

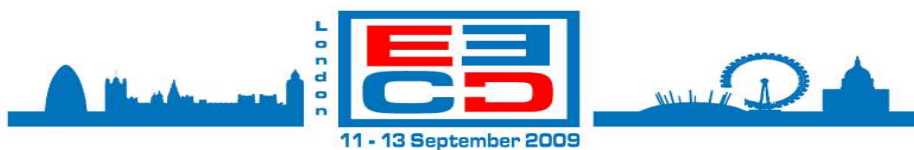


EUROPEAN COUNCIL ON EATING DISORDERS

***** *Twenty-Year Anniversary Meeting* *****
(1989 – 2009)



*London (1989); Leuven (1991); Prague (1993); Dublin (1995); Padua (1997); Stockholm (1999);
Barcelona (2001); Budapest (2003); Innsbruck (2005); Oporto (2007); London (2009)*





YOUR VENUE

THE ATHENÆUM CLUB

It often surprises visitors to the Athenæum to learn that the building was designed by an architect – *Decimus Burton* – who was just twenty-four when given the commission. He had been invited by the originator of the Club, *John Wilson Croker*, to become a Member on the Club's foundation in 1824 and was already noted for his work designing the layout of Hyde Park, the triumphal arches at the entrance to the park at Hyde Park Corner and the Holme in Regent's Park.



The Athenæum, circa 1832

When his building was nearly finished, Decimus was persuaded to include as a frieze around the outside a copy of the recently rescued marbles from the Parthenon in Athens ("The Elgin Marbles", now in the British Museum), the frieze to be executed by *John Henning*, a leading sculptor of the day. This proposal was pushed through the committee despite the enormous cost (over £2,000 – about 5% of the entire cost of the building). Others would have preferred the money to be spent on the creation of an ice house to provide cold storage in the summer, which led to the composition of the witticism:

*I'm John Wilson Croker,
I do as I please;
Instead of an Ice House
I give you - a frieze!*



The Drawing Room

Croker's marble bust, by *Francis Chantrey* (who was also a Member of the club) is to be seen on a mantel-shelf in **the drawing room**, close to a bust of the club's first secretary, *Michael Faraday*, who was to announce the discovery of electromagnetic induction in 1832. The club benefited from his inventiveness, as just before he died in 1886, it became one of the earliest buildings ever to be lit by electric light, using its own generator until a public supply became available in the mid 1890s.

The great staircase has seen many famous figures pass by. The clubhouse carries echoes of the presence of great men of the past that inspire each new generation. There are many stories - one on record describes the reconciliation at the foot of the stairs in 1863 between *Charles Dickens* and *William Makepeace Thackeray*, who had not spoken to each other for years, after a famous quarrel. Thackeray, although only 52 was clearly a dying man. Dickens, seeing him slowly descending into the hallway, stepped forward, offered his hand and here in the hall made up a quarrel of some twelve years duration so that Thackeray could die at peace with the man who had once been his close friend.



The Great Staircase

Fifty-two members of the club, past and present, have won a Nobel Prize, including at least one in each category of the prize. 1902 saw the first award to be held by a member - this was the prize for medicine (the first of twelve to be held in that category). Prizes for Physics and for Chemistry followed two years later, Literature in 1907, the Peace Prize in 1949 and Economics in 1972. The latest Nobel Prizes to be awarded to Members were those for Peace and Medicine, in 1998 and 2001. Portraits and biographies of all are inscribed in a memorial volume to be seen in the club, on the **first floor landing**.



The Garden Room

The clubhouse is entirely redecorated every few years, the style changing from time to time. The present treatment of the walls and curtains of the two largest rooms is derived from Decimus Burton's own sketches, lately retrieved from the archives. Some of the mahogany furniture that was designed for the club by Burton is still in use, and can be recognised from his drawings.

The Picture Room, is hung with portrait sketches, mainly drawn by members of the club. In the adjacent corridor are originals of famous newspaper cartoons featuring the club as it is imagined by the general public - not always bearing much resemblance to the real spirit of the place, but good fun nevertheless.

We hope that all our delegates will enjoy their visit to the Athenæum and find here that companionable welcome and stimulating conversation that is the hallmark of this, and all good clubs.



YOUR MENUS

Friday 11th September 2009

Cornish Cream Tea

English tea
Scones with strawberry jam and clotted cream
Fruit tartlets
Fruit cake
Selection of sandwiches: cucumber, smoked salmon, tomato and ham

Selection of Canapés:

Wild mushroom tartlets with melted brie
Seared scallop in bacon
Beef fillet with Béarnaise sauce
Thai fishcakes with sesame and lime sauce
Gazpacho
Fresh fruit skewers

Wines

Givry 2006, Picard, Domaine Voarick
Château Patache D'Aux 2003, Cru Bourgeois, Médoc
Château de Sours 2006, Rose, Bordeaux
Elderflower water

Cavell String Quartet:

Charis Jenson ~ Violin
Sophie Lockett ~ Violin
Bryony Mycroft ~ Viola
Ben Pont ~ Cello

Saturday 12th September 2009

Luncheon

Steak, kidney, oyster, mushroom and ale pie

Wild mushroom risotto

Darn of salmon, hollandaise sauce

New potatoes

Selection of seasonal vegetables

Salads

Crème brûlée

Chocolate and raspberry roulade, raspberry coulis

Fresh fruit

Wines

Givry 2006, Picard, Domaine Voarick

Château Patache D'Aux 2003, Cru Bourgeois, Médoc

Château de Sours 2006, Rosé, Bordeaux

Elderflower water

Afternoon Tea

Lemon cake, fruit cake and marble cake

*Selection of sandwiches: cucumber, smoked salmon, tomato
and ham*

Tea and coffee

Elderflower water

Sunday 13th September 2009

Luncheon

Roast beef and Yorkshire pudding, roast potatoes
Fish pie
Saffron and sun-dried tomato tart
New potatoes
Selection of seasonal vegetables
Salads

Bread and butter pudding, cream, crème anglaise, ice cream
Gooseberry pie, cream, crème Anglaise, ice cream
Campari and orange jelly with caramelised oranges
English cheeses: whole stilton, Davidstow mature cheddar, goat's cheese, celery and grapes
Wines
Givry 2006, Picard, Domaine Voarick
Château Patache D'Aux 2003, Cru Bourgeois, Médoc
Château de Sours 2006, Rosé, Bordeaux
Elderflower water

Afternoon Tea & Champagne

Mini scones with strawberry jam and clotted cream
Fruit tartlets
Tea and coffee

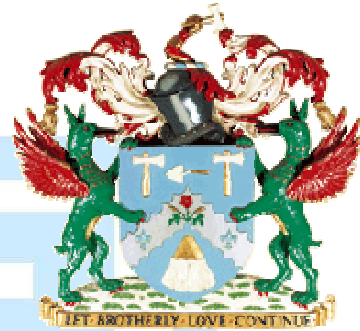
Victoire N/V
Elderflower water



YOUR BANQUET

PLASTERERS' HALL

The first Plasterers' Hall was bequeathed to the *Company of Plasterers* (a trade guild for plasterers) by William Elder in 1556. It was situated at the corner of Addle Street and Philip Lane and destroyed in the Great Fire of London in 1666. The second Hall was built in 1669 from the design of Sir Christopher Wren, but this was also destroyed by fire in 1882. A third hall was destroyed during the Blitz. The present Hall, opened in November 1972 has décor throughout of the neo-classical style created by Robert Adam in the 18th Century.



*The Company of Plasterers'
Coat of Arms*

The Company was granted its Armorial Bearings in 1546, and they depict a plasterer's trowel between two plasterer's hammers along with a plasterer's brush on a blue background. The plasterer's brush is separated from the trowel and hammers by a silver chevron on which are depicted a red rose and two fleurs de lys. These are supported on either side by a green opinicus which is an heraldic beast having the head, neck and wings of an eagle, except that the head has prominent ears, the body and legs of a lion but with a bear's tail.



Plasterers' Hall Interior

The modern-day Plasterers' Hall is the largest and one of the finest Livery Halls in London. Located in the heart of the City of London, it reflects the pomp and splendour of a bygone era, situated in an ultra-modern environment. Tonight you will have award-winning cuisine from *Create* food and party design.

Traditional London buses – sadly no longer on our streets – will leave the Athenæum for Plasterers' Hall at 18:30 on Saturday.

Saturday 12th September 2009

Dinner

Pan seared fillet of seabass

With a wilted spinach & wild mushroom & truffled cream sauce

Grilled fennel with goat's cheese, pine nuts & black olive oil (v)

Sorbet

Pink roasted breast of Gressingham duck

*With a chilli, acacia honey & ginger glaze served on roasted squash with
fine French beans, tossed scallions & chilli*

Rotollo of sweet potato, artichoke heart, spinach & feta cheese

With French beans & romesco sauce (v)

Create summer pudding

Coffee & petit fours

Wines

Sauvignon Blanc Les Bateaux, Francois Lurton

Merlot Les Bateaux, Francois Lurton

The Loving Cup

(See following page for more information)

Vocal Ensemble

Madeleine Pierard ~ Soprano

Tyler Clarke ~ Tenor

Marc Verter ~ Pianist

The Loving Cup

The passing of the Loving Cup, filled with spiced wine termed “Sack”, is characteristic of many City Banquets.

At the conclusion of a medieval City dinner and immediately after Grace, the Master of the Plaisterers would drink a hearty welcome to the assembled company. Upon rising to drink from the Loving Cup, the persons on each side of the Master would also stand, turning INWARDS towards the Master.

The Master would turn to his right-hand neighbour, bow to him and repeat the Company’s motto “LET BROTHERLY LOVE CONTINUE”. The right-hand neighbour would remove the cover of the Loving Cup with his right or dagger hand. This would prevent the right-hand neighbour from stabbing the Master! The Master then drinks to him, wipes the Loving Cup with the napkin and the right-hand neighbour replaces the lid.

The procedure is then repeated. The right-hand neighbour then turns to *his* right-hand neighbour who in turn rises turning INWARDS. The Master’s left-hand neighbour resumes his seat and the Master remains standing still facing to his right.

The procedure continues to be repeated so that there will ALWAYS BE THREE AND ONLY THREE PERSONS STANDING AT THE SAME TIME, the one in the centre drinking, and the other two facing INWARDS, towards the one drinking and each other.

It is traditional in the Plaisterers’ Company for the persons either side of the drinker to face INWARDS and towards the one being drunk to. This allows both to keep a wary eye on each other lest one attack the Master. Treachery was frequent!

Although this is an interesting old-time custom, it continues to be done at every Livery dinner in the City. Apart from fun for us this evening, it allows us to formally pledge the warmth and fellowship of the European nations which put together the ECED twenty years ago.



YOUR LONDON

London Underground Map (Zone 1: Central London)



The nearest stations to the Athenæum are **Piccadilly Circus** (*Piccadilly Line or Bakerloo Line*) and **Charing Cross** (*Northern Line or Bakerloo Line*).

Location of Plaisterers' Hall

Plaisterers' Hall – at One London Wall – is within walking distance from **St. Pauls** Underground Station (*Central Line*).





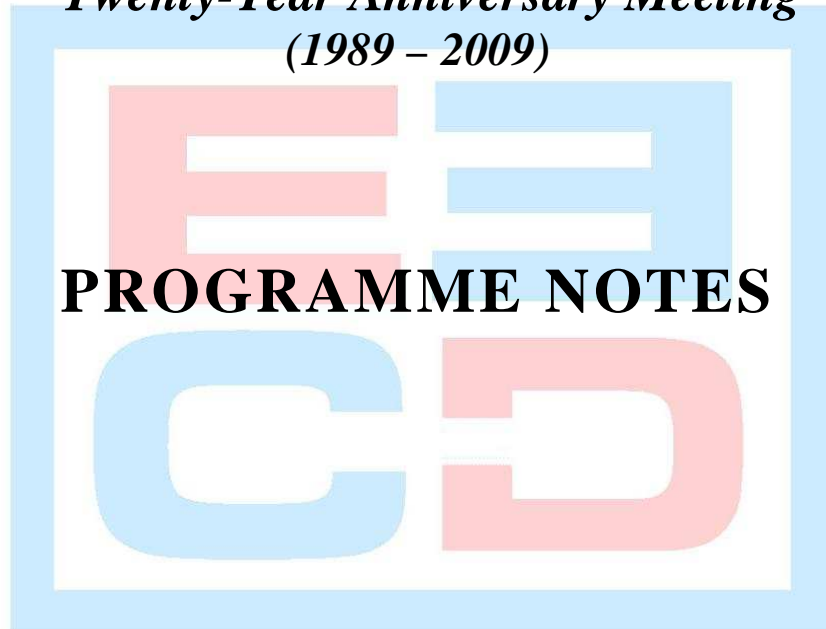
The ECED acknowledges with thanks the receipt of an educational grant from Capho Nightingale, central London's leading independent health care hospital.





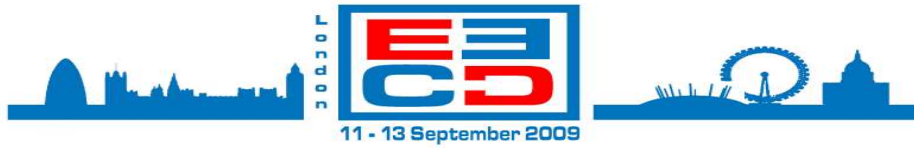
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A warm welcome to the ECED and to London. This is the twentieth anniversary of the first meeting of the ECED in 1989 in London. Since that time, we have met every two years in a different European city and I'm delighted that the meeting has now returned.

A quick look around you will show you that much has changed over these twenty years. The first meeting was in a series of student lecture-rooms at St George's and the main social event was in my home. My wife, Sue, cooked for 110 people and my, then, young children served the drinks! Now we are in the, rather, imperial surroundings of The Athenaeum and this evening we will dine in the neo-Adam styled Hall of the Plaisterers' Livery Company. A far cry indeed!

Although some things have changed, the principles and procedures have not. From its foundation, the ECED was seen as a clinical debating forum and this weekend's programme has kept very much to this tradition. Not only will you be debating, but you will also discuss relevant clinical topics in a semi-formal setting. The aim is always that you, the delegates, give your considered clinical opinions, and are not just an audience.

The ECED has a secondary aim of bringing colleagues throughout Europe together in a collegiate atmosphere. For this reason, we have ensured that there are many breakout rooms where you may sit and talk, and follow through on topics that either have been part of the plenaries, concurrent sessions or debates. To assist, there will be good food and wine, and hopefully laughter. Most of all, there is an appreciation that our problems are common from wherever we have come from and that we must determine how we will deal with clinical, ethical, financial and political problems which influence our work.

This meeting has been done on a shoestring. Bob Palmer, Lalitha De Silva and I worked out the structure and the programme. We have been helped by our Scientific Committee whose names appear adjacent to this. Walter Vandereycken and Gerry Butcher have guided our hands. Others too have helped, particularly my wife Sue and my secretary, Mrs Danuta Taylor. We would also like to thank the Secretary of The Athenaeum and the Master of The Plaisterers whose staff have been wonderfully helpful. Nothing could be too much for them. Thanks too to Mr Martin Thomas, Hospital Director of Capio UK, for support, advice and financial help. Thanks too to Professor Peter Kopelman, the Principal of St George's, University of London, who has extended help with the infrastructure of the meeting.

Our thanks to In Any Event and particularly to Vickie Hancock whose staff, together with my students, will assist you during these two days.

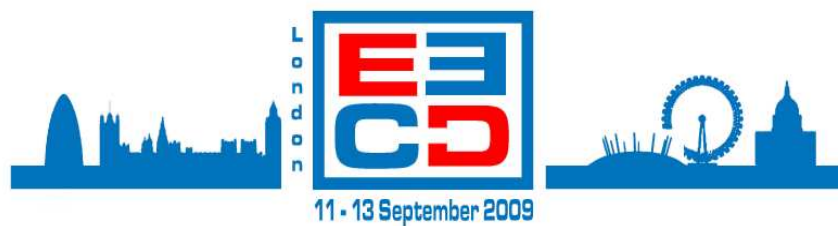
May I again warmly welcome you to London and the ECED!

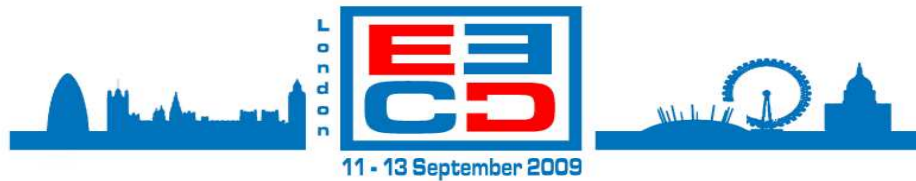
Hubert Lacey
11th September 2009

ECED Scientific Committee

Dr Angela Favaro (Italy)
Dr Claes Norring (Sweden)
Dr Eric van Furth (The Netherlands)
Dr Erika Toman (Switzerland)
Dr Fernando Fernandez (Spain)
Professor Finn Skårderud (Norway)
Mr Gerard Butcher (Ireland)
Dr Günther Rathner (Austria)
Professor Irena Namysłowska (Poland)
Ms Kristine Dietz Godt (Denmark)
Dr Manfred Fichter (Germany)
Dr Paolo Santonastaso (Italy)
Professor Paulo Machado (Portugal)
Dr Sandra Sassaroli (Italy)
Dr Ferenc Túry (Hungary)
Professor Walter Vandereycken (Belgium)

Dr Lalitha De Silva, Professor Bob Palmer and Professor Hubert Lacey





OVERVIEW

Friday, 11th September

15.15 – 18.30 **Reception and registration**

Saturday, 12th September

8.00 – 9.30 **Registration**

9.30 **Opening**

9.45	Debate 1: “This house believes we should invest much more of our limited resources into preventing eating disorders”
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11.15 **Tea and coffee**

11.45	<p><u>CONCURRENT SESSION I</u></p> <ol style="list-style-type: none"> 1. <u>Case presentation:</u> “An impossible clinical case – when should treatment be withdrawn?” 2. <u>Clinical discussion:</u> “Does dynamic therapy have a serious role in the treatment of eating disorders?” 3. <u>Research presentations:</u> “New technologies in the treatment of eating disorders”
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13.00 **Lunch**

14.15	<p><u>CONCURRENT SESSION II</u></p> <ol style="list-style-type: none"> 1. <u>Clinical discussion:</u> “Treatment options for patients with Severe and Enduring Eating Disorders (SEED)” 2. <u>Clinical discussion:</u> “Do we need a new instrument to measure recovery from eating disorders?” 3. <u>Clinical discussion:</u> “The changing face of eating disorders”
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15.30 **Afternoon tea**

Saturday, 12th September

16.15 **Plenary session:** “DSM-V: here we go again?”

18.00 Close

18.30 - 18.50 Bus departs for Plaisterers’ Hall

19.30 **Banquet**

Sunday, 13th September

8.30 **Breakfast**

9.00 **Business meeting**

10.00 **CONCURRENT SESSION III**
1. **Research-Practice Session**
2. **Clinical Discussion:** “Re-negotiating body image”
3. **Research presentations:** “New European research”

11.00 **Mid-morning refreshments**

11.30 **Plenary discussion:** “How does family treatment work?”

13.15 **Lunch**

14.30 **Debate 2:** “This house believes that information-sharing and carer involvement in the treatment of severe eating disorders should take precedence over confidentiality”

16.00 **Closing Reception**
Conference photograph

17.30 End



EUROPEAN COUNCIL ON EATING DISORDERS

PROCEDURE FOR DEBATES

1. Each debate lasts for an hour-and-a-half and the intention is that the delegates, not the proposers and opposers, should have as much time to debate the motion as possible. The role of proposers and opposers is to initiate the exchange of ideas, not to dominate the proceedings. All delegates are encouraged to participate.
2. The first proposer will propose the motion first. Each side of the debate will have 15 minutes to make their case. There will be two proposers and two opposers. The moderator will not allow them to go beyond their 15 minutes, which may be variably apportioned, between the two speakers.
3. The speakers and the delegates do not necessarily have to hold the opinions they express. Debates often flourish when a delegate takes an extreme stance. Delegates should not be concerned if their views appear too radical.
4. Delegates may speak by either informing the moderator prior to the debate that they wish to be called, or alternatively raising their hand once the debate has been “open to the floor”. It is preferable that speakers stand when speaking and give their name.
5. Remember that this is a debate and therefore the delegates should not ask questions of the proposer or opposer, but rather give their opinions.
6. The debate will end either by the proposer and opposer making a final brief statement or by the moderator giving a brief summary.
7. At the end of the debate, the moderator will call for a show of hands. Votes will not be scrupulously counted, but the moderator’s impression will suffice.



PROGRAMME NOTES

Friday, 11th September

15.15 – 18.30 **Reception and registration:** Cornish Cream Tea followed by wine and canapés, accompanied by a String Quartet

Saturday, 12th September

8.00 – 9.30 **Registration** and early morning breakfast

9.30 **Opening** Prof Gerald Russell

9.45 **Debate 1:** “This house believes we should invest much more of our limited resources into preventing eating disorders”

Chair: Prof J Hubert Lacey (UK)

Proposers: Dr Runi Børresen (N)
 Dr Greta Noordenbos (NL)

Opposers: Dr Eric van Furth (NL)
 Miss Kristine Dietz Godt (DK)

11.15 **Tea and coffee with biscuits**

11.45 **CONCURRENT SESSION I**

1. Case presentation: “An impossible clinical case – when should treatment be withdrawn?”

Speakers: Dr Ty Glover (UK) and Dr John Fox (UK)

Moderator: Dr Manfred Fichter (D)

The session will begin with a clinical presentation of a patient who has enduring anorexia and is medically unstable. She represents those patients who enter a cyclical pattern of admission, discharge and relapse with no discernable progress. She requires nasogastric feeding daily which is understandably very distressing to her. This case is further complicated by the fact that when the feeding is withdrawn, she becomes medically unstable very quickly. As a part of the presentation, the clinical choices

Drawing Room

that face the MDT will be discussed, including the option to withdraw treatment. Given the stark ethical dilemmas that this case brings, it is hoped that the debate will widen to the general topic with full audience participation.

Garden Room

2. Clinical discussion: “Does dynamic therapy have a serious role in the treatment of eating disorders?”

Speakers: Dr Finn Skårderud (N), Dr Ferenc Túry (HU)

Moderator: Dr Claes Norring (S)

Cognitive or cognitive-behavioural therapy dominates contemporary psychological treatments for eating disorders. Cognitive therapy is driven by evidence-based research, yet psychodynamic treatment has its adherents. This is because it has an emphasis on the patient-therapist relationship which most deem crucial to the treatment of eating disorders, and especially anorexia nervosa. Anorexia particularly struggles to respond to cognitive techniques and the long-term nature of its recovery fits well with dynamic treatment which has a long-term perspective for change. Further, contemporary psychodynamic treatment has integrated a developmental perspective and there is enough evidence for severe eating disorders to be seen as impaired development. The role of dynamic treatment as an adjuvant to cognitive therapy, nutritional counselling or nursing support, has its adherents too. These will be discussed.

Picture Room

3. Research presentations: “New technologies in the treatment of eating disorders”

Speakers:

Dr Fernando Fernández (E)

PlayMancer project: A serious videogame as additional therapy tool for eating disorders

Dr Isabelle Carrard (CH)

Internet-based treatment of bulimia nervosa: a European experience

Dr Hayriye Gulec (HU)

Development of an internet delivered support program for patients with bulimic symptomatology

Dr Peter Daansen (NL)

First drop-out analysis of an internet based treatment of eating disorders

Chair: Prof Ulrike Schmidt (UK)

13.00

Buffet lunch with wine (see Menu)

14.15

CONCURRENT SESSION II

Drawing Room

1. Clinical discussion: “Treatment options for patients with Severe and Enduring Eating Disorders (SEED)”

Speakers: Dr Hans Bloks (NL), Dr Bryony Bamford (UK)
The focus on management of eating disorders has hitherto been on reduction of symptoms, weight-gain and, as far as possible, eradication of the disorder. Whilst laudable, this approach risks neglecting those who remain unwell, due to failed or unavailable treatment. This group, with Severe and Enduring Eating Disorders (SEED), appear to require rehabilitation, adaptation to symptoms, and a greater emphasis on developing other capacities, while encouraging positive changes in eating disorder symptoms. Approaching patients using Eating Disorder Rehabilitation Psychiatry will require expanded services, extensive liaison with other professionals and research into appropriate models of care.

Moderator: Dr Paul Robinson (UK)

Picture Room

2. Clinical discussion: “Do we need a new instrument to measure recovery from eating disorders?”

Speakers: Prof J Sundgot-Borgen (N)
Prof Jan Rosenvinge (N)

Different criteria for recovery from eating disorders are used in effect and outcome studies, suggesting different rates of recovery. Not only researchers, but also patients and therapists have different ideas about criteria for recovery. Dependent on the instrument used to measure recovery the percentage of recovered eating disorder patients can vary from 3% till 95%. Do we need to develop a new instrument to measure recovery from eating disorders?

Moderator: Dr Greta Noordenbos (NL)

Garden Room

3. Clinical discussion: “The changing face of eating disorders”

Speakers: Dr Angela Favaro (I), Dr Johan Vanderlinden (B), Dr Gabriella Milos (CH)

This session will discuss the implications of changes in presentation and epidemiology of the eating disorders for the understanding of their pathogenesis. We will look at trends in the scientific literature and changes in the clinical characteristics of patients, variation in age of onset of the disorders, and the stability and instability of the conditions. These concepts will be expanded in the discussion with full audience participation.

Moderator: Prof Paolo Santonastaso (I)

15.30

Afternoon tea

16.15

Plenary session: “DSM-V: here we go again?”

16.15 – 16.35

DSM-V: Eating disorders revision process
Prof Hans Wijbrand Hoek (NL)

16.35 – 16.55

DSM-V: Eating disorders in children
Dr Rachel Bryant-Waugh (UK)

16.55 – 16.10

Discussants:
Dr Josefina Castro-Fornieles (ES)
Prof Paulo Machado (PT)

17.10 – 17.45

Open discussion with moderator:
Prof Walter Vandereycken (B)

Dr Rachel Bryant-Waugh and Prof Hans Hoek will deliver an overview of all proposed suggestions from the DSM-V workgroup, together with literature reviews. Dr Josefina Castro Fornieles and Prof Paulo Machado will be the critical discussants before Prof Walter Vandereycken engages the audience in further debate.

18.00

Close

18.30

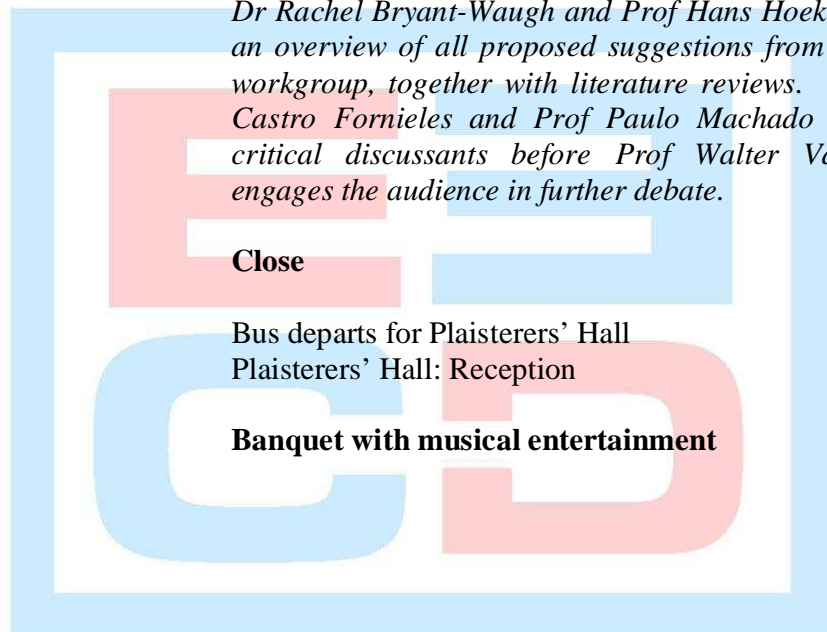
Bus departs for Plaisterers' Hall

18.50

Plaisterers' Hall: Reception

19.30

Banquet with musical entertainment



Sunday, 13th September

8.30 **Morning breakfast**

9.00 **Business meeting**
Mr Gerry Butcher (Chair), Prof Walter Vandereycken
and Prof Hubert Lacey

10.00 **CONCURRENT SESSION III**

Drawing Room 1. **Research-Practice Session**

Speakers: Ms Judith Banker (US), Prof Bob Palmer (UK),
Dr Angela Favaro (I)

There is a divide between researchers and clinicians in our field. Important research findings are not implemented in many clinical settings, and valuable clinical observations and experience do not inform the direction of eating disorders research. Researchers value the findings from randomized controlled trials (RCTs), which emphasize empirically-tested treatments, whilst clinicians tend to value clinical observation more and the wisdom and experience of experts. One place to start in bridging research and practice is by addressing the question: “What qualifies as evidence?” “Are the findings of empirical research the only worthwhile evidence?” “What do patients value?”

Garden Room

2. **Clinical Discussion: “Re-negotiating body image”**

Speakers: Dr Giovanni Ruggiero (I) & Prof Anita Jansen (NL)

The position of body image disturbance in eating disorders has evolved to encompass attitudinal and affective components, whilst treatments vary considerably in emphasis and focus. This lively session will explore different approaches to body image treatment, including the role of formalized body image interventions and new treatment approaches.

Moderator: Dr John Morgan (UK)

Picture Room

3. Research presentations: “New European research”

Speakers:

Dr Trine Wiig (N)

Job satisfaction amongst nursing staff on eating disorders units

Dr Andreas Birgegard (S)

Eating disorders, co-morbid psychiatry and self-image

Dr Manfred Fichter (D)

Self-injurious behaviour, in the context of impulsivity, borderline personality disorder and sexual abuse in eating disorder: Psychological and genetic factors

Dr Laurence Claes (B)

The roles of temperament, effortful control, and cognitive control in differentiating bingeing-purging and restrictive eating disorders

Dr Sandra Sassaroli (I)

Perceived criticism as the third variable between maladaptive perfectionism and symptoms of eating disorders

Chair: Prof Irena Namysłowska (PL)

11.00

Mid-morning refreshments

11.30

Plenary discussion: How does family treatment work?”

Speakers: Dr Ivan Eisler (UK), Dr Ulf Wallin (S), Prof Janet Treasure (UK)

This session will focus less on specific forms of family therapy and more on the possible mechanisms of change in family therapy for eating disorders which might be similar or different in alternative format. Ivan Eisler will examine the question from the perspective of the conjoint model; Ulf Wallin from multi-family therapy; and Janet Treasure from parent-carer counselling. Benefits of separated versus conjoint approaches and family therapy for adults may also inform the discussion. Simon Gowers will lead the discussion.

Moderator: Prof Simon Gowers (UK)

13.15

Buffet lunch (see Menu)

14.30

Debate 2: “This house believes that information-sharing and carer involvement in the treatment of severe eating disorders should take precedence over confidentiality”

Chair: Dr Günther Rathner (AUS)

Proposer: Dr Fernando Fernandez (ES)

Mrs Susan Ringwood (B-eat, UK)

Opposer: Dr Bridget Dolan (UK)

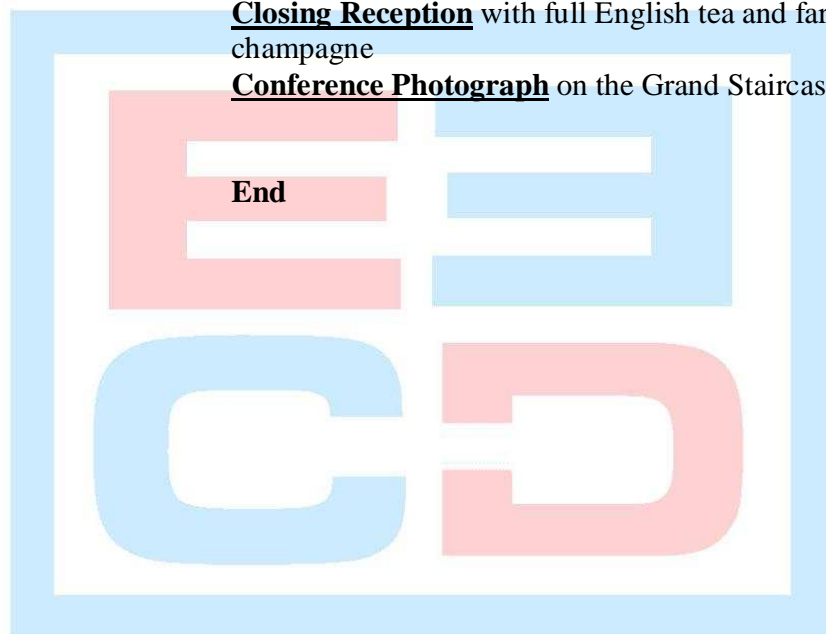
Dr Erika Toman (CH)

16.00

Closing Reception with full English tea and farewell champagne

Conference Photograph on the Grand Staircase

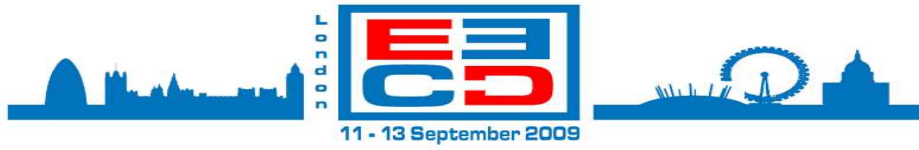
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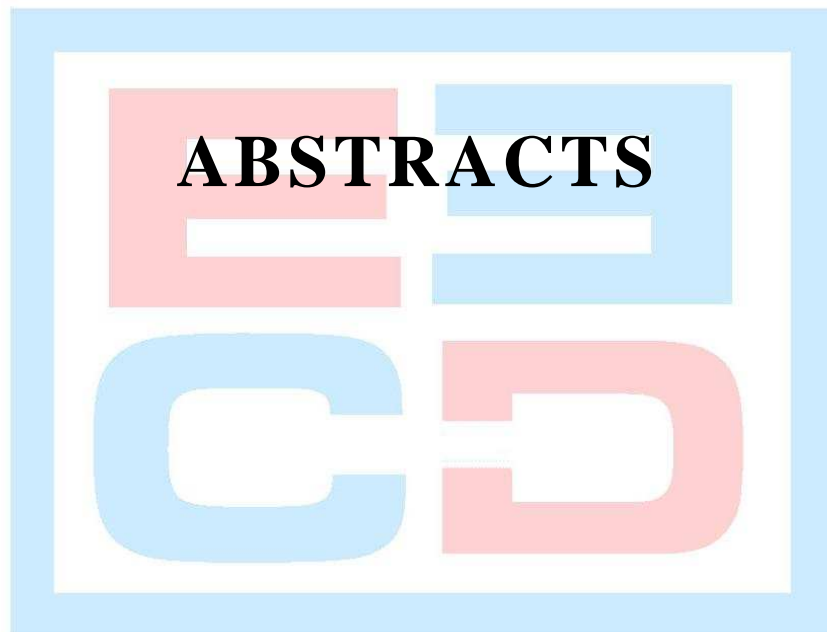
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CONCURRENT SESSION 1: Saturday, 11.45

Case presentation

An impossible clinical case – when should treatment be withdrawn?

Ty Glover, Cheadle Royal Hospital, Cheadle (UK)

John Fox, Cheadle Royal Hospital, Cheadle (UK)

This presentation will discuss a clinical case where the young lady ('Emily'¹) concerned has a severe and enduring form of anorexia nervosa. After two years of treatment, she continues to refuse to eat, and will only take sustenance by nasal gastric tube. This is further complicated by the fact that this young lady is medically unstable and has shown marked deterioration in physical health following the cessation of feeds. This clinical presentation has ultimately trapped this young lady in hospital, as she is unable to survive at home for any meaningful time. Over recent months, Emily's mood has dropped and she has become suicidal. The clinical team now feel that they are at a cross roads regarding her care and treatment, where decisions need to be made regarding her future. One idea being discussed concerns the removal of treatment, however, this raises serious ethical dilemmas for the team and for Emily. Emily's opinion is that she would like to go home so that she does not have to eat.

These challenges of working with chronic and enduring anorexia nervosa have only started to be considered within the research and clinical literature. Strober (2004) reflected on the clinical challenges in working with this client group by stating that clinicians are often "deeply discouraged by a lack of measurable progress, struggling with feelings of ineffectiveness, wavering inconsistently and confusingly between aggressively confrontational or passive approaches, and weighed down by paralyzing counter-transference". This quote does highlight the clinical challenges in working with these clients who often have no intention of changing. Tiernay and Fox (2009) undertook a Delphi study with clinicians who work with people with eating disorders which attempted to offer both a definition of chronic and enduring anorexia nervosa and to provide pointers for the clinician who works with the 'chronic anorexic'. Within this paper they stated that the key feature of chronic anorexia nervosa is how the person takes on the 'anorexic identity' and this is seen as being preferential to the previous, often poorly formed, sense of sense in the individual (in keeping with Strober, 2004; and Crisp, 1980). Interestingly, Tiernay and Fox (2009) also discussed how their participants spoke of the need to focus upon the social/ relational aspect of the 'chronic anorexic' presentation. In other words, there is a need for clinicians to assist in a more psychosocial rehabilitation that allows the 'chronic anorexic' to start to engage in everyday activities and relationships. These findings were supported by a qualitative study that looked at illness perceptions in anorexia nervosa. Many of the participants discussed that they did not see themselves as being 'ill', but often saw their anorexia nervosa as part of who they were. Furthermore, the participants often discussed how their anorexia nervosa played an important function for them by helping them to 'cope with their emotions and their lives' (Higbed and Fox, 2009). Although these pointers are useful in assisting the clinician both in managing the emotional drain of working with this client group and for identifying potential foci for treatment, they do raise interesting questions for the 'jobbing clinician'. For example, how do clinical teams ensure sufficient physical health in order to facilitate psychosocial rehabilitation? What happens if the anorexic identity is so enshrined that

¹ This is a changed name to protect 'Emily's' real identity.

that the individual shows no inclination to even engage in any form of clinical intervention?

Over this presentation, both psychiatric and psychological conceptualisations and formulations of Emily will be presented. Furthermore, some the broader dilemmas of chronic anorexia nervosa will be considered, such as considering the perceived options open to the team involved in Emily's care. It is hoped that this presentation will enable a full discussion of the issues that pertain to working with issues of chronic anorexia and the struggles that this evokes in the clinicians involved in the person's care.

Clinical Discussion

Does dynamic therapy have a serious role in the treatment of eating disorders?

Finn Skårderud (Norway)

Yes, contemporary psychodynamic therapy has a serious role in the treatment of eating disorders. Psychodynamic theory and practice deal with the task of understanding internal reality. To understand internal reality means to understand a human being who not only knows, but who also feels that knowledge. The mental experiential world is a representational structure, and the function of the mind is to produce and elaborate representations. Psychodynamic theory is basically an instrument to be used for understanding how the mind works with its representations, in order to handle demands originating both in the internal and the external. Contemporary psychodynamic traditions are closely linked to developmental psychology, have a strong emphasis on how mind develops through attachment relations, and are also integrated with newer findings in neuropsychology.

Psychodynamic therapy has a serious role in the treatment of eating disorders, because:

1. Psychodynamic theory contributes with conceptual and empirical models of severe eating disorders as self disorders, with emphasis on impairments in self organization and symbolization. To understand the seriousness and the clinically challenging complexity of eating disorders, there is a need for conceptual models describing more than "bad thinking".
2. Contemporary psychodynamic models have strong emphasis on the therapeutic relationship and therapeutic alliance, and these bonds are at the very center in clinical work. Such a focus is particularly important in severe eating disorders, with high drop-out rates and frequent ruptures in therapeutic relations.
3. There is growing evidence for the effectiveness of psychodynamic treatments, especially long-term treatment for complex mental disorders.
4. Psychodynamic models represents an anthropology including existential, cultural and moral issues, and in such a way represent a holistic humanistic approach which can further flexibility in therapeutic encounters, and serve as an antidote to reductionist overemphasis on techniques.

Research Presentations: Chair: Prof Ulrike Schmidt
NEW TECHNOLOGIES IN THE TREATMENT OF EATING DISORDERS

PlayMancer project: a serious videogame as an additional therapy tool for eating disorders

Fernando Fernandez-Aranda, University Hospital of Bellvitge (Spain)

(Fernández-Aranda, F., Jiménez, S., Gunnard, K., Kalapanidas, E., Konstantas, D. Ganchev, T., Kocsis, O., Lam, T., Raguin, T., Santamaría, J., Soto, A., Breiteneder, C., Kaufmann, H., Ben Moussa, M., Vollenbroek, M., Huis in 't Veld, R., Hermens, H., Jacobsen, J., Krabbe, J., & Davarakis, C.)

Previous literature review studies have suggested that, computer games, in general, can serve as an alternative or additional form of treatment in several areas, such as: schizophrenia, asthma or motor rehabilitation. Although, several naturalistic studies have been conducted, showing the usefulness of serious videogames for enhancing several positive attitudes, increasing problem-solving strategies and modifying some abnormal behaviours, there is a lack of serious games that are specially designed for treating mental disorders and of controlled studies on the subject. Goal: Based on the current difficulty to treat specific areas (e.g. some personality traits, attitudinal and emotional aspects, and uncontrolled behaviours), in Eating Disorders (ED), even after using standard and well established evidence-based psychological therapies, the purpose of PlayMancer was to create and design a serious videogame that may help to treat these factors. Hence, the purpose of this presentation is to introduce the current state of this innovative research, showing the design of the study and preliminary results. The final goal of this study is to analyze the efficiency and effectiveness of using a serious videogame, as additional therapy tool for treating ED, when compared with a control group of patients, where no additional videogame is applied. PlayMancer: The 3D environment videogame to be used, "Islands", is being created and developed within the European research project PlayMancer, and aims to prove potential capacity to change underlying attitudinal, cognitive-behavioural and emotional processes of patients diagnosed with ED (namely Bulimia Nervosa and Binge Eating Disorder). New interaction modes are provided by newly developed components, such as emotion recognition from speech (audio), face (video), and physiological reactions (bio-signals)". Each island permits access to one or several types of resources which will facilitate and improve the game character's, and hence the player's, relaxation techniques, planning skills and self-control strategies. The game encourages the player to learn and develop new confrontation strategies. A multi-disciplinary team consisting of clinicians, designers and engineers, have developed this serious videogame, by taking into account user requirements and the specific profile of the target patients, but also emotional reactions and personality profile of the potential users. Method and procedure: A prospective longitudinal cohort study (patients and controls), following a quasi-experimental design, will be used. Sixty Bulimia Nervosa patients, diagnosed according to the DSM-IV criteria, will participate in this study. All cases, will be assigned consecutively to two conditions: CBT+ weekly videogame vs. CBT without videogame. The CBT program will be composed of 16 individual outpatients weekly sessions. Psychometric scales administered previous to treatment, at the end of treatment and at 3 and 6 follow-up, will be used for the assessment of therapy outcome. Additional physiological testing, will be used to analyze the subject's perfor-

mance. In this presentation, we will introduce PlayMancer, and we will show preliminary results of a first pilot trial. Acknowledgements: This work is supported by the PlayMancer project (FP7-ICT-215839-2007), which is funded partially by the FP7 of the European Commission. The authors wish to thank the European Commission as well as all members of the project consortium for their support. The project received also partial support from ISCIII (CIBER06/03, FIS PI081573).

Internet based treatment of bulimia nervosa: a European experience

Isabelle Carrard, Geneva University Hospitals (Switzerland)

(Carrard, I., Lam, T., Rouget, P., Fernandez-Aranda, F., Nevenon, L., Norring, C., & Liwowsky, I., Volk.)

Introduction: This presentation summarises results from clinical evaluations of an online-guided self-help program for bulimia nervosa conducted in 4 European countries since 2001. While findings from the individual clinical evaluations have already been reported, data of the 4 countries were aggregated to determine program efficacy and outcome predictors from a European perspective. **Method:** 127 women with a mean age of 24.7 and average illness duration of 8.4 years, participated in a 4 months intervention using a CBT based online-guided self-help program for bulimia nervosa. Contact during the treatment period included weekly e-mails with a coach and 2 face-to-face evaluation interviews at baseline and after 4 months (T0 and T1). **Results:** A reduction in bingeing and vomiting episodes was found among 52.4 % of participants. Severity of the ED symptoms (measured by EDI-2 sub-scales) and general psychopathology (measured by the SCL-90R global index) improved significantly ($p < .001$). The global drop out rate was 25.2% and varied among countries. A lower score for general psychological health was a predictor of drop out and for a poor outcome. The participants evaluated the on-line program as easy to use and useful. The e-mail contact was underlined as being a helpful support. **Conclusion:** A transfer of self-help treatments to new technologies such as the Internet brings new advantages for dissemination and automatic feed-back for patients. This is not a “panacea” but this study showed that it was well accepted by patients and encouraged further developments and research, particularly for this illness which is hard to treat and prone to relapse.

Development of an internet delivered support program for patients with bulimic symptomatology Hayriye Gulec, Semmelweis University (Hungary)

(Güleç, H., Bauer, S., Moessner, M., Kohls, E., & Túry, F.)

Eating Disorders (ED) are serious and often chronic disorders. The chronic nature of the illness and the high relapse rates lead to direct and indirect costs. There is need for maintenance strategies at reasonable cost to prevent relapse and maintain therapeutic gains of patients who undergo treatment. An online support program entitled “EDINA” has been developed for this purpose. The 4 key modules of the program are psycho-education, supportive monitoring and feedback, forum and chat: 1) The psycho-education includes online information material related to eating disorders and recovery from an eating disorder. 2) The central module of the program is to monitor individuals’ well-being and diet. Therefore, participants complete brief weekly online questionnaires related to core ED symptoms. The program compares the results to the previous monitoring assessment and sends automatised supportive feedback e-mails back to the participant. This module also serves as a base for alarm cases about which the online counsellor receives an alert via e-mail. 3) A forum is offered to reinforce individual

contributions, exchange, and peer support between participants, 4) Moderated chat sessions are provided both on group and individual basis. All registered participants are required to attend to 90 minute long, weekly group chat sessions. If they wish, participants can also book an individual chat session to discuss topics on one-to-one basis with an online counsellor. In case of detected deterioration by the monitoring module, the online counsellor may also invite a patient to an individual chat session to counteract negative developments. The efficacy of the program is currently being studied in a RCT in Hungary: While patients in the intervention group have access to the program for 4 months, patients in the control group can only access it after a 4-months waiting period. The presentation will introduce the modules of the online support program and report our pilot experiences. This research is funded by the European Commission in the Marie Curie Research Training Network INTACT (Individually Tailored Stepped Care for Women with Eating Disorders: contract number: MRTN-CT-2006-035988)

First drop-out analysis of an internet based treatment of eating disorders
Peter Daansen, PsyQ Haaglanden (The Netherlands)

The study presents the first preliminary results of a Dutch online-guided self-help program for bulimia nervosa. Results from clinical evaluations will be presented. The discussion will be focussed on suggestions to improve the adherence. Objectives: The main objective to find out whether significant differences on pre-treatment marked several subgroups. Other objectives were to look at treatment characteristics in relation to drop out. Data from clinical evaluations of an online-guided self-help program for bulimia were analyzed to determine program efficacy and outcome predictors. Method: Pre-treatment data of 36 patients who initially started the internet program were analysed. Pre-treatment data consisted of patients characteristics and severity of pathology scores (SCL-90, BSI, EDI-II). Several subgroups were formed and compared according to their status in the internet program, namely, completers & drop-out and early drop-out & late drop-out. Results: Analysis indicates a significant difference between drop-out and completers at the level of anxiety. Drop-outs experienced more anxiety at start of the treatment. Potentials risk factors are discussed.

CONCURRENT SESSION II: Saturday, 14.15

Clinical Discussion

Treatment options for severe and enduring anorexia nervosa patients

Bryony Bamford, St George's, University of London (UK)

Whilst there have been recent advances in the treatment of anorexia nervosa, there are still many individuals who progress to a severe and enduring illness. These individuals have been said to experience serious medical and psychological consequences from their anorexia, be intensive users of healthcare provisions, suffer high unemployment levels and extreme isolation, and pose a significant burden to their families, carers and the community. The clinical literature attests to the difficulties engaging, retaining and adequately treating these individuals that are experienced by even expert clinicians. The current evidence base for how best to treat severe and enduring eating disorders is limited with many international treatment guidelines failing to address psychological treatment options for these individuals. This presentation will discuss the possible consequences of these limitations and aim to explore ways in which current evidence based treatments, specifically cognitive behavioural therapy, may be adapted in order to better suit the needs of this highly challenging client group. These adaptations are currently being evaluated in an international RCT for severe and enduring anorexia nervosa running across the Universities of Sydney, Chicago and St. Georges, University of London. The status and preliminary finding of this trial will also be addressed in this presentation.

Clinical Discussion

Do we need a new instrument to measure recovery from eating disorders?

Greta Noordenbos, Leiden University (The Netherlands) Prof Jorunn Sundgot-Borgen and Prof Jan H. Rosenvinge, (Norway)

Background

The plethora of criteria for judging patients as recovered from an eating disorder could be grouped according to their origin in at least four ways; i.e. psychometric versus clinical, stringency versus leniency, a "consumer (patient/relatives) versus an "expert" (clinician/scientist) approach, and criteria derived from goals of specific treatment traditions. This creates a deflated consensus. A higher level of consensus may 1) be beneficial in treatment and clinical evaluations, 2) bridge the gap between treatment effect studies and outcome studies, 3) bridge the gap between recovery and prevention, and 4) facilitate comparison across future outcome studies.

Previous studies

Empirical studies adopting a patient perspective on recovery are increasing in number and may fall into three groups, i.e. studies focusing on

- 1) the unwanted error variance in the number of recovered patients.
- 2) contrasts, e.g. refuting or questioning the clinical validity of outcome findings derived from "expert" evaluations,
- 3) common denominators by comparing the level of agreement between therapists and patients (e.g. Vanderlinden et al., 2007; Noordenbos, 2006) or between therapists and women from the general population against accounts of patient experiences (Pettersen, 2007). Also, some efforts have been made to develop a model of recovery (Pettersen,

2007). Overall, these studies show more agreement and few differences across groups than a substantial group disparity.

State of the art

Overall, the patient accounts of helping agents and of recovery is in principle a never-ending story, yet the fundamentals seem rather well established. The group 3 studies in fact document a clinical common sense suspicion, whilst the need for more validation studies (group 2 studies) seems rather pressing. For instance a direct comparison between patients, clinicians, relatives against a normal population sample would be interesting. A major prerequisite for such comparison is, however, that one has a reasonable account of or, at best, a psychometrically sound instrument of recovery.

Discussing research strategies

There are at least two complementary strategies to proceed and progress in order to understand recovery from various perspectives (researchers, clinicians, relatives, patients and general population).

Strategy 1: To validate well established clinical instruments like the EDE/CiA or the EDI-2 or 3 in order to calculate level of deviations using for instance the Reliable Change Index.

Strategy 2: To develop a new measure of recovery from an experiential and clinical perspective. Within this strategy a number of issues should be addressed:

- Should recovery criteria be universal or specific (related to gender, age, duration and severity of illness, special group considerations (e.g. athletes, patients with comorbid disorders))?
- Should criteria be arranged dimensionally (e.g. "primary" versus "secondary", "process-oriented" versus "end points") or hierarchically (i.e. that one criterion depends on one or more other criteria)?
- How may recovery aspects relate to normal developmental issues throughout life? At what time do we stop attributing event to the impact of the eating disorder (and recovery thereof) and start attributing it to life?
- Which groups should be compared (ill patients, former patients, relatives, therapists, general population samples with and without eating disorders or eating problems)
- scoring issues; what method (VAS, Likert or two-dimensional, statement versus questions) should be chosen in order to avoid introducing categories into a phenomenon (recovery) that seems to be continuous in nature?

Clinical Discussion

The changing face of eating disorders

Angela Favaro, University of Padua (Italy)

(Santonastaso P)

It is a common idea among clinicians that early-onset cases of anorexia nervosa (AN) are increasing, but no data in the literature are available, to our knowledge, to demonstrate this. At the Outpatient Eating Disorders Unit in Padua, we observed a recent increase in cases of AN with an early age of onset. This study aims to explore the time trends in age of onset of anorexia nervosa (AN) and bulimia nervosa (BN) in a large sample.

Methods: The sample is composed of 1,666 AN subjects and 793 BN subjects without previous AN consecutively referred to our outpatient Unit in the period between 1985 and 2008. Time trends have been analysed according to the year of birth of subjects.

Results: The most frequent age of onset was 16 years in AN patients and 17 in BN patients. In both AN and BN samples, the age of onset showed a progressive and significant decrease in younger generations. For example, in patients born in the period between 1970 and 1981, the average age of onset decreased from 18.6 to 16.8 in AN, and from 18.5 to 17.1 in BN. A regression model showed a significant independent effect of socio-economic status, age at menarche and number of siblings in predicting age of onset.

Conclusion: Age of onset of AN and BN is decreasing in younger generations. The implications of our findings in terms of long-term outcome remain to be understood. Biological and socio-cultural factors explaining this phenomenon need to be explored by future studies.

Trends in the scientific literature and changes in the clinical characteristics of ED patients (n=980) in the last 25 years

Johan Vanderlinden, University of Leuven (Belgium)

(Pieters Guido. MD, PhD & Probst Michel PhD)

In this lecture trends and changes in the scientific literature (based on Medline and PsycLit) in the last 25 years will be outlined. Next, characteristics of 980 ED patients who were admitted to our residential therapeutic program in the last 25 years, will be analysed following five different time episodes (before 1985, 1985-1989; 1990-1994; 1995-1999; 2000-2005). Some remarkable findings will be presented and will try to give an answer to the question if we are still treating the same kind of eating disorder patients anno 2009 compared to previous years or not?

Stability and instability of the eating disorders diagnoses

Gabriella Milos, University Hospital, Zürich (Switzerland)

The today's classification of the eating disorders - anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified - arouses some scepticism. Although eating disorders represent a clearly distinguished illness category, small symptom changes during the often long illness can cause changes of the diagnosis; f. e. changes from anorexia nervosa to bulimia nervosa and vice versa. In this context it is important to mention that the category of the eating disorders not otherwise specified is extremely heterogeneous. The diagnostic fluctuations can occur also in short laps of time and are well known from the clinician, this phenomenon was recently confirmed by the scientific search. The diagnostic instability together with the common symptoms present in the vast majority of persons with all eating disorders diagnoses - such f. i. the weight and shape concern - lead to a trans-diagnostic approach. This view does not only consider the current eating disorders symptoms, but lead to have a life time view of the disorder

including the frequent symptoms fluctuations. This global view has important therapeutic implications.

PLENARY SESSION: Saturday, 16.15
“DSM-V: Here We Go Again?”

DSM-V: Eating Disorders Revision Process

Hans Wijbrand Hoek, Parnassia Bavo Psychiatric Institute, The Hague, (The Netherlands)

The process for revising the eating disorder section of the Diagnostic and Statistical Manual of Mental Disorders (DSM) started in 2007. Based on comprehensive reviews of scientific advancements, targeted research analyses and consultations like this ECED meeting, the DSM-V eating disorder work group will develop draft *DSM-V* diagnostic criteria in 2010-2011. The release of the final DSM-V is expected in May 2012. One major difference between the DSM-IV and the DSM-V will be the more prominent use of dimensions. Currently the workgroup has conducted twelve literature reviews (most are in press for the International Journal of Eating Disorders). The literature reviews are related to identified questions, such as the potential utility of grouping all eating disorders into three broad categories. Another issue is the validity and utility of sub-typing Bulimia Nervosa and Anorexia Nervosa. Also the validity and utility of potential new disorders such as Binge Eating Disorder, Purging Disorder and Night Eating Syndrome has been reviewed by the work group. A major debatable topic is the consideration of obesity as a mental disorder in DSM-V.

DSM-V: Reviewing criteria for eating and feeding disorders from a cultural and developmental perspective

Rachel Bryant-Waugh, Great Ormond Street Hospital for Children, London (UK)

There has been much debate about the cognitively based DSM-IV diagnostic criteria for AN and BN, in particular in relation to their utility in younger patients and when applied cross-culturally. Members of the DSM-V work group have conducted literature reviews relevant to the clinical evaluation of cognitive systems in order to generate evidence-based options for consideration in the diagnostic criteria review process. These will be presented as part of the encouraged consultation process with others in the field. In addition a number of issues have been raised in relation to the application of non-cognitive criteria in younger patients and the existence of other childhood presentations that are characterized by avoidance of food or limited food intake, which are currently unclassifiable. Main points will be briefly reviewed. As well as Eating Disorders, the Work Group has been charged with reviewing DSM-IV criteria for Feeding Disorder of Infancy or Early Childhood, Pica and Rumination Disorder. Literature reviews on each of these topics support a range of options which aim provide clearer descriptions of subtypes, improve clinical utility, and promote research.

Josefina Castro-Fornieles, Hospital Clinic, University of Barcelona (Spain)

The necessity to change criteria for EDNOS and for anorexia nervosa (AN) and bulimia nervosa (BN) has been pointed out. Especially for EDNOS there can be many advantages in changing or better defining their criteria. At present, there are too many EDNOS, they

are not properly classified and they can be as severe as AN and BN. Specially with children, a different classification has been proposed. Regarding AN criteria things are different. Maybe current criteria are not adequate (amenorrhea, weight-phobia or weight cut-off have been discussed), but amending criteria will make comparison of data over time difficult, and besides that, these current criteria, if present, are clinically relevant both for treatment and outcome. Low weight has been related to physical consequences (heart, brain, bones) and cognition. Amenorrhea, if present, is an important characteristic as it has long-term consequences (bones, fertility, cognition) and its presence makes treatment and re-nutrition even more necessary. Weight-phobia maybe is not present in all cases, but still a majority of patients in western countries have it and when present it has to be addressed during treatment as it can influence outcome of the disorder. As conclusions, it can be said that for EDNOS to give a name and define the majority of them will be useful, especially for children. Nevertheless, for AN we can have some advantages but also we will loss specificity and we are at risk of not having important characteristics in the definition that are necessary for treatment planning. It would be adequate to have them at least in the sub-classification of the disorder.

CONCURRENT SESSION III: Sunday, 10.00

Research-Practice Session

Integrating Research and Practice: What Qualifies as Evidence?

Integrating Research and Practice: What Qualifies as Evidence?

Judith Banker, University of Michigan (US)

(Bob Palmer)

There is a divide between researchers and clinicians in our field. Important research findings are not implemented in many clinical settings and valuable clinical observations and experience do not impact the direction of eating disorders research. The causes of the research-practice gap are layered and complex, rooted in a range of attitudinal, relational and systemic factors. Perhaps the most salient factor contributing to the gap between researchers and practitioners is the difference in their views about what constitutes valid evidence. Researchers tend to value the findings from randomized controlled trials (RCTs), recommending that treatment be driven by adherence to approaches that have been empirically tested. Clinicians tend to value clinical observation and the wisdom and experience of expert clinicians, and adhere to an approach to treatment that adapts to the individual needs of the patient. Whilst this “parallel play” goes on between research and practice in our field, critical gaps in our knowledge base go unaddressed. Thus, a rapprochement between research and practice is likely to benefit our research, treatment, and prevention efforts.

The recently released Academy for Eating Disorders Guidelines for Research-Practice Integration suggest that to bridge the research-practice gap in our field, we must recognize that both research findings and clinical observation, judgment and experience contribute to our knowledge base. Further, we must expand our understanding of “research evidence” to include multiple types of evidence (e.g. efficacy, effectiveness, epidemiological etc.) drawn from a range of potential sources including laboratory and clinical settings and multiple research designs.

This session will examine the challenges and opportunities presented by this recommendation by addressing the questions: What qualifies as evidence? Are the findings of empirical research the only worthwhile evidence? Does clinical observation or qualitative research have a role in contributing to our knowledge base? What about patient values? Members of the Academy for Eating Disorders (AED) Research-Practice Committee (RPC), including Judith Banker, Bob Palmer and Angela Favaro, will use interactive exercises and guided discussion to address these questions and others to determine if common ground can be established.

Clinical Discussion

Re-negotiating body image

Body Image from a cognitive viewpoint: only fear of fatness?

G. M. Ruggiero °, S. Sassaroli *

* “Studi Cognitivi”, Post-graduate Cognitive Psychotherapy School, Milano, Italy.

° “Psicoterapia Cognitiva e Ricerca”, Post-graduate Cognitive Psychotherapy School, Milano, Italy.

ABSTRACT

Cognitive clinical theory of body image disorder in eating disorders is theoretically reductive. In fact, cognitive theory should focus only on cognitive beliefs that could be related with emotional discomfort with a supposedly fat or ugly body aspect. Consequently, the clinical treatment considers only assessment, disputing and reframing of this cognitive counterparts of the body image disorder. However, it could be possible to enlarge the strict cognitive ideology and conceptualize also perceptive and emotional aspects in the body image disorder. The work critically reviews cognitive literature of the body image disorder in eating disorders and reports argument in favor and against a strict cognitive interpretation of the issue.

Research Presentations: Chair: Prof Irena Namysłowska New European Research

Job satisfaction amongst nursing staff on eating disorders units

Trine Wiig, Oslo University Hospital (Norway)

(Wiig, T., & Lask, B.)

Background Recruitment and retention of nursing staff are major challenges within the eating disorders field. Although there exists an extensive amount of research on job satisfaction among nursing staff in the general and the psychiatric field, there appears to be none on job satisfaction and its possible correlates in eating disorder units (EDUs).

Aims: To explore which factors contribute to the job satisfaction of nursing staff working on EDUs. Design and methods :Multi-centre study using a descriptive and exploratory focus group design. Four focus groups have been conducted. The sample consisted of

nursing staff working on specialised in patient EDUs in Norway and the UK. A semi – structured interview guide was used. **Analysis:** The interviews have been taped and transcribed verbatim. The analysis is based on texts from the transcripts and notes taken during the interview. The original quotes have been condensed to meaning units, and categorised into main themes and sub themes. **Results:** Four main themes have been identified: i) Working conditions, e.g. time ii) relationships, e.g. support. iii) The nature of eating disorders, e.g. rejection, and iv) Expectations e.g. nursing identity. The themes have been incorporated into a conceptual model to add understanding of the contributing factors to job satisfaction. Details will be presented.

Eating disorders, co-morbid psychiatry and self-image

Andreas Birgegård, Karolinska Institute (Sweden)

(Birgegård, A., & Högdahl, L.)

Eating-disordered patients often have other DSM-IV Axis I disorders besides their eating disorder diagnosis, and the presence of such co-morbidity may complicate treatment. One possible reason for this complication is that negative self-image, in particular self-hate and self-blame, may be more pronounced in such patients. The present study investigated whether the presence of co-morbidity (diagnosed via SCID-I) was related to self-image, measured using the interpersonal Structural Analysis of Social Behavior model. 1,105 eating disorder patients from the Stepwise database, 18 years or older, participated with anorexia, bulimia, or eating disorder not otherwise specified. The pattern of co-morbidity was that bulimia was related to more mood disorders, whereas there was no difference in anxiety disorders. Self-image results showed a pattern such that anxiety and anorexia was related to more self-control than bulimia, and number of co-morbid diagnoses was generally related to more negative self-image. The results have specific implications for patient-clinician interaction based on interpersonal theory, and may help improve adherence and treatment motivation.

Self-injurious behaviour, in the context of impulsivity, borderline personality disorder and sexual abuse in eating disorder: Psychological and genetic factors

Manfred Fichter, Roseneck Hospital for Behavioural Medicine (Germany)

(Fichter, MM)

Self-injurious behaviour (SIB) is present in more than 1/3 of patients with an eating disorder (ED). In ED it frequently occurs in the context of impulsivity, borderline personality disorder or history of sexual abuse. We conducted a study with 100 ED-patients with either anorexia or bulimia nervosa of whom 50 in addition showed SIB. We used self-rating scales (e.g. EDI-2, SCL-90, IDCL-Diagnostic Check Lists for Axis-I disorders) and expert interviews (SIAB-EX, SKID-II, Abuse Interview). The major aim was to analyse the associations of self-injurious behaviour with other variables (impulsivity, BPD, SX-AB). In addition, we made molecular genetic assessments to analyse the connections between psychological diagnostic and molecular genetic variables. The most frequent SIB were 1) cutting, pricking, stabbing, scratching (4.1 %), 2) use of medication with damaging effects (2.8 %), 3) hitting oneself (1.2 %) and 4) burning oneself (e.g. burning cigarette on the skin). Reasons for SIB were (ranked): reduction of rage (52 %), to forget negative events (12 %), to get attention (10 %) or to provoke others (4 %). Borderline personality is the most frequent personality disorder found in ED-patients with SIB. Treating these patients is a challenge for treatment teams.

However, long-term outcome shows that treatment is worthwhile (Zanarini et al., 2007). According to our results ED- patients with SIB showed more impulsivity, aggressiveness, suicidal acts and more severe eating and general psychopathology than those without SIB. Molecular genetic associations showed an association with one specific genetic variable concerning the gene locus of the mono-amine-oxidase A (MAO-A). Specifically, there was an association of the MAO-A VNTR promoter polymorphism for ED and SIB as compared to healthy controls. The paper gives an overview of relevant new results concerning self-injurious behaviour in ED and reports the results of our study in this context.

The roles of temperament, effortful control, and cognitive control in differentiating bingeing-purging and restrictive eating disorders

Laurence Claes, University of Leuven (Belgium)

(Claes, L., Robinson, M., Muehlenkamp, J., Vandereycken, W., & Bijttebier, P.)

Scientific paper Impulsivity, defined as a predisposition toward uncontrolled behaviour, is prominent to multiple theories of eating disordered (ED) behaviour. The underlying basis of impulsivity, though, could be either motivational in nature or could reflect more basic deficits in effortful or cognitive control. Further, the motivational substrates of impulsive behaviour could reflect high levels of reward-sensitivity, low levels of punishment-sensitivity, or both. In the present study, forty ED patients were administered scales assessing reward and punishment sensitivity, effortful control, and cognitive control by a colour-word Stroop task. Bingeing/purging ED patients, relative to restrictive ED patients, exhibited lower levels of punishment sensitivity, effortful control, and cognitive control. Reward sensitivity scores did not discriminate among ED groups. Implications focus on understanding the processing basis of binge/purge symptoms and the importance of doing so in informing psychological interventions for ED.

Perceived criticism as the third variable between maladaptive perfectionism and symptoms of eating disorders

Dr Sandra Sassaroli. (Italy) Bertelli S., Lamela, C., Scarone, S., & Ruggiero, G.M.)

Aim: In this work we aimed to explore the relationship between perceived criticism and maladaptive perfectionism in the psychological process leading to eating disorders (ED). Method: Forty-nine individuals with ED and 49 controls completed the Concern over Mistakes subscale of the Multidimensional Perfectionism Scale, the Perceived Criticism Inventory, and the Drive for Thinness, Bulimia, and Body Dissatisfaction subscales of the Eating Disorders Inventory. We tested two rival models using a path analysis. In the first model, perceived criticism was the exogenous variable and maladaptive perfectionism the intermediate variable. In the second model, the exogenous variable was maladaptive perfectionism and the intermediate variable was perceived criticism. Measures of ED were the endogenous variable in both models. Results: Analysis showed that, in the case of drive for thinness, perceived criticism preceded perfectionism; while, in the case of bulimic behaviours and body dissatisfaction, perfectionism preceded perceived criticism. Discussion: Results could suggest that restrictive dieting would be related to a process in which perceived criticism is the initial relational factor which facilitates the arising of perfectionism, while feelings of body dissatisfaction and bulimic behaviours would be related to an initial perfectionism which would predispose individuals to develop a proneness to perceive criticism from others.

PLENARY SESSION: Sunday, 11.30

How does family treatment work?

Families helping families: multi-family therapy in anorexia nervosa

Ulf Wallin, Skånes Centre of Eating Disorders, Lund (Sweden)

Multi-family therapy means that you assemble families who will try to find ways together to fight against the anorexia nervosa disorder.

Multi-family therapy means that you gather forces around the patient so he/she might feel safer in eating – even though he/she is afraid of eating.

Multi-family therapy means that families learn to trust the help and support you can get from other families – families that are very much like your own. This might help you to trust yourself.

Multi-family therapy means that you can find a way to deal with the disorder and problems faced by the family and patient, without the need to rely only on hospital doctors and therapists; by finding strength and competence within your own family and the rapport you create together with other families.

Multi-family therapy means that you can challenge the stigma of a psychiatric disorder and identify a normal way of functioning in a normal social context.

Multi-family therapy means that you can find a way out of social isolation and find a more meaningful life.

How Does Working With Families Produce Change

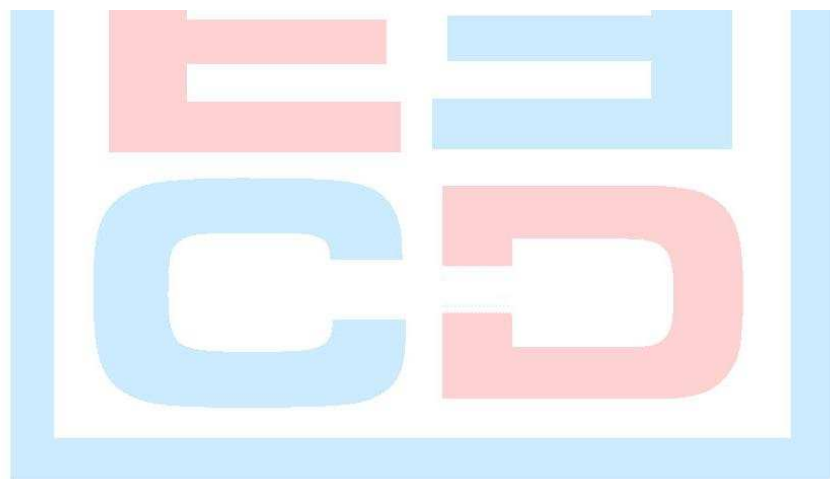
Janet Treasure Kings College, London (UK)

There are many questions as to what are the effective processes and relevant outcomes of change in anorexia nervosa. For example how does work with families or with parents alone produce change in AN? Why do cases become more resistant to treatment the longer the illness has persisted? We have produced a model describing maintaining factors in AN which aims to answer questions such as these (1). This model has four facets including two which are mainly consequences of eating disorder symptoms themselves such as the impact of poor nutrition on the brain and body and the interpersonal reaction to this. The others are vulnerabilities which may have preceded the development of AN and even predisposed to it including obsessive compulsive personality traits and the tendency to use avoidance as a coping strategy for social and emotional difficulties.

It is possible that work with families or parents can have an impact on all four of these maintaining factors. First there is the direct effect on moderating interpersonal relationships in particular reducing expressed emotion to the illness and maladaptive reactions to eating disorder symptoms and behaviour. Also parents can have an impact on all of the other areas.

Reference List

- (1) Schmidt U, Treasure J. Anorexia nervosa: valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *Br J Clin Psychol* 2006 September;45(Pt 3):343-66.



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