients were 13.5 (SD = 2.5) years old with a mean body mass index (BMI) of 15.61 (SD = 2.0) and at 84.1% of a presumed healthy weight. Most patients were female (83%; n = 38) and one third (33%; n = 15) had a co-morbid anxiety disorder. Two thirds (67%, n= 31) endorsed one or more underlying eating-related fears. A subset (24%; n = 11) identified an acute medical condition as a trigger for the ED. One third of patients (35%, n= 16) required medical admission to hospital with an average length of stay of 39.1 days (SD = 23.9). One third of cases received Family Based Therapy (33%; n = 15) and 33% (n = 15) of cases received olanzapine during treatment. At the time of last clinical encounter, only 30% (n = 14) were weight restored. Follow-up care with other sub-specialty medical clinics and mental health teams was observed in 37% (n = 17) and 24% (n = 11) of cases, respectively. Conclusions: Our experience suggests that patients with ARFID are complex, resource-intensive and difficult to treat. Prospective research is needed to better understand factors that optimize short and long-term outcomes.

E5. Ayahuasca-Assisted Therapy: A Promising Treatment for the Healing of Eating Disorders – But Can We See Past the Controversy?

Adèle Lafrance, PhD, CPsych, Laurentian University, Sudbury ON (Presenter)

Natasha Files, MSW, RSW, Three Story Clinic, Vancouver BC

Kenneth Tupper, PhD, University of British Columbia, Vancouver BC

Anja Loizaga-Velder, PhD, National Autonomous University of Mexico, Mexico City, Mexico

Jenna Fletcher, MA, Adlerian Counselling & Consulting Group, Ottawa ON

Celina De Leon, MPH (cand), MDiv (cand), UC Berkeley & Starr King School for the Ministry, Berkeley CA USA

Abstract:

Background: Ayahuasca is a psychoactive plant-based tea originally used by Amazonian indigenous groups for medicinal purposes. Traditionally administered in a ceremonial context by experienced healers, ayahuasca is increasingly recognized as having physical, psychological and spiritual benefits. Neuroscience shows that one of the ways ayahuasca functions is by activating the amygdala, the storehouse for emotionally-loaded memories. Once these memories are accessed, the cortex processes the memories, allowing the individual to gain appreciation for how the memories have impacted their life, behaviours and associated coping mechanisms (i.e. symptoms). A body of anecdotal evidence, preliminary scientific studies, as well as a strong history of ethnomedical use suggest that ayahuasca has promise in treating anxiety, depression, PTSD and substance dependence. Eating disorders (ED) share similarities with these disorders in that there are underlying deficits in emotion regulation. They have also been described as being among the most difficult to treat of all psychiatric disorders and for this reason, leaders in the field have suggested that promising treatments must be explored. Anecdotal reports have indicated that some individuals with EDs have engaged in ceremonial ayahuasca drinking with positive results. Objectives: Introduce participants to ayahuasca as a healing agent in the treatment

of mental health issues. In addition, and to illustrate its healing potential, a case study will be presented along with quantitative and qualitative data from 20 participants with a history of ED and past ayahuasca use. Design/Methods: Data were collected from 2-2.5 hour semi-structured interviews that reviewed: 1. clinical and treatment histories; 2. subjective evaluations of ayahuasca's therapeutic value, including experiences considered as important; and 3. undesired side-effects/unintended consequences. Transcripts were analyzed using a phenomenological approach. Data were also collected from self-report measures including the Beck Depression Inventory-II, the Beck Anxiety Inventory, the WHO - Quality of Life questionnaire, the WHO – Spirituality, Religiosity and Personal Beliefs questionnaire and the Eating Disorder Examination Questionnaire. Results/Discussion: The data suggest that ceremonial ayahuasca use can serve as a valuable therapeutic tool, giving hope to those along the continuum of ED, including individuals with refractory EDs or those for whom standard medical treatments have not been effective. Participants also outlined recommendations for optimizing outcomes, including perceived limitations. Conclusion: The study results suggest that further observational and clinical research studies are warranted. Following this workshop, participants will be able to (1) describe the use of ceremonial ayahuasca as a treatment approach for EDs and (2) identify key themes and findings, including perceived limitations. Case Presentation: Background demographic and clinical information will be provided with a specific focus on the individual's complementary experiences of Western-based and ayahuasca-assisted therapies for ED.

E6. Case Series: The Development of Anorexia Nervosa Following Bariatric Surgery

Jason A. Bond, MD, FRCPC, Montreal Children's Hospital – McGill University Health Centre,
Montreal QC

Leora Pinhas, MD, FRCPC, Ontario Shores Centre for Mental Health Sciences, Whitby ON

Melanie Stuckey, MSc, Ontario Shores Centre for Mental Health Sciences, Whitby ON

Abstract:

Background: Bariatric surgery has become an increasingly popular method of treating severe obesity. Postoperatively, in part as a result of a reduced gastric volume - though also due to new malabsorption problems that are created by the procedure, patients must be increasingly mindful of their nutritional intake. As such, many of the behaviours encouraged in the service of "healthy" lifestyle changes, are often behaviours classically found in eating disorders (calorie counting, restricting – or purging due to discomfort or bloating). While binge eating is the most common form of disordered eating post-Bariatric surgery, cases of Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are increasingly described in the literature. First degree relatives of people with AN or BN are more likely to have an eating disorder and children may learn disordered eating habits and attitudes through role modeling. While evidence is increasing to show the unintended adverse consequences of weight loss surgery on the patients, the potential effects on the family have not been elucidated. Objectives: 1. To compare the postoperative restrictions in patients who have undergone bariatric surgery with the behaviors seen in AN and BN. 2. To explore the possible mechanisms of transmission of disordered eating behaviours to the young family members of patients undergoing bariatric surgery. Design/Method: This case series describes three individuals affected with AN, who were exposed to bariatric surgery indirectly through an immediate family prior to the development of their eating disorder. Results/Discussion: Case 1 is that of an adult female, with no prior history of psychopathology who developed a severe AN following bariatric surgery and subsequently had her daughter develop AN. Cases 2 and 3 describe two adolescent females, who developed an eating disorder that required multiple inpatient admissions as well as admission to a residential treatment centre for Eating Disorders, following bariatric surgery in immediate family members. In all 3 cases, the children involved were normal weight and had not been encouraged to lose weight by family members. Rather, it was the change in eating patterns and attitudes around them that seemed to affect the children. While there is some consensus in the Eating Disorder community against

an etiological model where parents are seen as the primary cause of the young person's illness, disordered eating attitudes and behaviours in parents have been previously described in the literature and can be one amongst many factors that play a role in the development of an ED. Conclusion: While it is difficult to extrapolate conclusions from a sample of three – and further research on the association between bariatric surgery and AN/BN is needed, this case series should raise awareness about a potential additional complication associated with this already risky procedure.

E7. Characteristics and Treatment Outcome in Male Youth with Eating Disorders

Jennifer S. Coelho, PhD, RPsych, BC Children's Hospital, Vancouver BC (Presenter)

MacKenzie Robertson, BA, 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, RPsych, St. Paul's Hospital, Vancouver BC

Abstract:

Background and Objectives: This project was designed to address the need for additional research on male youth with eating disorders, and to elucidate knowledge about the clinical and medical characteristics of this group. **Methods:** This project involves a retrospective chart review of male youth who received treatment for an eating disorder at one of two specialized eating disorders program (BC Children's Hospital and Woodstone Residence) between 2004-2015. Diagnoses were according to the version of the DSM that was in use at the time of the assessment (i.e., DSM-IV-TR for charts reviewed between 2004-2013, and DSM-5 for charts from 2013-2015). **Results:** A total of 62 males were assessed during the study period, of whom 54 received a diagnosis of a feeding or eating disorder. The majority (n = 35; 64.8%) received a diagnosis of anorexia nervosa. The remaining youth were diagnosed with EDNOS/unspecified eating disorder (n = 15; 27.8%), bulimia nervosa (n = 2; 3.7%), and avoidant/restrictive food intake disorder (ARFID, n = 2, 3.7%). Additional diagnoses of the initial sample included food avoidance emotional disorder (n=1), failure to thrive (n = 1), and subclinical eating disorder (rule out EDNOS, n = 2). Admission and discharge weights were available for a portion of the total sample. A total of 21 males had a weight gain goal associated with admission, and there was a significant increase in weight from admission to discharge ($t(20)=5.92$, $p < .001$), from 84% to 96% of suggested body weight. Testosterone values were available for a subset of the sample, with a significant increase from admission ($M = 7.0$ nmol/L) to discharge ($M = 11.4$ nmol/L, $t(10) = 2.53$, $p < .05$). Males' mean age was 14.6 years (range: 9–24 years). Three males had a first admission at Woodstone Residence, and the remainder had their first admission for treatment at BC Children's Hospital. **Discussion:** The current findings extend previous published research on a subset of male inpatients who received treatment at BC Children's Hospital (Coelho et al., 2015). Anorexia nervosa was the most common diagnosis, despite inclusion of males who were treated across levels of care (i.e., outpatient, day treatment, residential, and inpatient settings). The role of gender, and clinical considerations for treatment, will be discussed.

E8. Community-Based Treatment of Eating Disorders Reduces Eating and Depressive Symptoms

Marie-Pierre Gagnon-Girouard, PhD, Université du Québec à Trois-Rivières, Loricorps, Trois-Rivières QC

Josée Champagne, SW, MSW, Anorexie et boulimie Québec, Loricorps, Pointe-Claire QC (Presenter)

Marilou Chamberland, BSc, Université du Québec à Trois-Rivières, Loricorps, Trois-Rivières QC

Johana Monthuy-Blanc, PhD, Université du Québec à Trois-Rivières, Loricorps, Trois-Rivières QC

Abstract:

Background: Community organizations are an integral part of eating disorders treatment alongside primary care settings and specialized treatment units. Most outcomes studies have shown the efficacy

of ED treatment in controlled settings, yet some evidences is needed to know if ED symptoms can also be effectively reduced in community-based settings (Lowe et al., 2011). Since community-based treatment settings are usually more including and more flexible regarding participation to treatment, it is imperative to conduct valid studies to document their efficacy. Objective: The aim of this study was to test the impact of a community-based psychoeducational and supportive group for eating disorders, on eating and depressive symptoms. Method: Overall, 269 participants were recruited within two types of groups (introduction or advanced level) provided by Anorexie et Boulimie du Québec (ANEB), a community organization offering treatment to individuals with clinical and subclinical eating disorders across the province of Quebec, Canada. Participants' mean age was 34.39 years old (SD = 11.87) and 98,1% were women. The Eating Attitude Test (EAT-26) as well as the Beck Depression Inventory (BDI) were fulfilled at the first and the last meeting of groups. Results: Eating disorders symptoms were significantly reduced at the end of treatment, $F(1,269)= 197.92, p < .000$, as well as depressive symptoms, $F(1,269)= 135.9, p < .000$. Mean EAT-26 score was near the clinical cut-off score at the end of treatment ($M=21.09, SD=11.97$), as post-treatment mean score was 10 points lower than baseline mean score. Mean BDI score was near the cut-off for minimal depression symptoms at the end of treatment ($M=14.24, SD=10.33$). Conclusion: This results indicate that the community-based treatment offered by ANEB in Quebec can significantly reduce eating and depressive symptoms. Clinically significant improvements were observed since most individuals showed final scores within the normal range.

E9. Determinants of Social Support Satisfaction in Adults with Eating Disorders

Megumi Iyar, BA, St. Paul's Hospital, Vancouver BC

Joanna Zelichowska, MA, St. Paul's Hospital, Vancouver BC

Suja Srikameswaran, PhD, RPsych, St. Paul's Hospital, Vancouver BC

Erin C. Dunn, PhD, RPsych, University of British Columbia, Vancouver BC

Josie Geller, PhD, RPsych, St. Paul's Hospital, Vancouver BC (Presenter)

Abstract:

Background: Social support reduces distress and promotes physical health and well-being across a variety of populations. The impact of support attempts has been shown to be determined by a number of factors, including the context of support receipt, and the type of support offered. While the role of support provided by family members is clearly established in the treatment of children and youth with eating disorders, little is known about factors that contribute to support satisfaction and outcomes in adults. Objective: This study examined the contribution of patient factors and perceived support stance in determining social support satisfaction in adults with eating disorders. Method: Individuals meeting DSM-IV criteria for an eating disorder ($n = 133$) completed measures of eating disorder and psychiatric severity, interpersonal functioning, readiness and motivation for change, social support satisfaction, and a newly-developed measure that assesses the type of approach, or stance used (cautious/concerned, encouraging or directive). Results: Correlations with readiness and interpersonal functioning were not significant. However, client psychiatric distress and body dissatisfaction were associated with support satisfaction. In addition, support satisfaction was associated with all three types of support used (cautious/concerned, encouraging and directive). Multiple regression analyses indicated that support approach type accounted for greater variance in social support satisfaction than did client factors. Discussion: The type of approach used by loved ones may play a central role in satisfaction with support received. These results suggest that interventions that assist carers reduce their use of a directive stance and maintain a cautious/concerned and encouraging stance with their loved one may be beneficial.

E10. Development of the Binge Eating Disorder Screener

Barry K. Herman, MD, MMM, Shire, Lexington MA USA (Presenter)

Linda S. Deal, MSc, Pfizer, Collegeville, PA USA

Dana B. DiBenedetti, PhD, RTI Health Solutions, Research Triangle Park, NC USA
Lauren Nelson, PhD, RTI Health Solutions, Research Triangle Park, NC USA
Sheri E. Fehnel, PhD, RTI Health Solutions, Research Triangle Park, NC USA
T. Michelle Brown, PhD, RTI Health Solutions, Research Triangle Park NC USA

Abstract:

Background: Binge eating disorder (BED) was first included as a specific diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The 12-month prevalence of BED in US women and men is estimated to be 1.6% and 0.8%, respectively. However, BED may be underdiagnosed because of a lack of awareness and familiarity in the general medical community. Objectives: The objective of this research was to develop a patient-reported screener to identify individuals with probable BED for further evaluation by their physicians and referral to specialists. Design/Method: Based on DSM-5 diagnostic criteria and existing instruments, draft BED Screener (BEDS) items were developed. Items were reviewed with 3 academic and clinical BED experts, revised accordingly, and debriefed in 2 iterative sets of cognitive debriefing interviews with adults reporting BED-consistent characteristics. In a multisite, cross-sectional, prospective, noninterventional study, the BEDS was administered to 97 adults, each required to have a body mass index of ≥ 19 , and with approximately half of the sample self-reporting DSM-5 BED characteristics. A structured clinical interview (updated to reflect the DSM-5) was administered to participants, who also completed the BEDS and 2 additional self-report instruments (the Binge Eating Scale [BES] and the RAND-36, which measures general health status). Data were used to evaluate the sensitivity and specificity of candidate classification algorithms, based on participants' BED diagnoses (presence vs absence of BED). It was the BEDS developers' intent to optimize sensitivity to ensure that those who truly have BED would be detected, to be conservative in identifying a broader range of individuals with probable BED, and to ensure that no one would be missed for further evaluation or referral. This study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki 2008 and received institutional review board approval. Results/Discussion: Following feedback from the experts, a 19-item version (including 6 alternative items) was tested in cognitive debriefing interviews (N=13), resulting in a 13-item BEDS pilot version. Based on the clinical interview, 16 participants (16.5%) were diagnosed with BED. An algorithm comprising 7 items (BEDS-7) produced optimal sensitivity (100%, 16/16) with reasonable specificity (38.7%, 29/75). These 7 items address the presence of overeating episodes in the last 3 months; lack of control; eating when not hungry; feelings of distress, embarrassment, and disgust; and self-induced vomiting. Based on this algorithm, participants who were correctly identified as true positives tended to have worse average BES and RAND-36 scores, indicating poorer health status, than participants identified as true negatives. Conclusion: The BEDS-7 is a sensitive and valid patient-reported screening tool that can be used to identify individuals with probable BED, identify the need for further evaluation, and facilitate referral. Future research should be conducted to test the real-world feasibility and value of the BEDS.

E11. Empowering Families/Carers Through Emotion Focused Family Therapy (EFFT) Can Help Beat ED in a Loved One

Patricia Nash, MEd – CCC, Eating Disorder Foundation of Newfoundland and Labrador,
St. John's NL (Presenter)

Cathy Skinner, Eating Disorder Foundation of Newfoundland and Labrador, St. John's NL (Presenter)

Abstract:

Background: At our work place we offer a two day Emotion Focused Family Therapy (EFFT) Workshop. This presentation will discuss the powerful benefits for families/carers of attending this workshop and learning the skills of EFFT. We have now given this workshop 16 times to over 100 carers with very positive feedback from participants. Both facilitators have been trained in EFFT. The presentation will

give an overview of the EFFT program we offer to families and discuss the feedback from families. It will discuss how carers often enter the workshop feeling lost and confused but leave the workshop feeling much more empowered to be able to help their loved one. We believe if families/carers are empowered it will increase the chances for recovery for their loved one. It will also look at the benefits to clinicians if EFFT is offered to families. Our EFFT workshop has been part of a National Research Study and is now an ethically approved ongoing Provincial Research Study. We will discuss some of the findings from the national study and look briefly at what has been accomplished so far with the provincial study from 75 carer participants. The presentation will also discuss the unique nature of this EFFT program offered at our workplace; both presenters have lived experience as mothers whose daughters suffered with anorexia some years ago and are now in recovery from their eating disorders. We bring our own lived experiences of journeying with our daughters to the discussions during the EFFT workshop. Carers tell us often how this means so much to them that we bring a heart connection to the discussion; they identify with our stories and hear our passion at wanting to help other families cope with this devastating illness. We incorporate our own struggles into the discussion of how EFFT can help them now have tools that we did not have when our daughters were sick.

E12. Health in Minds: Bridging the Gap Between Clinician and Client

Ali Eberhardt, BSc, FNH, RD, St. Paul's Hospital, Vancouver BC (Presenter)

Jeff Joa, HEALTHINMINDS, Vancouver BC

Abstract:

Background: Food records are a useful therapeutic tool in the treatment of eating disorders. Research shows that when people are conscious of their eating habits, they are better able to identify patterns and begin to make changes. Food records monitor the timing of meals, types of meals, hunger/fullness cues before and after meals, activity levels as well as thoughts/feelings associated with meals/snacks. Using these food records, the clinician is able to provide insight into patterns in which a patient may not be aware. Food records also keep patients accountable and engaged with the recovery process increasing the connection between the emotional mind and the physical body, normalizing eating patterns as well as increasing mindfulness at meals. Food records also serve as an important tool in relapse prevention for transition from treatment to an outpatient setting. Clinically, the presenter has observed that patients have difficulty remembering to fill out paper records in real time and also tend to forget to bring paper records to appointments. Food records are most useful when completed as close as possible to meal times for increased accuracy and promoting mindfulness skills. Patients report difficulty remembering to carry their food records with them when out in the community and embarrassment using paper food records while eating in public. As a means to mitigate some of these challenges, the presenter began to evaluate the eating disorder applications for smart phones that are currently available commercially, but found they lacked relevant clinical aspects which make food records useful in an eating disorder treatment setting. Objectives: With the assistance of a medical application designer, the presenter has designed a smart phone web application for eating disorder recovery called "Health in Minds". The goal of the application is to provide a similar experience to the paper food record but in a more accessible, transportable and discrete form. Design/Method: Eating disorder patients in a 6 month follow up program (which transitions patients from residential treatment to the outpatient setting) will be given the option to access the application in addition to dietitian support. Their experience, engagement and feedback will be evaluated before the program, at the 3 month mark and upon completion whether they use the paper or application form of the food record. Results/Discussion: The research will assess whether engagement, accountability and consistency of food record use increases when using the application. The research will also evaluate the application for acceptability, usefulness and patient feedback which will be used to improve the application. Conclusion: This goal of this application is to eventually expand use to other eating disorder treatment

programs and clinicians. Feedback from the EDAC conference will be a useful part of the expansion of this therapeutic tool and its potential national application.

E13. Hurry Up and Wait: A Case Example of a Novel Treatment Approach to Managing Patients with Anorexia Nervosa Awaiting Inpatient Care

Pauline C. Leung, MSc, Hotel Dieu Hospital, Kingston ON (Presenter)

Brad A. Mac Neil, PhD, CPsych, Hotel Dieu Hospital, Kingston ON

Pallavi Nadkarni, MD, Hotel Dieu Hospital, Kingston ON

Sandra Leduc, RD, Hotel Dieu Hospital, Kingston ON

Abstract:

Background: Currently in Canada, access to specialized inpatient care for eating disorders is extremely limited. Various factors affect the accessibility of such specialized treatment, including a small number of available inpatient beds and a given patient's geographical proximity to a provincially-funded program. However, even if a patient resides in a region that offers an inpatient program, wait times are extremely lengthy—sometimes upwards of six months. There is currently no evidence-based approach for managing patients while they await transition to inpatient care, leaving outpatient teams and physicians scrambling to manage patients with severe eating disorders such as anorexia nervosa (AN). **Objectives:** The purpose of the present paper is to present a novel approach for managing patients with severe AN who are awaiting access to higher levels of care. Initial patient engagement is critical, and there is a risk of patients becoming discouraged by little to no treatment support being offered during this transitional period. It has also been well-established that the sooner patients begin evidence based care, the better the prognosis (Fairburn 2008). **Method:** The case of a 24-year-old female patient with severe AN is presented. The patient was provided with an individualized treatment plan while awaiting transition to inpatient care. This plan took a multidisciplinary outpatient treatment approach, and included approximately 5 to 6 hours of weekly follow-up entailing individual therapy with a psychologist, individual nutrition counseling with a dietitian placing emphasis on re-feeding and weight restoration, follow-up for medical monitoring with a nurse practitioner, and psychiatric follow-up with a psychiatrist. In addition, the patient was able to participate in a weekly cognitive remediation therapy (CRT) group, acceptance and commitment therapy group (ACT) and E.A.T. therapeutic meal support group twice a week. **Results:** Over the course of six months, marked improvements were observed in physical health, nutritional intake, and weight status, as well as various psychological symptoms such as satisfaction with life, interpersonal insecurity, and asceticism. **Conclusion:** This novel group-based approach may represent a feasible and cost-effective intervention for the outpatient management of patients awaiting transition to higher levels of care, rather than leaving them to wait with little follow-up or support.

E14. Improving the Care Experience: Creating Meaningful Engagement Through the Development of a Patient and Family Advisory Committee

Patty Yoon, RPN, MA, Providence Health Care, Vancouver BC (Presenter)

Deb Snider, Providence Health Care, Vancouver BC (Presenter)

Jason MacLeod, Providence Health Care, Vancouver BC (Presenter)

Abstract:

Background: As health care providers, we have a commitment and obligation to provide the best care to patients and their families. The "Care Experience" in which the patients, residents, and families will experience culturally safe, socially just, person and family centered care should be the gold standard yet this is not always the case. Person and family centred care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among healthcare

providers, the people we serve and their families. How do we, as health care professionals know what is best or right for another person? How do we demonstrate patient and family centered care? What do we do to engage and involve our patients and families in their treatment and care? In order to engage in meaningful and impactful approaches to how we deliver treatment and care to patients and their families, we created a Patient and Family Advisory Committee. Hearing the voices and perspectives of patients, families and staff created shared and collective learning and understanding. This committee has been integral in bridging the care experiences of patients and families and how care providers can involve patients and families as partners in care. Objectives: The purpose is to help care providers understand the importance of including the voices of patient and family in improving the quality and delivery of care; and explore how other agencies can create Advisory committees.

E15. Medical Conditions That Require a Specific Diet and Disturbed Eating Behaviours

Marie-Pierre Gagnon-Girouard, PhD, Université du Québec à Trois-Rivières, Loricorps,
Trois-Rivières QC

Josée Champagne, SW, MSW, Anorexie et boulimie Québec, Loricorps, Pointe-Claire QC (Presenter)

Marilou Chamberland, BSc, Université du Québec à Trois-Rivières, Loricorps, Trois-Rivières QC

Johana Monthuy-Blanc, PhD, Université du Québec à Trois-Rivières, Loricorps, Trois-Rivières QC

Abstract:

Background: As digestive disorders are both linked to body and eating, they have a bidirectional relation with eating disorders (ED) (Satherley and al, 2015). In fact, digestive disorders as well as other medical conditions that require a specific adjustment of eating, like diabetes, are both a risk factor for eating disturbances and a consequence of ED (Rodin & al, 2002). More precisely, the way the person adapts to the prescribed diet influences the eating disturbances that can be developed. For example, a rigid adherence to the recommended diet can lead to restrictive eating behaviors (Satherley & al, 2015) while fear of gaining weight back can lead to bulimic behaviors (Smith & al, 2008). Objective: The aim of this study is to explore disturbed eating behaviors associated with medical conditions that require a specific diet. Method: Overall, 602 participants were recruited within a support group (introduction or advanced level) provided by Anorexie et Boulimie du Québec (ANEB), a community organization helping individuals with ED. Mean age of participants was 34.39 years old (SD = 11.87) and 98,1% were women. The Eating Attitude Test (EAT-26) and some questions concerning health problems and eating behaviors were fulfilled at the first and the last meeting of the groups. Participants were then categorized according to the presence or absence of a medical condition requiring a specific diet. For instance, 9,6% present a diabetes condition, 7,9% a cardiovascular condition and 6,5% a digestive problem. Results: Among the people who have a medical condition requiring a specific diet, 50.0% (against 72.6% in the group of people without a prescribed diet) reported restrictive eating behaviors ($\chi^2[1, N=119] = 6.25, p = 0.12$). Moreover, 91.7% of them presented bulimic behaviors, against 81.2% ($\chi^2[1, N=279] = 5.92, p = 0.15$). Both differences between groups were significant. Conclusion: This results indicate that having to follow a prescribed diet can play a significant role in eating disturbances, especially regarding disinhibited eating.

E16. Preliminary Study Examining Self-Evaluation of Body Image Scale (SEBI): Patient Areas of Self-Evaluation, Validity, and Reliability

Vanessa Montemarano, Research Assistant, Hotel Dieu Hospital, Kingston ON (Presenter)

Brad Mac Neil, PhD, Hotel Dieu Hospital, Kingston ON

Abstract:

Background: Body image represents an important variable in the emergence of eating disorders. Measuring the degree to which patients' self-evaluate based on their body image is important in order to understand how much worth individuals place on themselves based on body image so that treatments can target this variable more effectively. Objective: The purpose of this poster presentation is two-fold: (1) To examine areas of self-evaluation based on body image in a sample of Canadian adults who meet DSM-5 diagnostic criteria for an eating disorder; and (2) To examine psychometric properties of a newly developed 6-item scale measuring Self-Evaluation Based on Body Image (SEBI; Mac Neil, 2013). Method: Participants were 33 female adults meeting DSM-5 criteria for an eating disorder. They completed measures including areas of the self-evaluation pie chart activity (Fairburn, 2008), the weight, shape, restraint, and eating concern subscales of the Eating Disorders Examination Questionnaire (EDE-Q; Fairburn & Belgin, 1994), and the newly constructed Self-Evaluation Based on Body Image Scale (SEBI; Mac Neil, 2013). Results: Overall, body image comprised a large proportion ($M = 37.4\%$, $SD = 14.0$) of the way individuals with an eating disorder evaluated themselves as people. Preliminary results indicated that the SEBI was significantly correlated with other measures of body image (eating concern, shape concern, weight concern, restraint) and had high internal reliability (Cronbach's $\alpha = .84$). Conclusion: Body image encompasses a large proportion of how individuals struggling with eating disorders evaluate themselves as people. Therefore, measures of this construct having adequate validity and internal reliability are needed. Preliminary results highlight the usefulness of the SEBI in measuring this construct. Future work would benefit from further evaluation in a larger sample of participants.

E17. Preparing for Evaluation: The Use of a Logic Model in Describing the Adaptation of DBT in an Eating Disorders Program

Sherry Van Blyderveen, CPsych, Homewood Health Centre, Guelph ON (Presenter)

Abstract:

Our Eating Disorders Program (EDP) offers treatment to females and males, ages 16+, with a principle eating disorders diagnosis. The multi-disciplinary staff delivers an innovative therapeutic approach by infusing an adapted Dialectical Behaviour Therapy (DBT) approach with other evidence-based treatment practices. DBT theory, values, and skills are integrated throughout the program for patients, families, and staff. In 2015 our program celebrated 25 years of treatment provision, and we sought to examine how the current program was operating, how its activities aligned with the intended treatment outcomes, and determined if the adapted DBT initiative contributes to improved treatment outcomes. To integrate evaluative thinking, we partnered with researchers to develop a logic model that described the program's inputs, activities, expected outcomes, and overall goals. With the use of a logic model, this poster presentation will highlight our program components.

E18. Targeting Body Dissatisfaction in the Later Stages of Evidence-Based Care: Preliminary Outcomes

Pauline C. Leung, BSc, Hotel Dieu Hospital, Kingston ON (Presenter)

Brad A. Mac Neil, PhD, CPsych, Hotel Dieu Hospital, Kingston ON

Pallavi Nadkarni, MD, Hotel Dieu Hospital, Kingston ON

Abstract:

Background: Body image concerns, despite being very common among individuals struggling with eating disorders, often remain unaddressed. In fact, treatments targeting body dissatisfaction are commonly considered to be of lower priority in tertiary level eating disorder treatment programs for adults. Unfortunately, this may lead to programs either offering interventions targeting this area at times when patients may not be in a place to optimally benefit from the treatment (e.g., inpatient group therapy, early phases of CBT for bulimia nervosa (BN)), or not at all. Objective: The purpose of this study is to present pilot data in preparation for a randomized control trial (RCT) examining an innovative group

therapy approach for body dissatisfaction. This approach is based on current best practices and has been piloted with older adolescents and adults in outpatient eating disorder programs in Canada and the US. This study aims to elucidate the importance of addressing patients' dissatisfaction with their bodies, and when it might be optimal to do so. Method: Participants were adults (ages 18 to 50) who met DSM-5 criteria for an eating disorder. A battery of psychological measures were completed both before and after participation in a group therapy for body dissatisfaction. The battery included the Areas of Self-Evaluation Pie Chart, the Eating Disorders Examination (EDE-Q), and a patient satisfaction questionnaire. Results: Participants experienced a decrease in weight and shape concerns post group. Chi square analyses revealed a significant decrease in the degree to which participants' body image contributed to their overall evaluation of themselves as individuals, following participation in the group therapy. Conclusion: Body dissatisfaction and body image continue to represent a great concern for individuals struggling with eating disorders, and these individuals often use body image to evaluative themselves as people. Specific intervention targeting these areas are warranted, especially in the later stages of eating disorder treatment.

E19. The Story of Ubuntu

Gisele Marcoux-Louie, MSc, Alberta Health Services, Calgary AB (Presenter)

Lana Bentley, MSW, RSW, Alberta Health Services, Calgary AB (Presenter)

Abstract:

Background: It started as a question, "How do we better support patients with severe enduring eating disorders (SEEDs)?" After years of observing this subset of patients struggle with invalidating experiences in day treatment, multiple inpatient admissions, and adversarial relationships with staff, it was decided that something different was needed. The treatment component "Connections" was born of the idea that patients with SEEDs would fare better if staff moved from a place promoting full recovery to promoting connection. The focus was on supporting patients in establishing connection with: the self; supportive others; community; and safer ways of living. The component offered case management, a nursing clinic, and a weekly drop-in group called "Ubuntu" which means to discover one's humanity through connection with others (or the universe) and was selected to capture the essence of an innovative intervention that galvanized program staff, re-energized patients, and shifted the focus to compassionate acceptance. Discussion: In the absence of preferred outcomes, thoughtful reflection of the gap between clinical needs and available treatment modalities allowed us to identify that it was time for a new intervention. An outpatient treatment component was developed by integrating clinical wisdom with the literature and learnings from community agencies, other eating disorder programs, and chronic disease management clinics. Launching the component required staff to engage in a paradigm shift that took nearly five months of awareness raising, education, and discussion. With parallels system level and clinical engagement, we will review factors that have been central to the development and maintenance of this treatment component. In every good story are characters that you care for and a cause that you want to believe in. At the heart of Ubuntu is a belief that change is possible even if recovery isn't. Everyone gets to re-author their next chapter based on what matters to them.

E20. To Wait or Not to Wait: Evidence Based Waitlist Management for Outpatient Eating Disorder Treatment?

Kelty Berardi, PhD, Lakeridge Health Eating Disorders Program, Oshawa ON (Presenter)

Sarah Parks-Quinn, NP, Lakeridge Health Eating Disorders Program, Oshawa ON (Presenter)

Abstract:

Background/Objectives: A challenge for many patients suffering from an eating disorder is finding treatment services in a timely manner. Following a referral to treatment, some patients are faced with wait times that can be up to 1 year depending on the availability of services in their demographic area (Norris et. al., 2013). Theoretically, for some patients, this length of wait could be the difference between needing outpatient treatment services compared to more intensive, and costly, inpatient programming. In contrast to inpatient programs, which have clearer standards that may involve prioritizing patients based on medical criteria, it is less clear on how to prioritize patients on an outpatient waiting list, or if patients should be prioritized at all. Outpatient programs that provide services to children, adolescents, and adults may experience the additional challenge of determining whether to prioritize patients on the nature of age alone, given that the developmental consequences associated with prolonged paediatric malnutrition are well-documented (Locke and Le Grange, 2005). Thus, an objective of the current presentation is to examine whether there is any empirical evidence that can be used in wait list management decision making in an outpatient treatment setting. A second objective is to facilitate a discussion on how outpatient eating disorder programs make these decisions currently. **Design/Method:** Patient demographics and symptom presentation at time of intake were compared to patient presentation at time of assessment ($N=100$). Specifically, variables that are indicative of eating disorder severity (i.e. weight status in the case of restrictive eating disorders and frequency of symptoms) were analyzed using a repeated measures design to examine if patient clinical presentation significantly changed between the time of intake screening and the time of assessment. **Results/Discussion:** The wait time for services ranged from 12 to 301 days ($M 144.8, SD= 63.9$). Contrary to expectations, patients who were underweight at the time of referral ($BMI \leq 18.5$) demonstrated significant improvements in weight while on the wait list regardless of age ($t(22)=4.95, p<.001$). In contrast, frequency of reported binge eating did not significantly differ over time ($t(89)=-.145, p=.885$), nor did frequency of self-reported vomiting ($t(92)=.838, p=.404$), regardless of patient age. Thus, it appears that symptom presentation remains stable, and may even improve, while patients are on the wait list for services. In light of these findings, wait list management and decisions pertaining to how, and if, to triage patients on the basis of presenting demographic and clinical variables at the time of intake will be discussed.

E21. What Makes It Hard for Family and Friends of Adults with Eating Disorders to be Collaborative?

Joanna Zelichowska, MA, St. Paul's Hospital, Vancouver BC

Megumi Iyar, BA, St. Paul's Hospital, Vancouver BC

Michel Thibodeau, PhD, Toronto General Hospital, Toronto ON

Suja Srikameswaran, PhD, St. Paul's Hospital, Vancouver BC

Erin C. Dunn, PhD, University of British Columbia, Vancouver BC

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Abstract:

Background: A collaborative support stance in family and friends (carers) has been linked to patient motivation and positive clinical outcomes across a number of health care populations. In the eating disorders, little is known about factors that promote or interfere with use of a collaborative stance. **Objective:** This research described the type of support offered by carers of adults with eating disorders and examined determinants of the provision of collaborative vs. directive support. **Design/Method:** Participants were mothers, fathers, partners, friends and siblings ($N = 141$) of eating disorder patients in hospital or residential treatment. Two methodologies were used to assess directive and collaborative support stance: a questionnaire of support behaviours and coded responses to clinical vignettes. Measures of interpersonal functioning, psychiatric distress, caregiving experience and closeness with their loved one were also completed. **Results:** Whereas carers rated a collaborative stance as more helpful than a directive stance, 60% of responses to the clinical vignettes were coded as directive. Across

both methodologies, collaborative support behaviours were associated with beliefs about helpful support and with a less vindictive and cold interpersonal style. Whereas use of a directive support stance was exclusively associated with negative experiences, collaborative responses were associated with closeness and positive experiences as well as a combination of closeness, positive and negative experiences. Discussion: Although a central role has been assigned to using a collaborative stance, this is the first study to examine its determinants in carers of adults with eating disorders. Findings suggest a number of ways to support carers in maintaining collaborative relationships such as addressing beliefs and interpersonal style and capitalizing on both positive and negative experiences with their loved one.