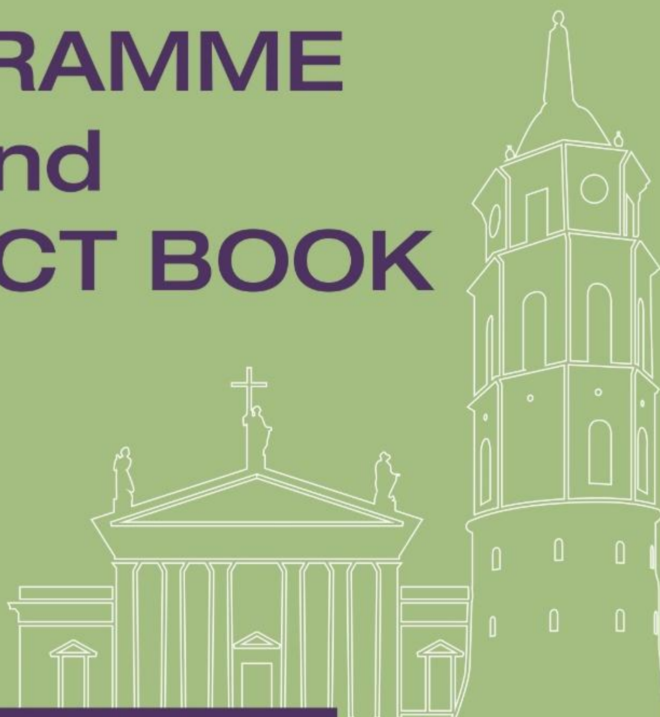
VILNIUS, 2017

EATING DISORDERS IN MULTICULTURAL SETTINGS

Vilnius | Lithuania

PROGRAMME and ABSTRACT BOOK



7-9 September 2017

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ECED 2017 FINAL PROGRAMME

Thursday, 7 September	
14.00-15.00	**Registration**
15.00-15.30	**Opening session**
15.30-17.00	**Plenary lecture:** MENTALIZATION-BASED THERAPY FOR EATING DISORDERS *(Paul Robinson)*
17.00-19.00	**Opening reception and excursion**

Friday, 8 September	
08.00-09.00	**Registration**
All day	**POSTER PRESENTATIONS**
Aida+Norma hall	
09.00-09.45	**Film:** "Eva wants to Live"
09.45-10.55	**Debate:** COMPULSORY TREATMENT OF EATING DISORDERS IS UNNECESSARY (Chair: Hubert Lacey[1]; Proponent: Ferenc Tury[2]; Opponent: Rachel Mathews[3]) [1]Newbridge House; St George's, U of London, United Kingdom; [2]Semmelweis University, Hungary; [3]Newbridge house, United Kingdom
10.55-11.15	**Coffee break**
11.15-13.00	**Simultaneous sessions**
Symposium ***Aida hall***	EATING DISORDERS: AN INTERNATIONAL PERSPECTIVE (Eric F. van Furth[1], Eva Trujillo[2], Nkonone Tema[3], Bernou Melisse[4], Anna Keski-Rahkonen[5], Yael Latzer[6,7]) [1]The GGZ Rivierduinen/LUMC, Netherlands; [2]Comenzar de Nuevo AC, Mexico, Academy for Eating Disorders, Tec Salud School of Medicine; [3]Department of Psychiatry, School of Clinical Medicine, University of the Witwatersrand, South Africa; [4]Leiden University, Netherlands; [5]Department of Public Health, Helsinki, Finland; [6]Faculty of Social Welfare and Health Sciences, University of Haifa, Israel; [7]Eating Disorders Institution, Psychiatric Division, Rambam Medical Center, Haifa, Israel
Workshop 1 ***Carmen hall***	ATTACHMENT, EMOTION REGULATION AND THE SELF: AN INTEGRATIVE MODEL AND CLINICAL ILLUSTRATION (Rasmus Isomaa[1], Andreas Birgegård[2], Emma Forsén Mantilla[2], Elin Monell[2]) [1]Department of social services and health care, Jakobstad, Finland; [2]Department of Clinical Neuroscience, KarolinskaInstitutet, Stockholm, Sweden

Paper session 1 ***Mikado hall***	**Lifestyle and body-image issues in eating disorders** (Chair: Stephanie McAlinden, United Kingdom) • BODY SIZE PERCEPTION AND DISSATISFACTION OF ADOLESCENT LITHUANIAN GIRLS IN RELATION TO THEIR REAL BODY SIZE AND SOCIAL FACTORS DURING THE YEAR 2000-2015 (Janina Tutkuviene) Department of Anatomy, Histology and Anthropology, Faculty of Medicine, Vilnius University • RATE OF WEIGHT GAIN IN INPATIENT TREATMENT OF ANOREXIA NERVOSA (Marit Danielsen[1,2], Sigrid Bjørnelv[1,2], Øyvind Rø[3,4]) [1]Eating Disorder Unit, Department of Psychiatry, Levanger Hospital, Hospital Trust Nord-Trøndelag, Levanger, Norway; [2]Mental Health, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway [3]Eating Disorder Service, Division of Mental Health and Addiction, Oslo University Hospital, Oslo, Norway; [4]Division of Mental Health and Addiction, Institute of Clinical Medicine, University of Oslo, Norway • TIME TRENDS IN THE PREVALENCE OF EATING DISORDERS IN SECONDARY SCHOOL POPULATION IN HUNGARY BETWEEN 1989 AND 2014 (Pál Szabó[1], Balázs Ludányi[1], Ferenc Túry[2]) [1]University of Debrecen, Institute of Psychology; [2]Semmelweis University, Institute of Behavioural Sciences • IS A SOCIALLY DESIRED BODY IMAGE A MOTIVATION FOR A HEALTHY LIFESTYLE, WEIGHT CONTROL, AND EXERCISE BEHAVIOUR? (Simona Pajaujiene) Lithuanian Sports University, Lithuania • HABITUS, CAPITAL AND THE FIT BODY: IS ORTHOREXIA NERVOSA THE NEW AND TRENDY EATING DISORDER? (Eniko Bona) Semmelweis University, Hungary
13.00-14.15	**Lunch**
14.15-15.45	**Simultaneous sessions**
Workshop 2 ***Aida hall***	MENTALIZATION-BASED THERAPY FOR EATING DISORDERS (Paul Robinson) Institute of Hepatology and Digestive Health, University College London
Workshop 3 ***Mikado hall***	THE BODY AS FRIEND OR FOE: PRACTICAL MANAGEMENT OF BODY IMAGE ISSUES IN EATING DISORDERS (Gerard Butcher[2], Michel Probst[1]) [1]University of Leuven, Belgium; [2]Cognitive Solutions Clinic, Dublin, Ireland
15.45-16.15	**Coffee break**
16.15-17.45	**Simultaneous sessions**

Workshop 4 ***Aida hall***	MALES AND EATING DISORDERS: CLINICAL FEATURES AND THERAPY (Fernando Fernandez-Aranda[1], Michel Probst[2,3], Johan Vanderlinden[3]) [1]Eating Disorders Unit, Psychiatry Department, University Hospital of Bellvitge-IDIBELL and CIBEROBN, Barcelona, Spain; [2]KU Leuven Department of Rehabilitation Sciences, Kortenberg-Leuven, Belgium [3]Univ. Psychiatrisch Centrum KU Leuven, Kortenberg-Leuven, Belgium
Workshop 5 ***Carmen hall***	INTERNAL LANGUAGE ENHANCEMENT THERAPY (ILET) - A CASE STUDY- FROM RED VEGETABLES TO SEXUALITY - LANGUAGE AND MEANING IN EATING DISORDERS (Barbara Pearlman) Exeter University, United Kingdom
Paper session 2 ***Mikado hall***	**Families and children** (Chair: Nathalie Godart, France) • HAVING MANY STRINGS TO ONES ` BOW" - A QUALITATIVE STUDY OF THERAPISTS ` PRACTICE IN MULTIFAMILY THERAPY FOR YOUNG ADULTS WITH SEVERE EATING DISORDERS (Berit Brinchmann, Cathrine Moe, Steven Balmbra, Siri Lyngmo, Tove Skarbo) Nordland Hospital Trust, Norway, Nord University, Norway • PARENTAL BURDEN IN ANOREXIA NERVOSA (Jeanne Duclos[1,2], Giulia Piva[3], Nathalie Godart[1,2]) [1]Institut Mutualiste Montsouris ; [2]CESP, INSERM, Univ. Paris-Sud, UVSQ, Université Paris-Saclay, Villejuif, France ; [3]University of Pavi, Italy • LONG TERM FOLLOW UP OF FAMILY TREATMENT APARTMENTS COMPARED WITH CHILD PSYCHIATRIC INPATIENT TREATMENT (Ulf Goran Wallin, Riitta Holmer) Eating disorder Unit, Psychiatry Skane, Lund, Sweden • ANOREXIA IN A PREPUBERTAL BOY AS DEVELOPMENTAL DISORDER (Darius Leskauskas) Lithuanian University of health sciences, Lithuania
19.00-23.00	**Gala dinner**

Saturday, 9 September	
All day	**POSTER PRESENTATIONS**
09.00-10.30	**Simultaneous sessions**
Paper session 3 ***Aida I hall***	**Co-Morbidity and diagnostic issues in eating disorders** (Chair: Darius Leskauskas, Lithuania) • BIPOLAR DISORDERS AND ANOREXIA NERVOSA: A CLINICAL STUDY (Nathalie Godart[1,3] , Marie Valentin[2], Jeanne Duclos[1], Florence Curt[1], Leslie Radon[1]) [1]Département de psychiatrie, Institut Mutualiste Montsouris, France ; [2]Centre Hospitalier d'Argenteuil, France ; [3]UVSQ, CESP,

<table>
<tr><td></td><td>Inserm, Université Paris-Saclay, Université Paris Sud, Villejuif, France
• DESIRE FOR A CHILD AND EATING DISORDERS IN WOMEN SEEKING INFERTILITY TREATMENT
(Melanie Bruneau[1], Agnes Colombel[3], Sophie Mirallie[3], Thomas Freour[3], Jean-Benoit Hardouin[4], Paul Barriere Barriere[3], Marie Grall-Bronnec[2])
[1]Cambridgeshire and Peterborough NHS Foundation Trust, UK; [2]CHU, Department of Addictology and Psychiatry, Nantes, France; [3]CHU, Department of Reproductive Medicine, Nantes, France; [4]INSERM UMR 1246 SPHERE, Nantes, France
• PSYCHO-SEXUAL HEALTH IN EATING DISORDER PATIENTS: A PILOT STUDY
(David Clinton[1,2])
[1]Karolinska Institutet, Sweden; [2]Institute for Eating Disorders, Oslo
• EATING DISORDER OR ACHALASIA DURING ADOLESCENCE: DIAGNOSTIC DIFFICULTIES
(Aurelie Letranchant[1,2], Benedicte Pigneur[3,4], Nathalie Godart[1,5])
[1]Adolescent and Young adult psychiatry Unit, Institut Mutualiste Montsouris, Paris, France; [2]Paris Descartes University, Medical school, Paris, France; [3]Institut National de la Santé et de la Recherche Médicale INSERM UMR1163, Laboratory of Intestinal Immunity, Institut Imagine, Paris, France ; [4]Department of Pediatric Gastroenterology, Hepatology and Nutrition, Necker Enfants Malades Hospital Assistance Publique – Hôpitaux de Paris, Paris Descartes-Sorbonne Paris Cite, Paris, France ; [5]CESP, INSERM, Paris-Sud University, UVSQ, Paris-Saclay University, France</td></tr>
<tr><td>Paper session 4
Aida II hall</td><td>Involuntary and hospital treatment outcomes in anorexia nervosa (Chair: Ulf Goran Wallin, Lund, Sweden)
• RATE OF WEIGHT GAIN IN INPATIENT TREATMENT OF ANOREXIA NERVOSA
(Marit Danielsen, Sigrid Bjornelv, Henrik Lundh, Harald Skogmo)
Levanger Hospital, Eating Disorder Unit, Norway
• EVALUATION OF HOSPITALISATION FOR ANOREXIA NERVOSA: THE EVHAN STUDY (Nathalie Godart[1,2], Sylvie Berthoz[1,2], Christophe Lalanne[3], Jeanne Duclos[1,2], Leslie Radon[1,2], Malaika Lasfar[4], Priscille Gerardin[4])
[1]Institut Mutualiste Montsouris, France ; [2]CESP, INSERM, Univ. Paris-Sud, UVSQ, Université Paris-Saclay, Villejuif, France; [3]AP-HP, Hôpital Saint-Louis, Département de Recherche Clinique, Paris, France ;
[4]CHU Charles Nicolle, Department of Adolescent's psychopathology and medicine, Rouen, France
• INVOLUNTARY TREATMENT FOR PATIENTS WITH ANOREXIA NERVOSA
(Silje Kathrine Fredheim)
Regional centre for eating disorders, Nordlandssykehuset,</td></tr>
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	Norway • HOW DO WE GET THE PATIENTS TO EAT? PATIENTS WITH ANOREXIA IN INVOLUNTARY TREATMENT (Jannike Karlstad, Maren Kristin Larsen, Liv Elisabeth Pedersen, Ann Kristin Nygård) Nordlandssykehuset, Regional centre for eating disorders, Norway
Paper session 5 ***Carmen hall***	**Neurobiological and cognitive factors in eating disorders** (Chair: Ilona Kajokiene, Lithuania) • COGNITIVE AND METACOGNITIVE VARIABLES IN EATING DISORDERS (Walter Sapuppo[1,2,3], Giovanni Maria Ruggiero[1,2], Gabriele Caselli[1,2,3], Sandra Sassaroli[1,2]) [1]Sigmund Freud University, Milan, Italy; [2]Studi Cognitivi, Milan, Italy; [3]London South Bank University, London • HORMONAL CONTRACEPTION MAY ENHANCE COGNITIVE FUNCTIONS IN EATING DISORDERS (Benedicte Nobile[1], Laurent Maimoun[2,3], Isabelle Jaussent[1], Severine Beziat[1,4], Maude Seneque[1,4], Sylvain Thiebaut[4], Patrick Lefebvre[5,6], Eric Renard[5,6], Philippe Courtet[1,4,7], Sebastien Guillaume[1,4,7]) [1]INSERM U1061, France, University of Montpellier, Montpellier, France; [2]Department of Nuclear Medicine, CHRU Montpellier, France; [3]INSERM U1046, UMR9214 CNRS, Physiology and Experimental Medicine of the Heart and Muscles, University of Montpellier, CHRU Montpellier, France; [4]Department of Emergency Psychiatry and Post-Acute Care, CHRU Montpellier, France; [5]UMR CNRS 5203, INSERM U1191, Institute of Functional Genomics, University of Montpellier, Montpellier, France; [6]Department of Endocrinology, Diabetes, and Nutrition, CHRU Montpellier, Montpellier, France; [7]FondaMental Foundation, France • ENHANCING IMPAIRED DECISION-MAKING AND COGNITIVE IMPULSE CONTROL IN BULIMIA NERVOSA BY RTMS : AN ANCILLARY RANDOMIZED CONTROLLED STUDY (Sebastien Guillaume) CHU Montpellier, France
Paper session 6 ***Mikado hall***	**Prevention, stigma, personality, and barriers to recovery** (Chair: Jan Norre, Belgium) • OPERATION SELF-ESTEEM: PRELIMINARY RESULTS OF A USER-ADMINISTERED PROGRAMME FOR EATING DISORDERS PREVENTION IN SCHOOLS (David Clinton[1,2], Andreas Birgegård[1], Catherine Hegerius[2], Emrika Larsson[2], Johanna Levallius[1], Stefanie Nold[2]) [1]Karolinska Institutet, Sweden; [2]Frisk & Fri, Sweden • HOW INDIVIDUALS WITH EATING DISORDERS EXPERIENCE STIGMA AND ITS CONSEQUENCES (Stephanie Úna McAlinden, Teresa Rushe, Rhiannon Turner, Lesley Storey)

	Queen's University Belfast, United Kingdom • INTRAPSYCHIC STRUCTURE OF EATING DISORDERS AMONG LITHUANIAN FEMALE ADOLESCENTS (Dalia Nasvytiene) Vilnius University, Lithuania • BARRIERS TO EFFECTIVE CARE IN EATING DISORDERS (Brigita Baks) Vilnius University, Lithuania
10.30-11.00	**Coffee break**
11.00-12.30 ***Aida hall***	**Debate:** FOCUSING ON BODY IMAGE IS AN ESSENTIAL TREATMENT COMPONENT FOR RECOVERY IN EATING DISORDERS (Chair: Gerry Butcher[1]; Proponent: Fernando Ferandez-Aranda[2]; Opponent: Cynthia Bulik[3]) [1]Cognitive Solutions Clinic, Dublin, Ireland; [2]Eating Disorders Unit, Psychiatry Department, University Hospital of Bellvitge-IDIBELL and CIBEROBN, Barcelona, Spain; [3]Karolinska Institute, Sweden
12.30-13.30	**Lunch**
13.30-15.00 ***Aida hall***	**Business meeting and closing**

ECED 2017 ABSTRACT BOOK

ORAL PRESENTATIONS

Keywords: adolescents, team, eating disorders

BARRIERS TO EFFECTIVE CARE IN EATING DISORDERS

Brigita Baks
Vilnius University, Lithuania

Interdisciplinary treatment of established eating disorders can be time-consuming, prolonged and costly. Lack of care or insufficient treatment can result in chronicity with major medical complications, social or psychiatric morbidity and even death. Barriers to care include lack of specialized treatment centres, the availability of a continuum of treatment through for all age categories, insurance coverage, inadequate scope of benefits, low reimbursement rates, and limited access to health care specialists and appropriate interdisciplinary teams with expertise in eating disorders, which may be the result of either geographic or organizational limitations. In addition to these extrinsic barriers, patients and families often demonstrate ambivalence or resistance to the diagnosis or treatment, which threatens active engagement in the recovery process.
At the moment, in most cases insurance coverage for treatment of eating disorders is insufficient. The labeling of the disorder as a purely psychiatric illness by insurance usually limits the ability of health care providers to meet the medical, nutritional and psychological needs of patients in either the medical or psychiatric setting. In addition, insurance limits the number of hospitalizations permitted per year, and restricts the number of outpatient visits per year.
In addition, according to Lithuanian law, treatment institutions have age limit policies that negatively affect treatment and limit access to care for older adolescents who may not satisfy the age limits at the institution able to provide the most appropriate care. Many older adolescents don't want to go to non-specialized general child psychiatric departments, while the Vilnius eating disorder centre can accept patients only from 18 years, or otherwise needs to organize schooling availability which is too costly and not cost-effective when on an annual basis at the department only 4 to 5 adolescents of 16-17 years of age would stay for a month. Adolescents of 16-17 years could easily join the day centre program, as many of them have a years' long history of the disorder and will remain in our care long after they reach adulthood.
Treatment should be provided by health care providers who have expertise in managing adolescents with eating disorders and who are knowledgeable about normal adolescent physical and psychological growth and development. In fact, it is the matter of one additional member on the team. Considering the current emigration of young doctors from Lithuania, the question is whether one should adapt to the situation or develop expensive private treatment for the more affluent clientele.

Keywords: orthorexia sociology qualitative fitness

HABITUS, CAPITAL AND THE FIT BODY: IS ORTHOREXIA NERVOSA THE NEW AND TRENDY EATING DISORDER?

Eniko Bona
Semmelweis University, Hungary

Introduction: In recent decades, as a response to the worrying statistics about obesity, healthy eating has become a particular fixation in the modern world, especially for people using the facilities of the fitness industry. Following a special (for example plant-based, sugarfree, soy-free, low carb etc.) diet may have obvious benefits for most people. However, we also come across those whose kitchen is their battleground – they become anxious while preparing food, obsessively counting calories and measuring how their body changes due to the presumed health benefits or their diet. They became labeled with the non-existing diagnostic label of orthorexia nervosa (ON). This paper aims to analyze this phenomenon from a sociocultural perspective.
Methods: This behaviour can be measured at its best by research that is based on qualitative methods. Content analysis of the vocabulary of online communities and focus group interviews helps reveal the attitudes and beliefs of individuals who follow strict diets. My interviewee sample consists of 15-20 fitness participants who exercise at least 3 times/week and who scored high on the ORTO-15 ON assessment questionnaire. I am looking for participants who are admittedly very outspoken about their dieting habits, however disordered eating and ON was not mentioned in the recruitment process. The aim of this approach is to check whether there are visible disordered practices in their daily eating habits, according to their personal narratives.
Results: At present, I introduce my results about the comprehensive qualitative thematic synthesis of the current body of research on ON. By applying Pierre Bourdieu's theory of social capital and habitus to fitness participants, one can see that their health behaviours are driven by the desire for more symbolic capital, in order to reach a higher status. Perfectionist dieting implies a rule-obeying body that has a higher value in fitness communities and western societies in general. The themes discovered and the participants' special vocabulary signifies a moralizing relationship with food: by organizing it into categories of good and bad, and eating, by turning the act into a test of discipline and morals. My main research aim is to find out whether strict eating regimes are a significant tool to uphold hierarchical social relations within the orthorexic society of the western world? Is this argument as strong as the well-known factors of neurochemical imbalances and cognitive schemas, that previous ON research had concluded?
Conclusions: Accounts from medical professionals and case studies show that obsessive health dieting often has health consequences of malnutrition and risk behaviour such as purging or restriction, and that it is an everyday stressor that leads to anxiety. The aim of this paper is to open a discussion about the possibilities of educating people for balance, for challenging their preoccupation with fit and "healthy" body images and "clean" diets. Our future research on ON will aim to explore the further social, cultural and spiritual background of these imbalances.

Keywords: eating disorders, adults, multifamily therapy, grounded theory, Aristotelian virtue ethics

HAVING MANY STRINGS TO ONES` BOW" - A QUALITATIVE STUDY OF THERAPISTS` PRACTICE IN MULTIFAMILY THERAPY FOR YOUNG ADULTS WITH SEVERE EATING DISORDERS

Berit Brinchmann, Cathrine Moe, Steven Balmbra, Siri Lyngmo, Tove Skarbo
Nordland Hospital Trust, Norway, Nord University, Norway

Introduction: Eating disorders are serious conditions which also impact the families of adult patients. There are few qualitative studies of multifamily therapy (MFT) with adults with severe eating disorders, and none concerning the practice of therapists in MFT.
Methods: This study uses a Grounded Theory approach to study the practice of therapists in MFT of adults with severe eating disorders. Data were collected through participant observation in two MFT groups (over 2 years), and qualitative interviews with the therapists in those groups. Data collection and data analysis were conducted in parallel.
Results: The core category was identified as ‘Having many strings to one’s bow’, consisting of three subcategories: ‘Planning and readjusting’, ‘Developing as therapist and team’ and ‘Recognising and regulating the temperature of the group’.
Conclusions: The paper examines and discusses the empirical findings in the frame of Aristotelian virtue ethics.

Keywords: infertile women, eating disorders, desire for a child, ambivalence, body preoccupations

DESIRE FOR A CHILD AND EATING DISORDERS IN WOMEN SEEKING INFERTILITY TREATMENT

Melanie Bruneau[1], Agnes Colombel[3], Sophie Mirallie[3], Thomas Freour[3], Jean-Benoit Hardouin[4], Paul Barriere Barriere[3], Marie Grall-Bronnec[2]

[1]Cambridgeshire and Peterborough NHS Foundation Trust, UK

[2]CHU, Department of Addictology and Psychiatry, Nantes, France

[3]CHU, Department of Reproductive Medicine, Nantes, France

[4]INSERM UMR 1246 SPHERE, Nantes, France

Introduction: Eating disorders (EDs) are severe illnesses affecting particularly adolescent females and young women of childbearing age. Many negative consequences, such as infertility, can result. Infertility also seems to be a symptom through which we could identify these women suffering from undiagnosed EDs. Indeed, the eating behaviour of infertile women appears to be more disturbed than in general population. Little scientific studies have been done on EDs in women seeking infertility treatment. The purpose of this study was to evaluate the prevalence of EDs in women seeking treatment for infertility, and to better characterize their clinical profile. Methods: Sixty participants completed self-report measures that assessed EDs, desire for a child, body preoccupations, quality of life, anxiety and depression. Results: Ten patients (17%) met criteria for a past or current ED. We showed a significant association between greater body dissatisfaction and a more ambivalent desire for a child. Furthermore, an ED was associated with (i) a lower quality of life, and (ii) more anxiety disorders. Conclusion: Screening for a history of ED in infertile women is recommended to plan for adapted care regarding infertility but also regarding ED and psychiatric comorbidities. Therefore, the assessment has to take into account the desire for a child and the body satisfaction, that are essential parts of the ED process on the one hand and infertility process on the other. This could help with the infertility treatment and the prevention of negative maternal and fetal outcomes. The interest of joint collaboration between the reproductive health care provider and the psychiatrist is emphasized in such cases.

Keywords: prevention, self-esteem, self-compassion, collaboration, users

OPERATION SELF-ESTEEM: PRELIMINARY RESULTS OF A USER-ADMINISTERED PROGRAMME FOR EATING DISORDERS PREVENTION IN SCHOOLS

David Clinton[1,2], Andreas Birgegård[1], Catherine Hegerius[2], Emrika Larsson[2], Johanna Levallius[1], Stefanie Nold[2]
[1]Karolinska Institutet, Sweden
[2]Frisk & Fri, Sweden

Introduction: The empirical utility of programmes for the prevention of eating disorders has been notoriously difficult to establish. To date most work in this area has focused on the evaluation of interventions developed by researchers and clinicians, with mixed results. The present study examined a programme of primary ED prevention, "Operation Self-esteem"(OS) developed by the Swedish patient advocacy group Healthy and Free (The Swedish Eating Disorders Association) together with partners and delivered by former sufferers of eating disorders. The interactive programme aims to provide participants with knowledge about what can influence their self-esteem, stimulate reflective awareness, provide increased understanding of peers, strengthen self-esteem and self-compassion, and identify young people with potential ED-related problems. The intervention comprises one 90-minute workshop for each participating school class and uses discussions, exercises and written material.
Methods: Girls (N=222; age M=16.4, SD=0.9) and boys (N=119; age M=16.4, SD=1.0) attending one of eight participating high schools completed measures of help-seeking behaviour, self-esteem, body dissatisfaction and media influence at initial assessment and 3 months later. Schools were randomised to either Operation Self-esteem or a control condition involving assessment and no intervention.
Results: Groups were comparable at initial assessment with the exception of significantly greater initial levels of media influence among controls. At follow-up there were no significant differences between groups on self-esteem and body dissatisfaction, although OS participants scored significantly lower on media influence (this difference remaining significant after controlling for initial group differences through covariance analysis). Controls had sought help for significantly more personal and emotional problems between initial assessment and follow-up, while OS participants were more inclined to seek help from others in the future (especially teachers and school nurses) if they were to encounter such difficulties. Potentially important gender differences emerged. There was a non-significant tendency for boys in the OS group to change more towards seeking help for problems compared to controls. Differences between OS participants and controls on media influence at follow-up tended to also be more pronounced for boys than girls.
Conclusions: Using minimal resources "Operation Self-esteem" shows promise for reducing ED risk behaviour and promoting healthy attitudes toward seeking help for personal and emotional problems among high school students. However, further refinement of the programme and research are needed to improve and test effectiveness. Our work illustrates the vital importance of closer collaboration between clinicians, researchers and users in tackling key issues in the field of eating disorders.

Keywords: psycho-sexual health, sexuality, intimacy, psychopathology, eating disorders

PSYCHO-SEXUAL HEALTH IN EATING DISORDER PATIENTS: A PILOT STUDY

David Clinton[1,2]
[1]Karolinska Institutet, Sweden
[2]Institute for Eating Disorders, Oslo

Introduction: Sexuality and psycho-sexual health are essential aspects of life and contribute to general well-being. However, the relationship between psycho-sexual health and eating disorder (ED) psychopathology, treatment and outcome is poorly understood. Disturbances in body image and affect regulation have been linked to sexual problems and satisfaction, and it has been suggested that exploration of sexual issues in treatment may provide an important means of helping patients with core ED psychopathology. The aim of the present study was to explore psycho-sexual health in ED patients using a new measure developed by the author and collaborators, the Clinical Assessment of Psycho-Sexual Health (CAPSex). CAPSex is a 20-item questionnaire using a five-point scale to assess five distinct components of psycho-sexual health: Sexual Intimacy, Sexual Anxiety, Sexual Impulsiveness, Sexual Destructiveness and Sexual Shame. The measure also provides a measure of overall psycho-sexual health.

Methods: Female ED patients with predominantly restrictive disorders (N=43; age M=30.1, SD=8.8) were compared to a random sample of age-matched normal female controls (N=43; age M=29.8, SD=8.1) and a clinical sample of females seeking help for sexual problems (N=19; age M=28.6, SD=4.2) on CAPSex. ED patients were recruited from five specialist ED units in Sweden. Both comparison groups were derived from a larger group of participants (N=675) used in standardising CAPSex.

Results: Internal consistency of CAPSex in the ED sample was generally good: Sexual Intimacy α = .90; Sexual Anxiety α = .79; Sexual Impulsiveness α = .55; Sexual Destructiveness α = .78; and Sexual Shame α = .88. The comparatively low alpha for Sexual Impulsiveness was due to one item ("I have difficulty controlling my sexual impulses"). One-way ANOVA with post hoc Scheffé tests revealed significant between-group differences on all CAPSex subscales except Sexual Destructiveness, which was low in all groups. Compared to normal controls ED patients reported significantly lower Sexual Intimacy and Sexual Impulsivity, and higher Sexual Anxiety and Sexual Shame. There were no significant differences between ED patients and clinical controls. Cluster analysis suggested that ED patients comprised three distinct subgroups: relatively good psycho-sexual health (N=18), anxious and low-impulsive sexual health (N=21) and highly destructive and shameful sexual health (N=4).

Conclusions: These preliminary results suggest that CAPSex can provide a useful measure of psycho-sexual health in ED. Patients with ED appear to have pronounced difficulties with psycho-sexual health compared to healthy controls, and their may be subgroups of patients with distinct sexual problems. Continued research into the sexual health of ED patients is needed. It will be especially important to study how psycho-sexual health is related to ED psychopathology and outcome. The relationship of sexuality to previous trauma needs to be explored, as does the importance of addressing sexual issues in treatment and the possible significance of types of psycho-sexual health for outcome.

Keywords: eating disorders, compulsive exercise, inpatient treatment, questionnaire

COMPULSIVE EXERCISE AND TREATMENT OF EATING DISORDERS: FIFTEEN YEARS OF CLINICAL EXPERIENCE AND RESEARCH

Marit Danielsen[1,2], Sigrid Bjørnelv[1,2], Øyvind Rø[3,4]

[1]Eating Disorder Unit, Department of Psychiatry, Levanger Hospital, Hospital Trust Nord-Trøndelag, 7600 Levanger, Norway, Levanger, Norway

[2]of Mental Health, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway, Trondheim, Norway

[3]Eating Disorder Service, Division of Mental Health and Addiction, Oslo University Hospital, Oslo, Norway, Oslo, Norway

[4]Division of Mental Health and Addiction, Institute of Clinical Medicine, University of Oslo, Norway, Oslo, Norway

Introduction: Compulsive exercise is a symptom associated with eating disorders and has been found to influence the course of illness. Studies have shown that compulsive exercise is a risk factor for development, maintenance and relapse in eating disorders. Treatment programs for eating disorders should include treatment approaches to help the patients to reduce compulsive exercise and incorporate healthy exercise as part of normal everyday activity. The aims of this presentation are to describe fifteen years of clinical experience of how to include physical exercise as part of a treatment program and present research findings about compulsive exercise in eating disorders. To be able to offer personalized treatment to the patients, it has been important for us to develop and evaluate our clinical approaches in a systematic way.
Methods: From 2003, treatment approaches towards compulsive exercise have been included in the adult inpatient treatment program. The program is divided into stages. In Stage 1, the focus is primarily directed towards basic needs. Stage 2 is the active treatment phase, and in Stage 3 the attention is increasingly directed towards life outside the unit. Approaches towards exercise are performed in accordance with treatment stages. During these years, a measurement tool (the Exercise and Eating Disorders (EED) has been developed to assess and evaluate compulsive exercise.
Personnel in the unit are educated in body oriented treatment and outdoor activities. In treatment, the patients are gradually exposed to modified physical activity, and outdoor activities (e.g., climbing, kayaking, and ice-skating in the winter). Psycho-education is important, and dysfunctional thoughts and emotions are systematically identified, challenged, and modified. Patients in Stage 2 (BMI ≥ 17) may attend two regular exercise groups per week involving 1 hour of aerobic activity and 1 hour of strength training. The intensity level is mostly moderate, but we also aim to expose patients to different levels of intensity of physical activity. A condition of attendance is that weight gain continues in accordance with the plan for underweight patients.
Results: Treatment approaches have been evaluated and developed in accordance with clinical experience and research results. The clinical experience confirms the importance of including exercise approaches in the treatment program. If patients are allowed to continue to exercise in rigid exercise regimes, it is very difficult to achieve changes in unhealthy thoughts, feelings and behaviours. The EED has been validated in a sample of female eating disorders patients. Analysis showed a four-factor structure and good psychometric property. EED measures have shown improvement during inpatient treatment, indicating reduced level of compulsive exercise. We have also found that these changes predicted long-term outcome at follow-up after inpatient treatment. This was indicated by reduced eating disorder pathology, measured by the Eating Disorder Inventory (EDI-2), and increased BMI for underweight participants at admission.
Conclusions: Our clinical experience and research results may contribute to increased knowledge of compulsive exercise in eating disorder patients. It supports the view that exercise approaches may be useful in inpatient treatment.

Keywords: weight gain, Anorexia Nervosa, inpatient

RATE OF WEIGHT GAIN IN INPATIENT TREATMENT OF ANOREXIA NERVOSA

Marit Danielsen, Sigrid Bjornelv, Henrik Lundh, Harald Skogmo
Levanger Hospital, Eating Disorder Unit, Norway

Introduction: Few studies reports rate of weight gain during inpatient treatment of anorexia nervosa in young adult patients. International guidelines recommend 0,5 – 1,5 kg weekly weight gain up to normal weight, and normalization of weight/BMI is thought to be important for recovery.
Methods: The Eating Disorder Unit, Levanger Hospital, covers an area of 780 000 inhabitants and all subtypes of eating disorders are referred. From January 2003 until April 2017 234 patients have been referred to the unit, 160 (70%) with BMI<20 at admission. The participants were mainly women, and the mean age at admission was 21, 7 years (15,9 – 46,7). Mean length of stay was 145 days.
The treatment program is step-wise, the patients sign a written contract where underweight patients are demanded a certain mean weight gain. In 2006 a change in the procedure was introduced, and the weekly weight claim was increased, dividing the participants in two groups. Group 1 were treated before 2006, and had a demanded weekly weight gain of 0,5 kg form week 2. For group 2 treated from 2006 the demand for weight gain started after 4 weeks, and was increased to 0,7 kg/week. Admission time for patients with AN was calculated on weeks necessary to reach target weight and time to stabilize. The target weight for underweight patient was BMI 20.
Results: 27 patients were treated when the weekly weight gain was 0,5 kg, while 133 attended have had a demand for 0,7 kg weekly weight gain. There were no significant differences in mean BMI at admission group 1 15,5 (11,7 – 19,2), and 16,0 (11,7 – 19,9) in group 2. Mean age in group 1 was significantly higher than in group 2 (25.8 vs. 20,9). The mean weight gain in group 1 was 9,1 kg (-2,2 – 29,6), in group 2 10,3 (-1,7 – 28) Mean BMI at discharge in group 1 was 18,8 (14,8 – 23,3), compared to 19,6 (13,8 – 25) in group 2. In group 2 a significant higher percent of the patients reached target weight (BMI 20). A few patients had a significant underweight (BMI <17,5) at discharge, 10 in group 1 (29,6%), 18 in group 2 (13,6%).). The patients in group 1 had more weeks in treatment compared to group 2 (26,5 vs 19,8).
Conclusions: Underweight patients in this program showed significant weight gain. Changing the procedure and increasing the demand for weekly weight gain seems to have little impact on mean weight gain, but more patients seems to reach target weight, and the length of hospitalization was shorter. The clinical evaluation showed improved weight gain in group 2, which may be due to the change in procedure which was a more systematic way of working with weight gain in underweight patients. Some of the differences may however be explained may the age differences due to another treatment program for patients above 25 - 30 years at admission.

Keywords: grief, burden, care giving, Anorexia Nervosa

PARENTAL BURDEN IN ANOREXIA NERVOSA

Jeanne Duclos[1,2], Giulia Piva[3], Nathalie Godart[1,2]

[1]Institut Mutualiste Montsouris

[2]CESP, INSERM, Univ. Paris-Sud, UVSQ, Université Paris-Saclay, Villejuif, France

[3]University of Pavi, Italy

Introduction: Anorexia Nervosa (AN) is a chronic disorder where carers are usually suffering from psychological distress and burden. Severe chronic disorders have been linked with the concept of grief. But grief has not been frequently investigated in AN. The objective of the present study were (1) to determine whether burden in carers in AN could be explained by grief, taking into account parental and patients variables that impact burden; (2) to explore the link between parental burden and the clinical state of their child with AN.

Methods: Eighty-four female patients aged 13 to 65 hospitalised for AN (based on DSM-IV-TR criteria) and their careers were assessed including 79 mothers and 55 fathers. All data were collected during the first 2 weeks of inpatient admission.

Results: Maternal and paternal scores of 'initial grief' were lower than those on the 'current grief'. Maternal scores of 'current grief were significantly higher than paternal scores. Total scores of burden for mothers tend to be higher than for fathers. High levels of psychological distress explained maternal current grief while paternal current grief was explained by his distress and by his child's severe clinical state. Maternal burden was explained independently by her current grief and her child's severe clinical state. In fathers, both his current grief and his level of anxiety explained burden.

Conclusions: Parents who are not able to grieve for their child would have a more consistent burden and would be less capable of mobilizing for the care of their children' difficulties. Treatment for AN should include both parental support helping them to cope with illness, with the filling of loss concerning their ideal healthy child and with their own anxiety.

Keywords: involuntary treatment, sectioning, anorexia nervosa, in-patient treatment

INVOLUNTARY TREATMENT FOR PATIENTS WITH ANOREXIA NERVOSA

Silje Kathrine Fredheim
Regional centre for eating disorders, Nordlandssykehuset, Norway

Introduction: Involuntary treatment for anorexia nervosa is used in most European countries when it comes to saving a patient's life. In the literature, there is however little to be found on how involuntary treatment is carried out, and there are few guidelines as to when it is useful and when it can ultimately be detrimental to a patient's long-term outcome. At the regional centre for eating disorders in Northern Norway, we have over the last seven years, made an effort to use a metalizing stance in our treatment of patients who are sectioned to treatment. We have also observed who benefits long term from involuntary treatment, and who does not. This presentation will say something about how to treat different subgroups of patients during involuntary treatment.
Methods: Whenever possible the patients have filled out standardized tests at admittance, when they finish involuntary treatment, and then a year after they started treatment. We have combined this material with clinical observations and made some guidelines as to how to conduct involuntary treatment at our in-patient ward.
Results: Amongst our 22 patients there seem to be three subgroups of patients who do less well in a structured treatment program for eating disorders, when they are there involuntarily. 1. People who have complex PTSD, often combined with a history of involuntary treatment with use of a lot of force to feed them. 2. People who have an attachment history that makes them vulnerable to forming strong attachments to the ward, and do not want to leave involuntary treatment. 3. People with borderline personality disorder and high risk eating disorders. We have developed some guidelines on how to assess and treat these subgroups to avoid a negative trajectory of treatment. The guidelines are based on few patients and are meant as a basis for further evaluation and research. They can however give a useful starting point for discussing how trauma and personality traits affects the outcome of involuntary treatment, and how we need to be concerned with more than somatic markers when making treatment decisions.
Conclusion: It can be necessary and helpful for patients with anorexia nervosa to receive involuntary treatment. If their life or recovery depends on it, they can experience it as care and be happy they received it. It is however essential to “do no harm” when going to such a step. Subgroups of patients can get caught in a negative cycle of conflict. Involuntary treatment can trigger negative behaviour patterns in certain patients, and as clinicians, we need to be aware of that and have alternative treatment options.

Keywords: Anorexia Nervosa, hospitalisation, multicentre, France

EVALUATION OF HOSPITALISATION FOR ANOREXIA NERVOSA: THE EVHAN STUDY

Nathalie Godart[1,2], Sylvie Berthoz[1,2], Christophe Lalanne[3], Jeanne Duclos[1,2], Leslie Radon[1,2], Malaika Lasfar[4], Priscille Gerardin[4]
[1]Institut Mutualiste Montsouris, France
[2]CESP, INSERM, Univ. Paris-Sud, UVSQ, Université Paris-Saclay, Villejuif, France
[3]AP-HP, Hôpital Saint-Louis, Département de Recherche Clinique, Paris, France
[4]CHU Charles Nicolle, Department of Adolescent's psychopathology and medicine, Rouen, France

Introduction: Anorexia nervosa is complicated by psychological, physical or social difficulties that can be life threatening for the individuals concerned. In the most severe cases one or several long periods of hospitalisation may be required. Although international guidelines define the main aims of inpatient treatment, modalities sometimes vary from one centre to another and not enough is known about the way the health of these individuals evolves during and after hospitalisation or about factors that might contribute to favourable or unfavourable outcomes. Likewise, little is known about the reasons why almost half of hospitalisations for anorexia nervosa are terminated prematurely or about the factors that could explain the varying length of hospitalisations.
Methods: We present the EVHAN study (Eudract number: 2007-A01110-53, Clinical trials): a multicentre research project conducted in France between March 2009 and December 2012. The aims were to assess: first, the different treatment modalities in 11 centres in France with inpatient units specialised in eating disorders, second, their impact on outcome at discharge and at 1-year follow-up, and third, predictive factors of dropout and length of stay. The primary hypothesis was that different treatment types impact patient outcome at discharge and at 1-year follow-up, even after adjustment for confounding factors (age, length of illness, number of previous hospitalisations, and clinical state at intake).
Results: We summarise the initial results of the study: description of the organisation of care available in the 11 centres and variations in modalities; the impact of inpatient treatment (at discharge and at 1-year follow-up).
Conclusion: We also describe how this study has contributed to open exchanges and partnerships among the eleven centres specialised in the care of eating disorders, and has enabled the establishment of a collaborative network between researchers and clinicians working on anorexia nervosa, both nationally and internationally.

Keywords: rTMS, neuromodulation, bulimia, neuropsychology

ENHANCING IMPAIRED DECISION-MAKING AND COGNITIVE IMPULSE CONTROL IN BULIMIA NERVOSA BY RTMS : AN ANCILLARY RANDOMIZED CONTROLLED STUDY

Sebastien Guillaume
CHU Montpellier, France

Background: Decision-making and cognitive impulse control may be involved in the pathophysiology psychiatric disorders such as bulimia nervosa (BN) and might underlined clinical improvement after neuromodulation.
Objective: Assessing effects of rTMS on these cognitive functions in a sample of subjects with BN
Methods: Thirty-seven subjects (22 in sham group and 17 in rTMS group) were assessed before and after ten sessions high frequency rTMS on the left dorsolateral prefrontal cortex (DLPFC).
Results: Performance on cognitive impulse control increased, in rTMS group only, both in a Go-No-Go task (p=0,03) and on a cognitive impulsivity scale (p=0,01). Switches toward good choice on Iowa Gambling Task were found in rTMS group and during the last visit only (p=0,002) and understanding of the contingency of the task increases between the two assessments in the rTMS group only (p=0,002).
Conclusion: Modulation of left DLPFC might improve two putative cognitive biomarkers of bulimia nervosa

Keywords: meal-support, involuntary treatment, MBT

HOW DO WE GET THE PATIENTS TO EAT? PATIENTS WITH ANOREXIA IN INVOLUNTARY TREATMENT

Jannike Karlstad, Maren Kristin Larsen, Liv Elisabeth Pedersen, Ann Kristin Nygård
Nordlandssykehuset, Regional centre for eating disorders, Norway

We work as mental health carers at an in-patient unit. In our program we have both voluntary and involuntary treatment. The most important aspects of the treatment are nutrition and meals. Here we would like to focus on the involuntary treatment and how we get these patients to eat. During the years we have gotten quite a lot of experience on how to carry through meals with this group of patients. To date, there appears to be a lack of evidence-based research on meal support therapy, and little is reported on what is going on during and around the meals.
This presentation is based on our clinical experiences, we all participate in meals with patients every day. We have been involved in framing guidelines for this purpose. We have also gathered information from the patients on how they experience this part of the treatment. To describe some of these challenges and how to solve them, we intend to do a role-play.
Our unit is based on metallization based therapy (MBT); in practice this means that we take into consideration which psychic mode the patients are in during mealtimes. We try to challenge the patient`s illusions and rigidity, statements like “I am fat” or “I cannot eat butter”. To regulate the mental temperature during the meal is one important aspect. Time, patience and curiosity are key words, while maintaining a steady and strict manner. We have some non-negotiable principles concerning the food and meals; these are a few examples:
You have to eat all the food on the plate, or replace it with nutritional-drinks.
Supervised resting time after meals.
It is not allowed to criticize the food during mealtime.
We regularly have patients on involuntary treatment, but only on a few occasions has there been need to resort to mechanical enforcement, like belts while performing nasogastric feeding or medications. Our experience is that this kind of meal support therapy deals with emotional and psychological issues which usually emerge thus reducing the need for forced interventions.

Keywords: epidemiology, anorexia nervosa, bulimia nervosa, binge eating disorder, atypical eating disorders

DISCUSSANT: EATING DISORDERS IN EUROPE

Anna Keski-Rahkonen
Department of Public Health, Helsinki, Finland

In this talk, the discussant will briefly overview epidemiological research on eating disorders in Europe and contrast these findings with reports from other parts of the world presented by previous speakers. In Europe, anorexia nervosa is reported by <1-4%, bulimia nervosa <1-2%, binge eating disorder <1-4% and subthreshold eating disorders by 2-3% of women. Of European men, 0.3-0.7% report anorexia or bulimia nervosa. In Western Europe, rates of anorexia appear relatively stable over past decades and in some countries bulimia may be declining; atypical eating disorders may be increasing. Much less is known about Eastern Europe, but cultural change may promote disordered eating. Only a minority of individuals with eating disorders are detected by healthcare. Although the long-term course of eating disorders is favorable for many, a substantial minority of individuals experience longstanding symptoms and health problems and an increased risk of mortality.

Keywords: eating disorders, immigration, Ethiopia, trauma, culturally-sensitive treatment, cultural formulation interview (CFI)

A FULL STOMACH": EATING DISORDER AMONG ETHIOPIAN IMMIGRANTS IN ISRAEL

Yael Latzer[1,2], Rinat Grundman Shem-Tov[3], Eynat Zubery[3], Noa Loevy Hecht[3]
[1]Faculty of Social Welfare and Health Sciences, University of Haifa, Israel
[2]Eating Disorders Institution, Psychiatric Division, Rambam Medical Center, Haifa, Israel
[3]Eating Disorders Treatment and Research Unit, Hanotrim Clinic, Ra'anana, Shalvata Mental Health Center, Clalit Health Services, Israel

In recent decades, there has been a significant increase in the prevalence of eating disorders among non-western populations. This article will address unique socio-cultural issues regarding the process of referral, diagnosis and treatment of eating disorders among young Ethiopian women in Israel. We will discuss cultural aspects relating to the perception of the disease and the circumstantial contexts relating to this population, such as the process of immigration, integration into Israeli society and issues related to identity and trauma. Case studies will be presented for illustration. In the discussion, a culturally sensitive diagnostic-therapeutic model is proposed. This model assumes that the observation of clinical cases from different cultural backgrounds cannot be achieved solely through a western diagnostic prism. In addition, the integrative diagnostic phase is presented, including western oriented diagnosis, an interview based on a cultural formulation as well as clarification of complex post-traumatic disorder.

Keywords: anorexia nervosa, prepubertal, development

ANOREXIA IN A PREPUBERTAL BOY AS DEVELOPMENTAL DISORDER

Darius Leskauskas
Lithuanian University of health sciences, Lithuania

This presentation will be based on the case analysis of a treatment of an 8-year old boy with anorexia nervosa. Particular attention will be given to the developmental disturbance which had led to the development of the disorder and was then corrected in the course of treatment leading to the cure from the disorder.

Keywords: anorexia nervosa, achalasia, adolescent, eating disorders

EATING DISORDER OR ACHALASIA DURING ADOLESCENCE: DIAGNOSTIC DIFFICULTIES

Aurelie Letranchant[1,2], Benedicte Pigneur[3,4], Nathalie Godart[1,5]

[1]Adolescent and Young adult psychiatry Unit, Institut Mutualiste Montsouris, 42 boulevard Jourdan, 75014 Paris, France

[2]Paris Descartes University, Medical school, 15 rue de l'Ecole de Médecine, 75015 Paris, France

[3]Institut National de la Santé et de la Recherche Médicale INSERM UMR1163, Laboratory of Intestinal Immunity, Institut Imagine, Paris, France

[4]Department of Pediatric Gastroenterology, Hepatology and Nutrition, Necker Enfants Malades Hospital Assistance Publique – Hôpitaux de Paris, Paris Descartes-Sorbonne Paris Cite, Paris, France

[5]CESP, INSERM, Paris-Sud University, UVSQ, Paris-Saclay University, France

Clinical case: Marine, a fourteen-and-a-half-year-old teenager is being hospitalized for a purging type anorexia nervosa. She has had a complicated life course, made up of breaks and discontinuities at both family and school level. She has been taken care of through an Oppositional Defiant Disorder since age 5, with irregular follow-up. One day, Marine presented spontaneous and induced vomiting associated with major weight loss (BMI = 15.27 kg.m-2). The diagnosis of anorexia nervosa was established after several opinions were given in five Parisian university pediatric services, where additional investigations were carried out without any somatic cause being identified. In this context, she was transferred to a child psychiatry service. Inside the service, after she fainted during the introduction of a nasogastric tube, a new specialized opinion was asked of a pediatric gastroenterologist and new explorations were carried out (oeso-gastro-duodenal transit and manometry), leading to the conclusion of an achalasia of the oesophagus witha requirement for surgery.
Discussion: Thereby, the exclusion of an organic disorder must be a priority in the diagnostic approach. Achalasia of the oesophagus can be a differential diagnosis of an eating disorder and one must be able to mention it when observing swallowing difficulties or dysphagia. Conclusion: Health care professionals must be mindful of providing an appropriate somatic follow-up for patients suffering from psychiatric disorders.

Keywords: stigma, qualitative, anorexia nervosa, bulimia nervosa, EDNOS

HOW INDIVIDUALS WITH EATING DISORDERS EXPERIENCE STIGMA AND ITS CONSEQUENCES

Stephanie Úna McAlinden, Teresa Rushe, Rhiannon Turner, Lesley Storey
Queen's University Belfast, United Kingdom

Introduction: Eating disorders (EDs) are a stigmatised illness, with some evidence suggesting they are even more heavily stigmatised than other mental illnesses. This stigma has been shown to translate even into the healthcare community, with patients viewed as less likable and in control of their disorder. Experience of stigma is associated with greater ED symptomology and longer duration of illness. It also discourages people with EDs (PWED) from seeking help or treatment. It would be beneficial to design an intervention for the general public that focuses on reducing the stigma of EDs, so as to better improve the quality of life for PWED and improve their help-seeking. Previous research has stressed the importance of including service users in anti-stigma campaigns. Research that looks at the impact of stigma on PWED is mainly quantitative, or else looks at inpatient females with anorexia nervosa (AN). This study wished to investigate the experience of stigma as told by PWED from a more diverse sample, including people with AN, bulimia nervosa (BN), eating disorder not otherwise specified (EDNOS), men and people who have avoided ever seeking help for their condition.
Method: 16 semi-structured interviews were conducted. Participants ranged in age from 19-41. 10 participants had AN, 4 had BN, and 2 had EDNOS with AN/BN symptomology. 12 participants were female, whilst 4 were male.
Results: Preliminary analysis suggests extremely strong and debilitating experiences of stigma from nearly every participant. Experience from stigma in the medical community included several reports of health professionals refusing to diagnose an ED, and a lack of consideration of patient needs once in care. Two of the men were denied diagnosis on the basis of their gender. Stigma was reported to have caused the breakdown of several friendship and family relationships, sometimes beyond repair. Participants described significant shame and embarrassment about their condition, as well as negative effects on their self-esteem and self-worth. Many discussed the misconceptions surrounding the aetiology of an ED, and about how people thought they were a diet gone wrong and something they were in control of. Several remarked how they thought EDs were glamorised, and that people even expressed envy of their symptoms due to the emphasis by society on the thin ideal.
Conclusion: PWED are strongly stigmatised by family, friends, the general public and even the medical community. This stigma impacts their sense of self-worth and often discourages them from engaging in treatment after negative experiences from health professionals. PWED report a lack of understanding about the seriousness of their illness and a lack of willingness from others to talk with them about it. Men and even sometimes women are being denied diagnoses due to a lack of understanding about EDs from the medical profession. These issues will have to be addressed through proper education across a variety of audiences, from laypeople to medical.

Keywords: Eating Disorders Saudi Arabia

THE CULTURAL TRANSITION OF SAUDI ARABIA

Bernou Melisse
Leiden University, Netherlands

The Saudi society separates men and women. Women have to cover them selves in public, wearing an abaya and hijab. Also, sometimes within families women cover them selves in mixed occasions (men and women). However, women strive to look good among each other. In the past they admired curviness but recently thinness is admired more.
Since the discovery of oil in the 1930's Saudi Arabia underwent several socio- cultural changes. Socio economic status increased, the country westernized, media use and travel increased, a rise of obesity and the thin ideal are some of these changes that potentially contributed to an increase in eating disorders. Recently female gyms are officially allowed and girls will all get PE at school.
However, very little is known about the prevalence of eating disorders, since no valid assessment tool is available. Further research is essential in order to identify eating disorders and their risk factors in Saudi Arabia.

Keywords: adolescent personality, MACI, eating disorders

INTRAPSYCHIC STRUCTURE OF EATING DISORDERS AMONG LITHUANIAN FEMALE ADOLESCENTS

Dalia Nasvytiene
Vilnius University, Lithuania

Introduction: Some personal characteristics are considered to be typical for individuals with eating disorders [hereinafter ED] - perfectionism (Bardone-Cone et al, 2007). Neuroticism, negative emotionality, deficits in impulsivity and inhibitory control (Delgado-Rico et al, 2012), and low self-directedness to mention but few (Cassin & von Ranson, 2007). However much is left to be investigated with regard to cross-fertilization of the onset of ED and emerging personality patterns in young people (Liley et al, 2013); its sensitivity for cultural context.
Method: Our research was based on Millon‘s (2004) theoretical framework which integrates personality dimensions, diagnostic concerns, and coping patterns in youngsters. The main goal was to assess the intrapsychic structure of ED in Lithuanian adolescents. The second-order goal was aimed at evaluation of criterion-related validity of the Millon Adolescent Clinical Inventory [hereinafter MACI] in response to opinion that self-observation instruments tend to overestimate the characteristics of personality disorders (Cassin & von Ranson, 2007). Matched-group design was applied. 47 girls with diagnosed ED (mean age = 16.5 years) and 52 who were without this disorder (mean age = 16.3 years) completed a paper-pencil self-report form of MACI. Data were analyzed using SPSS-24.
Results are discussed from two perspectives – intergroup comparison and intragroup specifics of Anorexia Nervosas and Bulimia. Implications for counselling are offered.
Conclusion: Criterion validity of MACI for this diagnostic category is strongly confirmed. Half of clinical scales statistically significantly differentiate Lithuanian female adolescents with ED from their age- and gender- matched peers without ED; these adolescents are prone to suicidal tendencies, delinquent predisposition, anxiety feelings, and depressive affect.

Keywords: eating disorders, hormonal contraception, cognitive functions

HORMONAL CONTRACEPTION MAY ENHANCE COGNITIVE FUNCTIONS IN EATING DISORDERS

Benedicte Nobile[1], Laurent Maimoun[2,3], Isabelle Jaussent[1], Severine Beziat[1,4], Maude Seneque[1,4], Sylvain Thiebaut[4], Patrick Lefebvre[5,6], Eric Renard[5,6], Philippe Courtet[1,4,7], Sebastien Guillaume[1,4,7]

[1]INSERM U1061, France, University of Montpellier, Montpellier, France

[2]Department of Nuclear Medicine, CHRU Montpellier, France

[3]INSERM U1046, UMR9214 CNRS, Physiology and Experimental Medicine of the Heart and Muscles, University of Montpellier, CHRU Montpellier, France

[4]Department of Emergency Psychiatry and Post-Acute Care, CHRU Montpellier, France

[5]UMR CNRS 5203, INSERM U1191, Institute of Functional Genomics, University of Montpellier, Montpellier, France

[6]Department of Endocrinology, Diabetes, and Nutrition, CHRU Montpellier, Montpellier, France

[7]FondaMental Foundation, France

Introduction: Growing evidence suggests a role of sexual hormones, especially estrogens, in maintaining cognitive function. Women having undergone an oophorectomy or menopausal women showed a decline in cognitive function like verbal memory, working memory, attention, and spatial visualization… Hormonal therapy substitution provides a conservation of those cognitive functions.
Eating disorders are associated with cognitive impairment both secondary to the disease in itself or to the nutritional state. Given the low levels of sexual hormone found in eating disorders it might be possible that hormonal contraception within eating disorders patients would enhance their cognitive functions. The aim of this study was to assess the performance in four cognitive functions known to be impaired in eating disorders (anorexia and bulimia nervosa) according to hormonal contraception intake.
Materials and methods: This is a retrospective study on a cohort of 244 women with eating disorders (151 anorexics and 79 bulimics) according to the DSM-V criteria. Participants were aged between 15 and 45. They were screened on eating disorders severity and symptomatology (EDE-Q and EDI-Q), on pre-morbid intelligence (NART). Cognition was assessed using four neuropsychological tests: D2 (attention and capacity of concentration), IGT (decision making), Brixton (set-shifting) and Rey figure test (central coherence). Scores from these tests were categorized into tercile for analyzes. Data were analyzed in univariate model, then baseline sociodemographic and clinical variables associated with the outcome ($p<0.15$) were included in the logistic regression models to estimate the adjusted odds ratios (OR) and 95% confidence intervals (CI) for hormonal contraception effect on neuropsychological test. Results: The study sample consisted of 244 women with a mean age of 25.68 years (SD = 7.39). The mean duration of the current pathology (anorexia or bulimia) was 6.69 years (SD = 6.80), the mean BMI was 18.32kg/m2 (SD = 3.46) and 36.89 % of patients were taking hormonal contraception (oral, transdermal or intrauterine). Patients were divided in two groups: those taking hormonal contraception (N = 90) and those non taking hormonal contraception (N = 154). There were no significant differences between groups concerning age (P-value = 0.654), duration of pathology (P-value = 0.785), pathology severity (EDE-Q: P-value = 0.257; EDI-Q: P-value = 0.948), psychiatric co-morbidity (Current major depressive episode: P-value = 0.393, Bipolarity: P-value = 0.082…) and pre-morbid intelligence (P-value = 0.848). Patients taking hormonal contraception had significant greater scores concerning D2 Ratio (P-value = 0.017), IGT51-100 (P-value = 0.014) and IGT comprehension (P-value = 0.004), even after adjustments: D2 Ratio (OR = 0.37, 95%CI = [0.17; 0.81]), IGT51-100 (OR = 2.40, 95%CI = [1.06; 5.42]), IGT comprehension (OR = 4.79, 95%CI = [1.49; 15.42]).
Conclusions: This study shows that hormonal contraception has beneficial effects on cognitive function in women with eating disorders. This positive effect on cognitive functions involved in eating disorders might be taken into account in the risk-benefit balance when introducing hormonal contraception.

Keywords: body image, exercising, motivation, weight control behaviour, eating disorders

IS A SOCIALLY DESIRED BODY IMAGE A MOTIVATION FOR A HEALTHY LIFESTYLE, WEIGHT CONTROL, AND EXERCISE BEHAVIOUR?

Simona Pajaujiene
Lithuanian Sports University, Lithuania

Introduction: Though it is well known that regular exercise promotes health and fitness benefits, unfortunately, most adults exercising in the fitness area can experience social pressure to be thin or muscular. Body image perception may impact health-promoting behaviours. There is a significant increase in the number of individuals who e overuse physical activity, dieting, utilize drastic and harmful weight loss methods or even experience eating disorders (Sanchez-Carracedo et al, 2012). More research is needed to better understand the psychosocial factors which influence exercise and eating behaviour. The aim of the study – to find out the relationship between sociocultural influence towards appearance, exercise motivation, weight control behaviour and risk of ED among the people exercising in the health and fitness sector.
Methods: 412 participants from fitness clubs (mean age – 29 (11) years) completed anonymous questionnaires, which consisted of the Sociocultural Attitudes Towards Appearance scale (SATAQ-3, Thompson et al., 2004), the Motives for Physical Activity Measure - Revised scale (MPAM-R, Ryan et al., 1997), EAT-26 (Garner et al., 1982) and, especially for this study a created Weight loss behaviour scale. The sample was selected using a random cluster sampling approach, i.e. selecting one group of exercising people from each club.
Results: Body image is a problematic issue among people exercising in the health and fitness centers. Less than a half (47.6 %) are satisfied with their body. Customers of fitness clubs use a lot of unhealthy weight control methods: most prevalent are skipping meals, low calorie diet (≤800 kcal), too intensive and prolonged exercising. 37.7 % of respondents go on diets, and 9.4 % are at risk of ED. Unhealthy weight loss behaviour was more prevalent among women ($p<0.05$) and underweight participants ($p<0.05$). The pursuit of sociocultural body image expectations is significantly linked to the health-harmful weight control behaviour and risk of ED: higher internalization of appearance ideals was related with the more unhealthy weight control (eating and exercising) behaviours ($p<0.05$) and higher scores of the risk of ED ($p<0.05$). Extrinsic motivation is prevalent among the exercisers of fitness centres: subjects are practicing more because of their physical fitness, appearance improvement, and social participation. Motivation to exercise was related with all SATAQ scales and the risk of ED. Exercise motivation for appearance improvement was directly related to the risk of eating disorders ($p<0.01$). Higher scores of intrinsic (enjoyment) motivation were related with lower scores of unhealthy weight control behaviour ($p<0.05$).
Conclusions: The findings of our study suggest that internalization of socially adored body image, emphasis on appearance, fitness and weight control can be associated with a number of negative consequences. Although appearance improvement is a strong driving force for the health and fitness industry, this motivation is not only a short duration, but also related with unhealthy behaviour and risk of ED. Thus, the question of the socially desired body image motivating customers for a healthy lifestyle, weight control, exercising behaviour, and give long term results, is open for the future investigation.

Keywords: eating disorders, anorexia nervosa, bipolar disorders, co-morbidity, family history

BIPOLAR DISORDERS AND ANOREXIA NERVOSA: A CLINICAL STUDY

Nathalie Godart[1,3], Leslie Radon[1], Marie Valentin[2], Jeanne Duclos[1], Florence Curt[1]
[1]Département de psychiatrie, Institut Mutualiste Montsouris, France
[2]Centre Hospitalier d'Argenteuil, France
[3]UVSQ, CESP, Inserm, Université Paris-Saclay, Université Paris Sud, Villejuif, France

Introduction: Anorexia Nervosa (AN) is often accompanied by comorbid mood disorders, in particular depression, but individual or family history of bipolar disorders (BD) has not frequently been explored in AN. The objectives of the present study were 1) to assess the frequency of BD in patients with AN hospitalised in adolescence and in their parents, 2) to determine whether the patients with a personal or family history of BD present particular characteristics in the way in which AN manifests itself, in their medical history, in the secondary diagnoses established, and in the treatments prescribed.
Method: 97 female patients aged 13 to 20 hospitalised for AN and their parents were assessed. The diagnoses of AN and BD were established on the basis of DSM-IV-TR criteria.
Results: A high frequency of type II and type V bipolar disorders was observed. The patients with AN and presenting personal or family histories of BD had an earlier onset of AN, more numerous hospitalisations, a longer time-lapse between AN onset and hospitalisation, more suicide attempts and more psychiatric comorbidities.
Conclusion: The occurrence of AN-BD comorbidity appears to be considerable and linked to the severity of AN, raising the issue of the relationship between AN and BD.

Keywords: eating disorders, metacognition, control, worry

COGNITIVE AND METACOGNITIVE VARIABLES IN EATING DISORDERS

Walter Sapuppo[1,2,3], Giovanni Maria Ruggiero[1,2], Gabriele Caselli[1,2,3], Sandra Sassaroli[1,2]
[1]Sigmund Freud University, Milan, Italy
[2]Studi Cognitivi, Milan, Italy
[3]London South Bank University, London

In scientific literature, perfectionism and low self-esteem are generally considered as the most important non-adaptive cognitive beliefs in eating disorders. Some theorists consider metacognitive beliefs about control and worry as a third underlying factor of the disorder. This study aimed to confirm that the three above-mentioned beliefs are present in higher degree in eating disordered subject. 48 bulimic patients and 36 anorexic patients, as well as 38 nonclinical volunteers, completed 7 measures of cognitive and metacognitive dimensions: the Multidimensional Perfectionism Scale, the Rosenberg Self-Esteem Scale, the Anxiety Control Questionnaire, the Penn State Worry Questionnaire, and the Metacognition Questionnaire. The study suggested that the body of cognitive factors underlying eating disorders is composed of a number of variables greater than the classical couple perfectionism/low self-esteem. Need for control, worry, and negative beliefs about uncontrollability and danger may be added to the list of core cognitive beliefs of eating disorders. The clinical implications of these findings are discussed.

Keywords: prevalence, eating disorders, anorexia nervosa, bulimia nervosa, subclinical eating disorders, time changes, secondary school students

TIME TRENDS IN THE PREVALENCE OF EATING DISORDERS IN SECONDARY SCHOOL POPULATION IN HUNGARY BETWEEN 1989 AND 2014

Pál Szabó[1], Balázs Ludányi[1], Ferenc Túry[2]
[1]University of Debrecen, Institute of Psychology
[2]Semmelweis University, Institute of Behavioural Sciences

Introduction: Eating disorders are rather complex phenomena influenced by a large variety of biological, psychological, social and cultural factors. Controversial data are available about the time changes in the prevalence of eating disorders. The first epidemiological studies in Hungary on eating disorders were carried out in the late eighties in populations of university and secondary school students. The objective of the present study was to follow the changes in the prevalence of syndromes and symptoms of eating disorders during a period of 25 years.
Methods: The questionnaire survey was conducted in 1989, then the authors repeated the study in three waves, in the 1998/1999 school year, in 2007 and in 2014. The symptoms of eating disorders were assessed on the basis of self-reported anthropometric data and by means of 26-item version of the Eating Attitudes Test (EAT-26, Garner & Garfinkel, 1979), and the Eating Behaviour Severity Scale (Yager et al., 1987). The degree of body satisfaction was measured, too (Folk et al, 1993), during the 3rd and 4th study waves. The questionnaires were distributed in secondary schools. The participation was voluntary and anonymous, the response rate was almost 100 per cent. In the 1st and 2nd waves, 9-12th grade students took part in the study, however, in the 3rd and 4th waves, 7th and 8th grade students were also involved, in addition to the 9-12th grade students.
Results: In the first study 959 students (119 males and 840 females), in the second wave 1,885 (497 males and 1388 females), in the third wave 735 (310 males and 425 females), and in the fourth wave 540 students (241 males and 299 females) participated. In the males, the mean scores of the EAT-26 were 3.0 ± 3.2, 4.5 ± 3.9, 5.2 ± 4.9, and 6.7 ± 5.8 in the four waves of the study. The mean scores of the EAT-26 were 7.0 ± 6.5, 9.1 ± 8.1, 8.7 ± 8.2, and 12.4 ± 10.8 in the females, respectively. The percentage of clinical and subclinical eating disorders (according to DSM-IV) were also higher in the newer study waves, in both the male and the female subgroups. Female subjects were significantly more dissatisfied with their body parts (face, body in general, arms, hip, waist, legs, hair) and body characteristics (body weight) than the male subjects. It is remarkable that in the 4th wave, the symptoms of eating disorders and body dissatisfaction were present in a much younger age of females, in comparison with the 1st, 2nd and 3rd waves.
Conclusions: The results convincingly indicate that the prevalence of eating disorders has risen significantly among secondary school students during the past 25 years. The increasing prevalence rates are likely to be associated with the growing significance of physical appearance and the ideal of slenderness in this age group. These effects are mainly influenced by the media. Because of the limitations of the study (cross-sectional study, self-report questionnaire) the results must be evaluated with caution, further studies are necessary.

Keywords: eating disorders, epidemiology

EATING DISORDERS IN SOUTH AFRICA

Nkokone Tema[1,2], **Thebe Madigoe**[1,2]
[1]Department of Psychiatry, School of Clinical Medicine, University of the Witwatersrand, South Africa
[2]Adolescent and Eating Disorders Unit, Tara H. Moross Hospital, Johannesburg

Introduction: There are numerous influences on the epidemiology of psychiatric disorders that have been debated over and over. Eating disorders have not escaped this debate due to the longstanding popular notions related to its selective bias. Many authors have sought to disprove these notions. The significant historical socio-political changes, two-tiered health system and the wide gap between the affluent and a more prevalent poverty in South Africa provide an interesting platform to explore these biases.
Methods: A review of South African publications on the epidemiology of eating disorders for the last 30 years to date revealed a number of similar patterns.
Results: Selection bias based on study location, higher socio-economic representation and over-representation of Caucasians etc. made it challenging to facilitate a convincing argument to support or refute these notions. Conclusions: It does suffice to say the debate is still open. The available publications seem to point out that eating disorders in Blacks could possibly present in a different pattern. There is still a need for more epidemiological studies to provide clarity.

Keywords: eating disorders, Latino, evidence based interventions

EATING DISORDERS: AN INTERNATIONAL PERSPECTIVE

Eva Maria Trujillo
Comenzar de Nuevo AC, Mexico, Academy for Eating Disorders, Tec Salud School of Medicine

In the past decades, eating disorders have been known to occur among ethnic minority individuals and not only on the White Western individuals as thought for a long time. One group at a particular risk to develop eating disorders is the Latino women with a significant risk for body dissatisfaction, disordered eating and eating behaviors (Franko, Jenkins, Rodgers, 2012). Food is central in the Latino culture and community. Is a primary symbol to maintain group solidarity and cultural identity, especially in those individuals who have experienced immigration. The eating patterns are modified by these experiences and the cultural norms. Family units are large, with traditional gender roles and extensive family involvement. In most countries, government efforts are focused on weight control and weight loss due to the high prevalence of obesity and diabetes in latino countries, so ED patients have little or no attention. We will discuss a review of the literature on prevalence rates, clinical presentations and the clinical dilemma most clinicians faced at attempting to do evidence based interventions that historically have not been very culturally sensitive or adaptable in the Latino countries.

Keywords: adolescent girls, body size perception, body image, body mass index, mass media

BODY SIZE PERCEPTION AND DISSATISFACTION OF ADOLESCENT LITHUANIAN GIRLS IN RELATION TO THEIR REAL BODY SIZE AND SOCIAL FACTORS DURING THE YEAR 2000-2015

Janina Tutkuviene

Department of Anatomy, Histology and Anthropology, Faculty of Medicine, Vilnius University

Background: Body image is defined as an internal perception of person's external appearance: both representation of body size (height, weight, body shape, etc.) and perceptual and cognitive reflections are important. Body image issues may depend on many factors: biological, geographic, economic, cultural, social – (peer pressure and mass media). The aim of the present study was to reveal trends in body size perception and dissatisfaction of adolescent Lithuanian girls in relation to their real body size, mass media and other social factors during the last 15 years.
Material and methods: Actual body mass index (BMI) and body image issues of 16-19 yr. old girls were investigated in the year 2000 and 2015. Total sample size consisted of 1405 girls in the year 2000 and 308 girls in the year 2015. Standard anthropometric methods were used for body size measurements. Self-administered questionnaire was used to evaluate body size perception and dissatisfaction, and also, the influence of possible social factors.
Results and conclusions: The measured BMI of adolescent Lithuanian girls has increased during the last 15 years evidently. Despite that, less than 60% of overweight girls in the year 2015 and nearly all overweight girls in the year 2000 stated that they were fat ($p<0.001$). As for normal BMI girls, more than 30% of them in the year 2000 and less than 20% in the year 2015 rated their bodies as too fat. Additionally, more girls from this group estimated their body size as normal in the year 2015 than in the year 2000. Hence, self-esteem of body size in girls recently became more positive and more objective. This phenomenon was in parallel to changes in depiction of preferable body size in magazines aimed at adolescents: during the last 15 years, the attention given to healthy body image has increased and the promotion of very skinny female bodies has decreased almost twice. However, underweight girls remain very problematic with respect to their own body image, and the present study revealed them as having slightly more distorted perception of body size recently than in the year 2000. Lean girls very often have more vulnerable psychological status, but it remains unclear if dieting girls more often are prone to have body dissatisfaction and eating disorders, or they become severely underweight because of their lower self-esteem, higher body dissatisfaction and fatness phobia. The other social factors related to body image and dieting habits in adolescent Lithuanian girls will be discussed as well.

Keywords: Anorexia Nervosa, family treatment, child and adolescent, follow-up

LONG TERM FOLLOW UP OF FAMILY TREATMENT APARTMENTS COMPARED WITH CHILD PSYCHIATRIC INPATIENT TREATMENT

Ulf Goran Wallin, Riitta Holmer
Eating disorder Unit, Psychiatry Skane, Lund, Sweden

Introduction: There is growing evidence for family therapy in the out-patient treatment of the young patient with anorexia nervosa. The use of family therapy when the patient is severely ill and in need of in-patient care is not well studied. Family Treatment Apartments (FTA) is a treatment model developed at the Eating Disorders Unit in Lund. FTA was developed as an intensive family therapy as an alternative to psychiatric in-patient treatment for the young patient with severe anorexia nervosa. The whole family stays together in an apartment. The treatment program focuses on family meals, but also consists of regular family sessions. At the ward at the Child Psychiatric Clinic (CPC) parents are invited to stay, but are not involved in treatment. The aim of the study is to investigate if the long term prognosis differs between those who have been in FTA compared with those who have been in more traditional inpatient treatment.
Methods: All patients who had been in the FTA during the period 1990 to 2009 were asked to participate in the follow-up. We also invited all those who had been admitted to in-patient care at the CPC in Malmö during the same period, diagnosed with anorexia nervosa. The follow up interview consisted of a semi structured clinical interview, a SCID interview, 6 questionnaires and measurement of height and weight.
Results: 44 patients that had been in FTA, and 25 patients who had been in CPC were followed up after on average 14, 2 years after admission to treatment.
At follow-up, 32 % had still an eating disorder, without any difference between the groups. There was a greater proportion of those who have been in FTA that had no psychiatric diagnosis compared to those who have been in the CPC (51, 2% compared to 36, 0%). According to Morgan Russell Scale the FTA group had a better outcome on Average Outcome Score (9, 9 compared to 8, 6). The FTA group also had a better outcome on SCL-90 (0, 53 compared to 0, 89). There was also a higher proportion of those who had been in the FTA that had better quality of life, according to RAND 36.
Conclusions: We found a better result for those who had been in FTA. The treatment in FTA was more intensive, family-based and shorter compared with the CPC, which could make a difference in the outcome. Many patients had other in-patient treatments during the follow-up period, 50% of the FTA group and 40% in the CPC group, so it is hard to draw safe conclusions about the importance of an individual treatment.

WORKSHOPS

Keywords: eating disorders, males, clinical features, therapy

MALES AND EATING DISORDERS: CLINICAL FEATURES AND THERAPY

Fernando Fernandez-Aranda[1], **Michel Probst**[2,3], **Johan Vanderlinden**[3]

[1]Eating Disorders Unit, Psychiatry Department, University Hospital of Bellvitge-IDIBELL and CIBEROBN, Barcelona, Spain

[2]KU Leuven Department of Rehabilitation Sciences, Kortenberg-Leuven, Belgium

[3]Univ. Psychiatrisch Centrum KU Leuven, Kortenberg-Leuven, Belgium

Eating disorders (ED) are less frequent in males than in females, with the former representing just 5–9% of all ED cases. Epidemiology studies have been carried out in both clinical and community populations. The aim of this workshop is to provide an up-to-date overview of the clinical and personality traits that characterize males with ED. The issues considered include: a) characteristics of male ED patients (from risk factors, clinical, personality and psychopathological features, to neuropsychological vulnerabilities); (b) gender-specific treatment goals; (c) modalities and internal structure of individual and group outpatient therapy with ED males; (d) comparison of therapy response of ED males when compared to ED females. Most studies suggest, given their clinical resemblances, similar treatment strategies are appropriate for both male and female ED patients. However, due to some gender specific traits (e.g. differences in compensatory behaviours, body image concerns, specific personality traits and emotion-regulation strategies), targeted interventions in ED males need to be addressed. The main aim of this workshop is also to give basic therapy guidelines for the assessment and treatment of such patients and video-recorded cases will be presented. The issues considered include: a) state of the art on male ED; b) patient characteristics among different ED subtypes and evaluation (from eating patterns, to body image and activity); c) interventions (specific vs. non-specific); (d) future implications and research. Participants will be expected to relate what they learn to their own clinical experience and to take an active role. The workshop should be of interest to all those involved in assessing and treating eating disorder and obese patients, such as psychologists and psychiatrists, therapists, dieticians and nurses. Bibliography and relevant hand-outs including case studies will be given.

Keywords: attachment, self-image, emotion regulation

ATTACHMENT, EMOTION REGULATION AND THE SELF: AN INTEGRATIVE MODEL AND CLINICAL ILLUSTRATION

Rasmus Isomaa[1], Andreas Birgegård[2], Emma Forsén Mantilla[2], Elin Monell[2]
[1]Department of social services and health care, Jakobstad, Finland
[2]Department of Clinical Neuroscience, KarolinskaInstitutet, Stockholm, Sweden

Eating disorders (ED) have been the subject of significant theoretical work in recent years, and the workshop aims to synthesize such research into a clinically useful model. Centered on the SASB (Structural Analysis of Social Behaviour) model of self-image, we will show empirically that attachment processes and emotion regulation underlie how patients experience and relate to their EDs, how they relate to themselves, and ultimately concrete symptom expression. Finally, we will use patient examples to illustrate how self-image is related to interpersonal behaviour and psychopathology.
ED patients have limited awareness and understanding of their own emotions, and negative affect becomes a threat that they lack strategies for dealing with. This can be understood as poor access to attachment-based emotion regulation resources, such as an internalized safe haven to self-soothe when in distress. Patients then need alternative ways to regulate emotion, which has been proposed as the primary function of ED symptoms.
Relatedly, research shows that EDs have the particular quality that they are easily spontaneously externalized, i.e. seen as an “external other” (protector, demon, judge), a characteristic often utilized in treatment. The result is that the ED may function as a vicarious attachment-like figure that helps regulate emotion, although at a terrible price. How the ED treats patients in turn affects their self-image (or self-treatment), which is closely tied to concrete symptom expression. Therefore, SASB self-image can be an important mediator and treatment target to impact factors of attachment and emotion regulation that underlie and maintain disorder.
In conjunction, we will focus on how SASB self-image related to ED symptoms and general psychopathology in three female ED psychotherapy cases: a 29-year old (A) referred for continued treatment for bulimia nervosa, a 17-year old (B) in anorexia nervosa relapse, and an 18-year old (C) with anorexia treated in conjunction with day-hospital care. All were assessed with the SASB self-image questionnaire at beginning of treatment and follow-up assessments. The function of self-image was explained to patients using a Babushka doll, where the layers of the Babushka represent 1) our biological basis as innermost, 2) core assumptions of ourselves and other people formed by attachment, 3) self-image and interpersonal strategies, 4) thoughts/feelings, and 5) behaviour. Explaining the role of self-image and interpersonal strategies offers patients a rationale for understanding the processes underlying the ED.

Keywords: neurobiology, emotion, language, symbolisation, concretisation

INTERNAL LANGUAGE ENHANCEMENT THERAPY (ILET) – A CASE STUDY- FROM RED VEGETABLES TO SEXUALITY – LANGUAGE AND MEANING IN EATING DISORDERS

Barbara Pearlman
Exeter University, United Kingdom

This paper presents a case study of 'Bella', a patient treated with ILET, that demonstrates the ILET theory of how emotions are processed in the brain via the symbolic language functions or concrete body expression and the effect this has on internal language function.
It introduces the necessity of including our patients in the understanding of their disorder and the importance of an equal and enquiring stance alongside them. Our patients have lost the ability to understand the meaning hidden in their concrete thoughts and symptoms. The therapist gives them the tools to understand what has happened to the brain in order to develop an eating disorder, and what has to happen to bring it to an end.
This paper follows on from the previous theoretical paper presented at ECED 2015 in Heidelberg. With some necessary reference to ILET theory, this presentation will give professionals access to innovative ways of thinking about and treating eating disordered patients.

Keywords: body image, body perception, eating disorders, practical management

THE BODY AS FRIEND OR FOE: PRACTICAL MANAGEMENT OF BODY IMAGE ISSUES IN EATING DISORDERS

Gerard Butcher[2], Michel Probst[1]

[1]University of Leuven, Belgium

[2]Cognitive Solutions Clinic, Dublin, Ireland

Among the core features of eating disorders presentations, anxiety related to body image is central. This can present in many forms, including: a strong desire to be thin or extremely thin, a distorted body-image, unrealistic expectations regarding body shape and composition and an overall disparaging attitude toward one's body or body parts. Many patients/clients experience their body almost as a foe or enemy, rather than a friend to be nurtured and cared for. Among the challenges faced by therapists and their clients/patients is the reality that the world they inhabit is often dominated by attitudes within the general population toward shape and weight that mirror their own concerns. Creating realistic expectations in the therapy setting is thus part of the overall challenge. Thus, aiming for acceptance of body shape, and reduction in rumination and over-concern about body image in the context of an appropriate weight is a major aim of therapy. This workshop will explore the research background pertinent to body image disturbances found in eating disorders and aims to engage participants in effective and practical means by which body image problems can be managed in therapy. Participants will also be encouraged to take an active role during this workshop and share their clinical experiences.

Keywords: mentalization, theory of mind MBT-ED, therapy, randomised trial

MENTALIZATION-BASED THERAPY FOR EATING DISORDERS

Paul Robinson
Institute of Hepatology and Digestive Health, University College London

Mentalization-based treatment is evidence-based medicine for borderline personality disorder and self-harm. Today there is great interest in implementing such principles in other areas, e.g. addiction, PTSD, depression and as mentalization-based therapy for eating disorders (MBT-ED) (Skårderud & Fonagy, 2012).
Mentalizing is defined as the ability to understand feelings, cognitions, intentions and meaning in oneself and in others. The capacity to understand oneself and others is a key determinant of self-organisation and affect regulation. Eating disorders will be described as examples of different forms of impaired mentalizing, and such impairments are stated to be central psychopathological features in eating disorders. Psychotherapeutic enterprise with individuals with compromised mentalizing capacity should be an activity that is specifically focused on the rehabilitation of this function. Mentalization-based psychotherapy for eating disorders should also have a special emphasis on how the body is involved in representing mental states. The presentation will describe and demonstrate structures, clinical stances and techniques in MBT-ED.
Skårderud, F. & Fonagy, P. (2012). Eating disorders. In A. Bateman & P. Fonagy (Eds.), Handbook of mentalizing in mental health practice, s. 347-383. Washington DC: American Psychiatric Publishers.

POSTER PRESENTATIONS

Keywords: eating disorders, physical exercise, dietary theraphy, therapist`s perspective

CAN NON- HEALTH PROFESSIONALS CONTRIBUTE IN TREATING PATIENTS WITH EATING DISORDERS?

Maria Bakland[1], Rolf Wynn[2], Jan H. Rosenvinge[3], Annett V. Stornæs[4], Gunn Pettersen[1], Jorunn Sundgot-Borgen4[4]

[1]Department of Health and Caring Sciences, Faculty of Health Sciences,Uit, Artic University of Tromsø, Norway
[2]Department of Clinical Medicine, Faculty of Health Sciences, UiT –The Arctic University of Norway
[3]Department of Psychology, Faculty of Health Sciences, UiT –The Arctic University of Norway
[4]Department of Sports Medicine, Norwegian School of Sport Sciences, Oslo, Norway

Introduction: Patients with eating disorders (ED) often deny or conceal their illness and delay seeking treatment. Moreover, there is a shortage of evidence-based treatments, the access to such treatments is poor, and every other ED-sufferers who seek treatment fail to respond to them. Hence, there is a need of evidence supporting new treatments that address the nature of the ED-heterogeneity in different manners than the existing evidence-based treatments, notably basic maintaining of affective-regulatory mechanisms. A previous randomized controlled trial (RCT) has shown that guided physical activity is as effective as cognitive-behavioral therapy (CBT) in alleviating bulimic symptoms. An ongoing RCT expands on these findings, examining the benefits of CBT versus a novel treatment program combining physical exercise- and dietary therapy (PED-t). This program is provided by therapists holding a master's degree in exercise science or medicine, or nutrition. To our knowledge, no previous studies have explored to what extent those who provide a particular kind of ED-treatment experience how they can contribute, and such an exploration is the purpose of the current study. Methods: Semi-structured interviews were conducted with all the 10 therapists running the PED-t. The transcribed interviews were analyzed by systematic text condensation approach. Results: The text analysis provided two main categories. The first category showed that the therapists experienced their knowledge about physical exercise and nutrition as important and useful, and that they could share their knowledge with the women with ED in different ways and with confidence in their own role. The therapist experienced that for the women with ED, the knowledge might have the function as tools in the future, helping them to manage daily life after the treatment program. Because of individual differences among the group participants, the therapists put much effort in in adjusting their teaching to fit each individual. In general that meant adjusting exercises, knowledge level and how much to “push” and to “hold back”. The second category showed that the therapists experienced their personal qualities to be important. They reported a feeling of needing to be a fellow human being and experienced a mutual trust-building between themselves and the women with ED. In addition, they reported working towards creating a good group dynamic and a positive atmosphere.
Conclusions: The findings showed that the therapists experienced that they had much to contribute with during the PED-t treatment. Thus, the therapists experienced the value of sharing their knowledge and drawing on their personal qualities, and thereby, showing that also non-health professionals may have an important role in the treatment of ED. The term ‘clinical confidence’ may stand out as an overarching “meta-category” covering the experiences revealed in this study. Such confidence is detrimental to install patients’ positive expectance of treatment success. In a study underway we will explore the experiences of the participating patients. Along with ED-relevant outcome measures, the experiential data contribute in an evidence base for how the PED-t might be disseminated to ED-sufferers in new contexts.

Keywords: manual, systemic, family, therapy

DEVELOPMENT OF A FAMILY THERAPY MANUAL

Benjamin Carrot[1], Nathalie Godart[1], Irène Kaganski[1], Zorica Jeremic[1], Jeanne Duclos[1], Eva Carletti[1], Leslie Radon[1], Aude Van Effenterre[2], Juliette Gueguen[3], Helen Pote[4]
[1]Institut Mutualiste Montsouris, CESP, Paris, France
[2]MDA-Cochin-CESP, Paris, France
[3]INSERM CESP- Paris, France
[4]Royal Holloway University of London, UK

Introduction: The gold standard of adolescent Anorexia Nervosa (AN) treatment is family therapy (FT). IMM team is currently developing a research program (THERAFAMBEST) with MDA-Cochin team comparing systemic FT (SFT) for one family and multiple FT (MFT) and evaluating their relative efficacy and differential indications.
We first write a manual describing the SFT for AN with a validated protocol developed by Helen Pote (2001, 2003)
Methods and sample. Subjects: 13-18 year old female suffering from either AN or EDNOS (DSM-5), and their family involved in FT at IMM and living in Paris/suburb.
Previous work done by Helen Pote in the UK to write a systemic FT manual started with semi-structured interviews with expert family therapists, with qualitative and quantitative analysis. The Brief Structured Recall (BSR) method was used to structure the interviews (Elliott and Shapiro, 1988), inviting therapists to review and comment their own recorded FT sessions. Emerging themes from these interviews were (1) therapist intentions; (2) systemic guiding principles; (3) systemic methods and techniques; (4) indirect work; (5) proscribed practice
We conducted new series of semi-structured interviews on those topics with two expert family therapists at IMM, with qualitative and quantitative analysis.
Then we did an observational rating of 15 video-recorded IMM expert FT sessions at the beginning, middle and end of FT, using Helen Pote's previously developed observational rating schedule and quantitative analysis of (1) therapists' intentions, (2) techniques, (3) content of family discussion in FT and (4) family event leading to therapist intervention.
We present here the first version of this systemic FT manual describing the SFT work at IMM.
Perspectives: We still need to define precisely the process of the family therapy, the techniques and models of therapeutic change, the goals of families and therapists. This allows us to develop research on various types of FT (for one family and multiple FT) and evaluate their relative efficacy and differential indications so that each patient would benefit from an individualised treatment pathway in its family therapy, whereas nowadays our decisions rely more on our clinical impressions, depending on each clinician, leading to a great heterogeneity of therapeutic approaches.

Keywords: prevention, body-image, compulsive exercise, training, users

"I CARE" AND "WE CARE": USER-BASED PSYCHO-EDUCATIONAL PROGRAMMES OF EATING DISORDER PREVENTION THROUGH PROMOTION OF HEALTHY EXERCISE AND BODY IDEALS

David Clinton[1,2,3], Andreas Birgegård[1], Emma Forsén[1], Elina Johansson[3], Thor Rutgersson[3], Johanna Krook[3], Stefanie Nold[3]

[1]Karolinska Institutet, Sweden

[2]Institute for Eating Disorders, Oslo, Norway

[3]Frisk & Fri, Sweden

Introduction: Contemporary society attaches significant importance to body shape and physical appearance. Many young people experience considerable pressure to eat and exercise in unhealthy ways that increase the risk of developing eating disorders. Combating unhealthy ideals about eating, exercise and body ideals can be an important component in the primary prevention of eating disorders. The present project details the development, implementation and evaluation of two user-based programmes of psycho-education designed to promote healthy exercise and body ideals among exercise trainers and sports coaches, and within their organisations.
Methods: The programmes have been developed by the Swedish patient advocacy group Healthy and Free (The Swedish Eating Disorders Association), and are delivered by members of the group. "I Care" is web-based and more general in nature, comprising lectures and podcasts that discuss exercise and body ideals in relation to eating disorders and stimulate reflective thinking about healthy exercise and body shape. "We Care" is more focused and involves additional components to the web-based programme, such as workshops on eating disorders and self-image, dissemination of healthy training ideals, and the development and implementation of an organisational policy on how to deal with problems associated with exercise and body image. The development of "We Care" is on-going. It is delivered by volunteers trained in the programme with a background in sports who have themselves been affected by eating disorders earlier in life. Completion of "We Care" leads to certification that participating organisations have met specified criteria for creating and maintaining high standards pertaining to healthy exercise and sound body ideals.
Results: The development and implementation of "I Care" and "We Care" is taking place in collaboration with the Resource Centre for Eating Disorders at Karolinska Institutet. This work is focusing on systematically evaluating the programme, and using the results to improve the programmes further. Initial indications are positive, and suggest that the programmes can help to change attitudes within participating organisations. Plans for a randomised controlled trial of key features of the programmes are currently being formulated.
Conclusions: "I Care" and "We Care" may prove to be important psycho-educational programmes for fostering healthy exercise and body ideals among sports coaches, exercise trainers and their organisations, thereby aiding in the prevention of eating disorders. The project also further illustrates the importance of collaboration between eating disorder researchers and user organisations, and how such work may be mutually beneficial and help to prevent eating disorders.

Keywords: Anorexia Nervosa, ghrelin, animal model, refeeding, biomarker

ALTERATIONS IN THE GHRELINERGIC SYSTEM IN ANOREXIA NERVOSA PATIENTS: INPUTS FROM ANIMAL MODELS

Philibert Duriez[1,4], Else-Yona Berreby[1], Mathieu Mequinion[2], Dominique Grouselle[1], David Alexandre[3], Nicolas Chartrel[3], Roland Dardennes[4], Philip Gorwood[1,4], Virginie Tolle[1], Odile Viltart[1,5]

[1]INSERM U894, Centre de Psychiatrie et Neurosciences, France
[2]Dept Physiology, Monash 34 University, Clayton, VIC, Australia
[3]UMR 982 INSERM, IRIB, Mont-Saint-Aignan, France
[4]CMME, Hopital Sainte Anne, Paris, France
[5]Université Lille Nord de France

Introduction: The physiological mechanisms involved in the adaptation to chronic food restriction are largely unknown. Those mechanisms could constitute an important perpetuation factor in anorexia nervosa (AN), limiting weight restoration and favoring relapse, one of the most important clinical challenge. Interestingly, plasma levels of ghrelin, a gut orexigenic hormone, remain elevated throughout the undernutrition condition. Despite this adaptive hyperghrelinemia, AN patients maintain their food restriction behaviour. We aim to decipher whether ghrelin is a valuable biomarker responsible for the deleterious consequences of chronic undernutrition and relapse after nutritional recovery. In a translational perspective, we have developed a preclinical mouse model which combined chronic food restriction and voluntary activity, that mimics most of the alterations observed in AN.
Methods: 8-week old female mice (n=6/group) were placed in a cage containing a wheel (FRA) or not and were fed ad libitum (AL) or subjected to a progressive food restriction from 30 to 50 % (FR) for a 2-weeks or 10-weeks protocol. Food restriction was followed or not by 20 days of refeeding consisting of ad libitum access to food. Body weight, food intake and physical activity were measured daily. Blood samples were performed during the restriction and refeeding periods. Hypothalamus were collected at the sacrifice to measure mRNA levels (qPCR) of ghrelin receptors and its main targets within the hypothalamus amongst orexigenic (AgRP, NPY, orexin and 26RFa) and anorexigenic (POMC) peptides. Clinical data were obtained during inpatient weight restoration and at post discharge period. Blood collection for ghrelin assays were performed at admission, after weight restoration and one month post discharge. In addition, repeated blood assessment around a meal were carried out for all animal groups and one patient. Ghrelin assays were performed with commercial kits. Results were considered significant for $p<0.05$.
Results: As in AN patient, this mouse model displayed similar weight loss trajectory and inappropriate physical activity. Acylated ghrelin (AG) plasma concentrations increased throughout the undernutrition both in mouse model and AN patient. In mice, AG and DAG were differentially impacted by physical activity in the early stage of caloric restriction. The refeeding period did not permit to properly restore the plasma AG and DAG levels. At the hypothalamic level, FR and FRA mice showed a drastic increase in expression of AgRP and NPY mRNA while POMC mRNA was down-regulated only in FRA mice. After 10 weeks of undernutrition, FRA mice displayed similar NPY and AgRP mRNA levels than AL mice whereas POMC mRNA expression was down-regulated in both FR and FRA mice. Expression of hypothalamic ghrelin receptor was down-regulated only in FRA mice whatever the duration of caloric restriction. Preliminary clinical data in AN showed that AG and DAG concentrations did not present similar periprandial kinetics.
Conclusion: The FRA model appears to be a preclinical model useful to decipher the role of biomarkers like ghrelin in adaptations to undernutrition and throughout refeeding processes. A critical clinical challenge will be to clarify how the ghrelinergic system can influence or reflect the duration of recovery and predict relapse.

Keywords: Anorexia Nervosa, binge eating disorder, Bulimia Nervosa, co-morbidities, male

EATING DISORDERS IN YOUNG MALES ADMITTED TO A SPECIALIST EATING DISORDER CENTRE IN DUBLIN: CASE STUDIES

Madeeha Iqtidar[1], Natasya Nor[2], Lilly Molloy[2]

[1]Health Service Executive, Ireland, Ireland

[2]Lois Bridges Eating Disorders treatment centre

Introduction: Lifetime prevalence for anorexia nervosa (AN) in males is 0.3%, 0.5% for bulimia nervosa (BN) and 2% for binge eating disorder (BED) according to National Co morbidity Survey Replication. The same survey suggested that these 3 disorders are significantly co- morbid with other Psychiatric Diagnoses.
Aim: We reviewed 3 male residents to observe different presentations of eating disorders. We also aimed to note any identified co-morbidities. Progress through the inpatient admission was also studied and reported.
Methods: Written consent was obtained by these patients.
Case Studies: Case 1 was a 24 year old married man referred by the community mental health team with 12 year history of bingeing and high Body Mass Index (BMI) associated with poor body image and low self esteem. There was a background history of poly-substance misuse and depressive disorder with past suicidal attempts and self harm. In secondary school patient disclosed to a close friend that he was gay. He started using food as a way to cope with shame, guilt and fear. He was diagnosed with BED with co-morbid Emotionally Unstable Personality Disorder- Borderline Type. He progressed well but relapsed after discharge secondary to stress of college.
Case 2 was a 30 year old, single man referred by his General Practitioner with 14 year history of both anorexic and bulimic patterns and normal BMI. Patient gave history of recent relationship breakdown. He also gave history of Alcohol misuse to suppress binges, Pseudo ephedrine abuse to suppress appetite and 1 gram Cocaine use per month. He was diagnosed with Atypical BN and Mental and Behavioral Disorder due to Alcohol Dependency. Although patient was following the program but continued to drink and discharged self against medical advice.
Case 3 was a 22 year old, single, unemployed student with Type 1 Diabetes Mellitus referred by his Consultant psychiatrist with 11 years history of active eating disorder behaviour and low BMI. He had extreme fear of weight gain, body dysmorphophobia, food restriction and insulin manipulation in the background of negative self perception, poor self confidence, bullying and family history of alcoholism. Eating disorder was perpetuated by stress at college, anxious/dependant personality traits, high expressed emotions at home and high expectations in self performance with fear of failure. He was diagnosed with Anorexia Nervosa and emotionally unstable personality disorder. He discharged self twice, impulsively, against medical advice.
Conclusion: All 3 men studied had Co-morbidity along with the diagnosis of an Eating Disorder. Personality disorder and Substance misuse also affect the concordance with the treatment and subsequent prognosis. There is increase in presentation of males seeking treatment of Eating Disorders; more structured research is required to identify any broader needs of this specific patient population.

Keywords: hypercholesterolemia, Anorexia Nervosa, cardiovascular, lipoproteins

HYPERCHOLESTROLEMIA IN ANOREXIA NERVOSA: A REVIEW

Madeeha Iqtidar[1], **Natasya Nor**[2]
[1]Health Service Executive, Ireland, Ireland
[2]Lois Bridges Eating Disorders treatment centre

Introduction: Anorexia Nervosa (AN) is an eating disorder manifested by restriction of calories and excessive exercise along with other psycho pathological behaviors and cognition. It would be expected that patients with AN would have low cholesterol. However, our clinical observation differs. We reviewed the Literature to learn how prevalent Hypercholesterolemia is, in Anorexia Nervosa? What is the etiology of hypercholesterolemia in AN? Whether there is any improvement after treatment of AN?
Method: We reviewed articles from PUB MED and Google Scholar.
Results: The general consensus is that hypercholesterolemia is very common. There are few speculations on the etiology of Hypercholesterolemia. Some studies suggest that lipoprotein synthesis is increased as a result of starvation. As the body is in starvation mode, it relies on fat metabolism to derive energy. The lipoproteins mobilize fat molecules to be metabolized. This, probably is the reason for high cholesterol levels in people with AN. Another study stated that apart from high cholesterol levels, patients have high level of an enzyme, Cholesterylester transfer protein (CETP). It transfers cholesterol and fats between lipoproteins. It is postulated that CETP action increases cholesterol yield to compensate for its low intake. Also low levels of thyroid hormones and decreased breakdown of existing cholesterol adds to high levels. Most reports mention that the cholesterol and CETP levels reduce and normalize after weight restoration.
Conclusion: Considering hypercholesterolemia is a risk factor for cardiovascular diseases, it is important to discuss this with our patients so they can comprehend one of the manifold complexities and risks of this illness.

Keywords: food addiction; Bulimia Nervosa; therapy

FOOD ADDICTION IN BULIMIA NERVOSA: CLINICAL CORRELATES AND ASSOCIATION WITH RESPONSE TO A BRIEF PSYCHOEDUCATIONAL INTERVENTION

Susana Jimenez-Murcia[1,2], Ines Hilker[1], Isabel Sanchez[1], Roser Granero[2], Ashley N Gearhardt[3], Fernando Fernandez-Aranda[1,2]

[1]University Hospital of Bellvitge-IDIBELL, Barcelona, Spain

[2]CIBEROBN, Spain

[3]Michigan University, USA

Food addiction (FA) has been examined in different populations. Although high FA levels are associated with greater eating disorder severity, few studies have addressed how FA relates to treatment outcome.

Goals: The study aims (1) to determine whether a brief intervention for bulimia nervosa (BN) reduces FA diagnosis or severity compared with baseline and (2) to determine if FA is predictive of treatment outcome.

Method: Sixty-six female BN patients participated in the study. The Yale Food Addiction Scale was administered at two time points: prior to and following a 6-week intervention. The number of weekly binging/purging episodes, dropout and abstinence from bulimic behav- iour were used as primary outcome measures.

Results: This brief intervention reduced FA severity and FA diagnosis in the 55 patients who completed treatment. FA severity was a short-term predictor of abstinence from binging/purging episodes after treatment ($p = .018$).

Conclusions: Food addiction appears to be prevalent in BN although FA severity can improve following a short-term intervention.

Keywords: eating disorder, inventory of interpersonal problems, IIP, psychometrics, circumplex model

VALIDATION OF THE LONG AND SHORT VERSION OF THE INVENTORY OF INTERPERSONAL PROBLEMS (IIP64/IIP32): A COMPARISON OF SWEDISH FEMALE PATIENTS WITH EATING DISORDER AND CONTROLS

Karolin Lindberg[1], Lauri Nevonen[2], Sanna Aila Gustafsson[2], Erika Nyman-Carlsson[2], Claes Norring[1]

[1]Centre for psychiatry research, Department of clinical neuroscience, Karolinska Institutet

[2]School of Medical Sciences, Örebro University

Introduction: Interpersonal problems may contribute to and be part of the maintenance of eating disorders (ED). For some patients, interpersonal problems are the core problem that has to be addressed in order to recover. The Inventory of Interpersonal problems (IIP) measures interpersonal distress in two dimensions; affiliation (ranging from having an indifferent and distant stance to others to displaying an overly nurturant and close relational style) and dominance (ranging from being dominant in relation to others to being submissive in relations). The instrument is widely used in treatment planning and evaluation. The aim of the study was to explore and compare the psychometric properties of the 64-item and the 32-item version of IIP in Swedish young adult female patients with eating disorder (ED) compared to age- and gender matched controls.

Methods: Totally 438 participants between 17-24 years of age were included, ED patients (n=196) and controls (n=242). Patients with ED completed the IIP and Eating Disorder Inventory (EDI). Normal controls completed the IIP.

Results: Internal consistency of both versions of IIP was acceptable to good, ED patients reported generally higher levels of interpersonal distress than controls. There were no significant differences in interpersonal problems between patients with different EDs. The structural validity of the two dimensions in IIP was confirmed. Significant correlations between EDI-3 composites Ineffectiveness and Interpersonal Problems and IIP were found.

Conclusions: This is the first study to compare two versions of the IIP in an ED sample. Both versions of instrument can be considered to have acceptable to good reliability and validity in a Swedish ED sample. The short version is almost equivalent to the long version. IIP can be a useful complement in assessment of interpersonal problems in ED.

Keywords: ADHD, adult women, comorbidity, eating disorders, epidemiology

ADHD AND EATING DISORDERS, EPIDEMIOLOGY AND THERAPY

Hana Papezova, Tereza Štěpánková
Eating Disorders Centre Psychiatric Department 1st Medical Faculty Charles University, Czech Republic

Introduction: Recently published meta-analytic studies showed increased interest in studies of the ADHD and ED comorbidity but only a few were based on empirical data. The association between these two diagnoses remains unclear and the prevailing multifactorial interpretation model contains various heterogeneous issues. We are presenting data from our epidemiology case-control study (N=226; 133 ED female patients/93 control) conducted at Centre for Eating Disorders.
Methods: In a consequential study, ADHD current and childhood symptoms were assessed by self-report and other-report versions of a BAARS-IV questionnaire and eating pathology with EDE-Q. ED patients were diagnosed using the ICD-10 criteria at admission. Patients with ED and ADHD comorbidity underwent a structured interview (DIVA 2) and Integrated Visual and Auditory Performance Test (IVA Plus) to confirm the ADHD diagnosis.
Results: 37 % (49) of ED patients were detected as likely having ADHD compared to 16% (15) from a healthy control group (using self-report questionnaire of current and childhood symptoms, scores placing above the 84th percentile). This shows a significant difference (chi-squared test, p = 0.0007). Further we compared results placed above the 93rd percentile. These differences were significant (chi-squared test, p = 0,008) only when self-report questionnaire of current symptoms was used.
Our findings were implemented gradually into prevention and treatment programs. First as part of the research project of ADHD and ED at a time when there were neither verified diagnostic methods nor specialized therapeutic programs for adults with ADHD in the Czech Republic. We tested the diagnostic battery (DIVA 2 and IVA plus, and other standardized psychodiagnostic methods).We examined the feasibility and acceptance of the supportive program for adults with ADHD. Besides psychoeducation and CBT techniques, relaxation and meditation exercises inspired by the mindfulness approach specifically designed for adult ADHD patients were used. The positive results of the pilot program (6 group meetings in 3 months) will be demonstrated.
Supported by PROGRES Q27, AZV 17-28905A
Literature
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Keywords: obesity, emotion regulation, Alexithymia

EMOTION REGULATION AND ALEXITHYMIA IN OBESITY

Conxa Perpina[1], Maria Roncero[1], Mara Segura[1], Lorena Blasco[2], Sonia Ciscar[2]
[1]University of Valencia, Spain
[2]Hospital de la Ribera, Spain

Introduction: Obesity is defined as a medical condition not included with the eating disorders in the mental disorders classification manuals. However, obesity and ED share a continuum of problems related to food intake and weight. It has been widely demonstrated that ED present a deficit in emotion regulation and emotion recognition - or alexithymia-, constructs that have been found to be related. These deficits are especially marked in anorexia nervosa, but are also present in bulimia nervosa and binge eating disorder. However, in obesity they have been studied less.
Objective: The aim of the present study was two-fold: (1) to analyse differences between obese patients and a non-clinical population in emotion regulation and alexithymia; and (2) to analyse the association between emotion regulation and alexithymia in obese patients.
Method: The sample was composed of a group of 40 women with obesity (BMI>30) without binge eating disorder (OB-G), and 50 women in the healthy group (HG) without a diagnosis of ED and with normal weight. All participants completed the Difficulties in Emotion Regulation Scale (DERS, Gratz & Roemer, 2004; Hervás & Jódar, 2008) and the Toronto Alexithymia Scale 20 (TAS-20, Bagby, Parker, & Taylor, 1994).
Results: Differences were found between groups in emotion dysregulation on 4 out of the 5 DERS subscales: Inattention, $t(88)=2.80$; $p=0.007$, Confusion, $t(88)=3.82$; $p<0.001$, Rejection, $t(88)=3.04$; $p=0.003$, and Out of control, $t(88)=2.70$; $p=0.008$. Regarding the alexithymia, differences were found on 2 out of the 3 TAS-20 subscales: Difficulty in identifying feelings, $t(88)=3.82$; $p<0.001$, and Describing and communicating feelings, $t(88)=3.35$; $p=0.001$. For every subscale, the OB-G showed higher scores than the HG. However, the two groups scored similarly on Externally oriented thinking (TAS-20) and Interference (DERS). Regarding the association between emotion regulation and alexithymia in obese patients, results showed significant associations (r range from .35 to .76) between DERS and TAS factors, except for Externally oriented thinking (TAS-20) with Rejection (DERS), Interference (DERS), and Out of control (DERS).
Discussion: Results showed that obese patients presented an impairment in emotion regulation and emotion recognition compared to non-clinical people. Moreover, as previously observed in ED, emotion regulation and alexithymia are related. Our results represent further support for the similarity between obesity and ED. The role of this emotion regulation and recognition impairment in the eating pattern of obese patients should be analysed in future studies.

Keywords: eating disorders, obesity, IAPS, emotional processing

TO BE OR NOT BE… SAD. A COMPARISON OF EATING DISORDERS, OBESITY PATIENTS, AND HEALTHY CONTROLS IN THEIR REACTION TIME TO EMOTIONAL RESPONSES. ITS RELATIONSHIPS WITH INHIBITORY/APPROACH SYSTEMS

Conxa Perpina[1], Mara Segura[1], Maria Roncero[1], Lorena Blasco[2], Sonia Ciscar[2]
[1]University of Valencia, Spain
[2]Hospital de la Ribera, Spain

Introduction: Emotion regulation forms a key part of conceptual models of eating disorders (ED). More recently, the study of emotion regulation difficulties have become a focus of interest in patients with obesity. The objective was to compare the reaction times (RT) of emotional responses to a set of IAPS pictures with different valences in ED patients (divided according to their symptomatology), patients with obesity, and analyze the relationship between these RTs and inhibition/approach systems.
Method: The total sample was composed of 162 female participants. Sixty-six fulfilled diagnostic criteria for an ED, according to the DSM-IV-TR (APA, 2002); specifically, 22 patients had AN restricting-type, 4 AN purgative-type, 11 BN purgative-type, 16 EDNOS-AN type, and 13 EDNOS-BN type. ED patients were classified in two groups according to their symptomatology; the “Restrictive group” (RG) included 38 patients (with AN-R and EDNOS.AN), whereas the “Bingeing/purging group” (BPG) included 28 patients (with AN-P, BN and EDNOS.BN). Fifty-two patients were suffering from obesity (BMI>30) (OB-G) without binge-eating disorder comorbidity; and 44 women (HG, healthy group) from the general population were not overweight and had no ED diagnosis.
Stimuli consisted of 3 pictures (negative, neutral, and positive) selected from the standardized International Affective Picture System (IAPS; CSEA, 1995), with three different value valences (#9001=Mean:3.14; #7150=Mean:4.85; #5830=8.11). The images were shown on a computer using E-prime software, and participants were instructed to rate each picture on the affective dimension of valence, using a computerized version of the Self-Assessment Manikin (SAM; Hodes et al., 1985). Additionally, participants filled out the BIS-BAS scale (Carver & White, 1994).
Results: There were differences in the RT in determining the emotional valence of the pictures. There was a significant type of image effect (Pillai:0.52; F(2,157): 4.26; p=0.01), (neutral faster than sad images, p<.01), and a significant group effect (F(3,158): 4.41; p=0.005), with OB-G being slower than HG (p<.004), with the remaining ED groups in intermediate positions. OB-G were the slowest in sad picture. There were differences among groups in BIS (F(3,132)=10.341; p<.001), with HG showing a significantly lower score. Regarding the analysis of correlations, there were negative and significant associations between RT in the rating of the negative image and BIS (r:-.261, p<.002), BAS-Drive (r:-.215, p<.01), and BAS-Reward responsiveness (r:-.289, p<.001).
Discussion: Results showed that obese patients were the slowest group in deciding which emotion was produced by each picture, especially the sad one. All the clinical groups were characterized by an inhibitory tendency. The delay in deciding which emotion the person was feeling when viewing a sad picture was associated with low sensitivity to punishment, low motivation, and low reward responsiveness. There were no associations between the avoidance/approach systems and neutral or positive stimuli. The relationship between emotional regulation and inhibition/approach behaviour in eating and weight-related problems requires further research (Turton, Chami, & Treasure, 2017).

Keywords: Anorexia Nervosa, malnutrition, nutrition therapy, food related anxiety, body composition

THREE YEARS AFTER INTENSIVE NUTRITION THERAPY TREATMENT IN HOSPITAL; A FOLLOW-UP OF YOUNG WOMEN WITH ANOREXIA NERVOSA

Cecilia Pettersson[1], Ola Wallengren[2], Gunilla Paulson Karlsson[1], Lars Ellegård[2]

[1]Queen Silvia Childrens Hospital, Sahlgrenska University Hospital, Gothenburg, Sweden

[2]Sahlgrenska Academy at University of Gothenburg, Department of Internal Medicine and Clinical Nutrition

Introduction: Anorexia nervosa (AN) is a psychiatric disorder with many physical symptoms. Most individuals suffering from AN will be helped by outpatient care treatment including nutrition therapy, psychotherapy and medication. Some individuals need inpatient care for a period to achieve help to recover from starvation and start eating. The specialized eating disorder unit at Sahlgrenska University Hospital, Gothenburg, Sweden consists of outpatient care, day care and inpatient care. During 2012-2015 we asked inpatients with AN to participate in a study and 22 young women 16-24 years were included. The aim of the study was to measure changes in energy and nutrient intake, energy expenditure, body weight and BMI, body composition by DXA and biochemistry. Patients also completed a Food Attitude Questionnaire to capture the change in food related anxiety during the intensive nutrition therapy for three months.
Methods: Current study is a three year follow-up after an intensive three months inpatient treatment. Twenty out of twenty-two accepted (90%) participation and attended our unit for half a day including:

- Dietary record for 4 days
- Food Attitude Questionnaire, same as in the first study
- Questionnaire regarding health, medications and life situation, quality of life
- Questionnaire regarding physical activity
- CIA version 3.0 (Fairburn 2008)
- EDE-Q
- Blood and serum analyses: Vitamin A, D, E, folic acid. Hb, ferritin.
- Anthropometry Body composition by DXA

Results: Current study was recently closed. Preliminary results show that Body Mass Index was at pre-treatment 15,5 kg/m^2 and post-treatment 19,0 kg/m^2. Three years after the intensive treatment Body Mass Index was 19,6 kg/m^2. More results will be presented in September 2017.
Conclusions/Discussion: Intensive nutrition therapy in a specialized eating disorder hospital care has shown positive results in young individuals with anorexia nervosa. It is crucial to evaluate the results in a longer perspective.
Reference: Pettersson C, Tubic B, Svedlund A, Magnusson P, Ellegård L, Swolin-Eide D, Forslund HB.
Description of an intensive nutrition therapy in hospitalized adolescents with anorexia nervosa. Eat Behav. 2016 Apr;21:172-8. doi: 10.1016/j.eatbeh.2016.03.014. Epub 2016 Mar 4.

Keywords: Anorexia Nervosa, adolescents, partial hospitalization, effectiveness, inpatient treatment

EFFECTIVENESS AND CHARACTERISTICS OF A NEW PARTIAL HOSPITALIZATION MODEL TO TREAT ADOLESCENTS WITH ANOREXIA NERVOSA AS AN ALTERNATIVE TO INPATIENT TREATMENT

Eduardo Serrano, Marta Carulla, Mónica Godrid, Marta Casanovas, Marta Curet, Raquel Cecilia, Bernardo Sánchez, Laura Cañas, Montse Dolz
Hospital Sant Joan de Déu, Spain

Introduction: Inpatient Treatment (IT) is the treatment of choice for moderate or severely ill adolescents with Anorexia Nervosa (AN) or for those who have not improved with outpatient treatment. Nevertheless, it is expensive, and the risk for relapse or readmissions is high. A less costly alternative to IT is Partial Hospitalization (PH), which may also help to avoid relapses and readmissions as this resource would greatly aid the hospital to home transition.
Aim: To assess the effectiveness for adolescent with AN of a new intensive out-patient treatment, the Partial Hospitalization Day Program for Eating Disorders of 11 hours (DP-ED-11h), as an alternative to IT (avoiding admissions) and as a resource to continue the treatment after IT discharge (to reduce length of stay).
Method: DP-ED-11h discharges during 2 years (2015 and 2016) were analyzed regarding variables of age, sex, type of AN, length of stay, BMI progression and percentage of readmissions. The average length of stay of AN patients in IT was compared before and after starting the new program, with the objective of measuring the impact in the decrease of IT length of stay. DP-ED-11h is an intensive outpatient treatment program for adolescents with AN (from 8:45am to 7:45pm from Monday to Friday). The multidisciplinary treatment includes individual and group therapy, parents group (multifamily and psychoeducation group) and nutritional advice, among other therapeutic activities. The program ensures all the main meals and controls binge eating as well as compensatory behaviours. It also provides the possibility of programming weekend meals in case it was not possible at the patient´s home.
Results: During these 2 years period there were 77 discharges from DP-ED-11h. Seventy-two (93.5%) of the sample were females. The average age was 14.4 years old (SD: 1.62). With regard to the type of AN, 72 (93.5%) were restrictive AN and 5 (6.5%) purgative AN. The length of stay at DP-ED-11h was 28.9 days (SD: 18.5). The Body Mass Index increased significantly at discharge (17.2 vs. 17.9, $p<0.001$) and at follow up 6-12 months later (17.9 vs. 19.3, $p<0.001$). Fifty-four (70%) of patients who received treatment at DP-ED-11h avoided an IT admission and achieved the therapeutic objectives. Fourteen (18.2%) required readmission at DP-ED-11h in those two years. The average length of stay at IT reduced from 33 to 24 days (27.3%) since the implantation of the new resource.
Conclusion: DP-ED-11h has shown to be an effective resource as an alternative to IT for adolescents with moderate to severe AN. Through this program, 7 out of 10 patients have avoided IT; and from those already hospitalized, the program has provided a 9 days reduction in average length of stay. This new resource promotes the autonomy and self-confidence of the patients, enhances social skills and empowers the family in the management of disrupted eating behaviours at home. Patients discharged from DP-ED-11h maintain a healthy weight at 6-12 months follow-up. This new model has cost effectiveness implications as it is a secure resource and is less costly than IT.

Keywords: multifamily therapy, severe eating disorders, young adults, innovation

A MULTIFAMILY THERAPY PROGRAM DEVELOPED FOR YOUNG ADULTS WITH SEVERE EATING DISORDERS IN NORTH NORWAY

Tove Skarboe, Steven M. Balmbra, Berit S. Brinchmann
Nordland Hospital Trust, Norway

Introduction: Our clinical experiences at the Regional Centre for Eating Disorders (RESSP) in north Norway did show that proportionally many young adult patients with a severe eating disorder, to a relatively high degree still was actively involved in their family of origin on a daily basis. Aspects related to the eating disorder could often make the social interaction in the family difficult, and could represent an obstacle for change and development, both for the patient and the family. In addition, there was an expressed need for insight into the eating disorder, as well as a need to throw light on the different positions and experienced burden's of the family members.
In the treatment of children and adolescence with an eating disorder, there is a strong tradition for including the family, and a program for multifamily therapy (MFT) is established. This was not the case for young adults with an eating disorder. Therefore, it was necessary to develop a MFT program for young adults. The aim of the MFT program for young adults is naturally different than for children and adolescents. For young adults, the aim of the program is to assist them in taking responsibility for their own health. And, how family members positively can contribute in the healing process, and at the same time take care of themselves.
Methods: For this developmental work a model for innovation was chosen including three phases: initiation, implementation and institutionalisation. The developmental work started at our regional clinic in 2006. And during these years, there has been a systematic, long-term development based on continual evaluation for establishing a MFT program for the patients and their families.
Results: A MFT program has been developed and established at our clinic. The program includes young adults (age 18 – 30 years) with a severe eating disorder (AN or BN) who has not yet established their own family.
The MFT program consists of gatherings during a year. Altogether there are six gatherings (2 or 3-day gatherings) – in total 13 days spread over the year. In each group about 6-8 families are taking part. The gatherings are addressing various important issues like relationships, communication and feelings of guilt.
The first group was arranged in 2006. Up to now 55 patients have taken part in the MFT program, and about 200 family members. 49 patients have completed the program, showing a low drop-out rate.
Another result of this developmental work is the start-up of an educational program for MFT for professionals working other places in the country with adult patients with eating disorders. The aim for the education is to pass on knowledge and experiences from the MFT program and develop skills for this treatment among the professional participants.
Conclusion: The MFT program has been established and take care of the family perspective in the treatment of young adults with a severe eating disorder. The program has received good evaluations, both from patients and family members. There is now being carried out research and results will be published.

FINAL DELEGATE LIST

No.	Last name	First name	Country
1	Avizoniene	Ruta	Lithuania
2	Bakland	Maria	Norway
3	Baks	Brigita	Lithuania
4	Balciunas	Robertas	Lithuania
5	Banas	Anna	Poland
6	Barzdaitiene	Daiva	Lithuania
7	Baublyte	Jurgita	Lithuania
8	Beradze	Tina	Ukraine
9	Berg	Johan	Norway
10	Bickiene	Jolanta	Lithuania
11	Birgegard	Andreas	Sweden
12	Bjornelv	Sigrid	Norway
13	Blanchet-Collet	Corinne	France
14	Bona	Eniko	Hungary
15	Brinchmann	Berit	Norway
16	Brune	Jelena	Germany
17	Bruneau	Melanie	France
18	Brustolin	Giulia	Hungary
19	Buckett	Geoffrey Robert	Australia
20	Bukelskis	Laurynas	Lithuania
21	Bulik	Cynthia Marie	Sweden
22	Butcher	Gerard	Ireland
23	Carrot	Benjamin	France
24	Clinton	David	Sweden
25	Criquillion	Sophie	France
26	Danielsen	Marit	Norway
27	Darguziene	Jurita	Lithuania
28	de Vos	Jan Alexander	Netherlands
29	Deksnyte	Ausra	Lithuania
30	Dembinskiene	Laisve	Lithuania
31	Devine	Marie	Ireland
32	Dubava	Maija	Latvia
33	Duclos	Jeanne	France
34	Duriez	Philibert	France
35	Emmanouilidis	Sokratis	Sweden
36	Evans	Rose Anne	United Kingdom

37	Fatieieva	Maryna	Ukraine
38	Fernandez-Aranda	Fernando	Spain
39	Flament	Martine F.	France
40	Forsen Mantilla	Emma	Sweden
41	Fredheim	Silje Kathrine	Norway
42	Gerliakiene	Auristida	Lithuania
43	Gevorgyan	Mariam	Armenia
44	Godart	Nathalie	France
45	Grazulyte	Ruta	Lithuania
46	Greibel	Janine	Germany
47	Grigonis	Tomas	Lithuania
48	Guillaume	Sebastien	France
49	Hansson	Berit Eira	Sweden
50	Hastings	Jacinta Patricia	Ireland
51	Haugnes	Sylvi Norang	Norway
52	Hilbig	Jan	Lithuania
53	Holmer	Riitta Helena	Sweden
54	Huon de Penanster	Guenole	France
55	Yachnik	Iuliia	Ukraine
56	Ilnytska	Tetiana	Ukraine
57	Ioseliani	George	Ukraine
58	Iqtidar	Madeeha	Ireland
59	Isomaa	Rasmus	Finland
60	Jauniskyte-Ingeleviciene	Ausra	Lithuania
61	Jimenez-Murcia	Susana	Spain
62	Kajokiene	Ilona	Lithuania
63	Karlstad	Jannike	Norway
64	Keski-Rahkonen	Anna	Finland
65	Kiesaite	Dalia	Lithuania
66	Klemaite	Ausra	Lithuania
67	Kratulyte	Edita	Lithuania
68	Kuncaite	Renata	Lithuania
69	Lacey	Hubert	United Kingdom
70	Larsen	Maren Kristin	Norway
71	Latzer	Yael	Israel
72	Laukyte-Gaule	Ieva	Lithuania
73	Leiteritz	Andreas	Germany
74	Leskauskas	Darius	Lithuania
75	Letranchant	Aurelie	France
76	Lindberg	Karolin Leonora Maria	Sweden
77	Lundblad	Suzanna	Sweden

78	Marcinkevicius	Martynas	Lithuania
79	Matthews	Rachel	United Kingdom
80	McAlinden	Stephanie Una	United Kingdom
81	Melisse	Bernou	Netherlands
82	Meskauskaite	Diana	Ireland
83	Mickute	Vitalija	Lithuania
84	Myers	Elissa	United States
85	Monell	Elin	Sweden
86	Morozovaite	Julija	Lithuania
87	Mudenaite-Savickiene	Veronika	Lithuania
88	Muradyan	Armen	Armenia
89	Nasvytiene	Dalia	Lithuania
90	Nieuwhof	Marja	Netherlands
91	Nigard	Ann-Kristin	Norway
92	Nikoncukiene	Irina	Lithuania
93	Nobile	Benedicte	France
94	Nold	Stefanie	Sweden
95	Nor	Natasya	Ireland
96	Norre	Jan	Belgium
97	Orton	Roberta	United Kingdom
98	Pajaujiene	Simona	Lithuania
99	Pakanaviciute	Rasa	Lithuania
100	Papezova	Hana	Czech Republic
101	Paulauskiene	Zivile	Lithuania
102	Paulson Karlsson	Gunilla	Sweden
103	Pearlman	Barbara	United Kingdom
104	Peciulyte	Algima	Lithuania
105	Pedersen	Liv-elisabeth	Norway
106	Pennings	Anja	Netherlands
107	Perpina	Conxa	Spain
108	Pettersen	Gunn	Norway
109	Pettersson	Cecilia	Sweden
110	Pipiraite-Lazareviciene	Daiva	Lithuania
111	Pociene	Dalia	Lithuania
112	Probst	Michel	Belgium
113	Pupsyte	Daiva	Lithuania
114	Robinson	Paul	United Kingdom
115	Roche	John James	United Kingdom
116	Rosenvinge	Jan H.	Norway
117	Rucinskaite	Urte	Lithuania
118	Sahuc	Nicolas	France

119	Samusyte	Rima	Lithuania
120	Sapuppo	Walter	Italy
121	Schaapherder	Johanna M	Netherlands
122	Serrano	Eduardo	Spain
123	Sestule	Ilze	Latvia
124	Simanauskiene	Margarita	Lithuania
125	Simon	Yves	Belgium
126	Skarboe	Tove	Norway
127	Slavickaite	Aida	Lithuania
128	Stankute	Vaida	Lithuania
129	Stankute	Dovile	Lithuania
130	Stornaes	Annett Victoria	Norway
131	Subaciute	Gabriele	Lithuania
132	Sulciene	Inga	Lithuania
133	Szabo	Pal	Hungary
134	Tamosaityte	Viktorija	Lithuania
135	Telksniene	Ruta	Lithuania
136	Tema	Nkokone	South Africa
137	Thorsrud	Tora	Norway
138	Toleikyte	Ursule	Lithuania
139	Trujillo	Eva Maria	Mexico
140	Tury	Ferenc	Hungary
141	Tutkuviene	Janina	Lithuania
142	Uleviciene	Jurate	Lithuania
143	Uleviciute-Sigajeviene	Egle	Lithuania
144	van der Ster	Gisela	Sweden
145	van Furth	Eric	Netherlands
146	van Kaam	Fleur Elsje	Netherlands
147	van Voren	Robert	Netherlands
148	Vanhaelen	Christine Barbara	Netherlands
149	Vareviciene	Kotryna	Lithuania
150	Versockiene	Aiste	Lithuania
151	Vignau	Jean	France
152	Vilciniene	Grazina	Lithuania
153	Virpikari	Sarianna	Finland
154	Wallin	Ulf Goran	Sweden
155	Wuensch-Leiteritz	Wally	Germany
156	Zdoryk	Iryna	Ukraine
157	Zykute	Vaida	Lithuania
158	Zilinskaite	Giedre	Lithuania