CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

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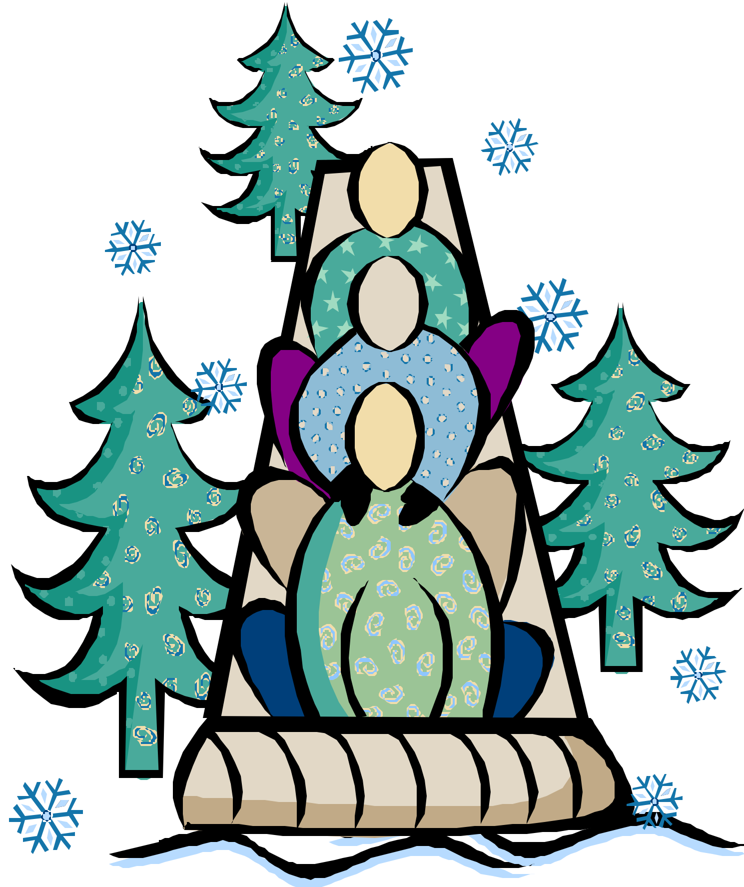
PRO-TEEN

In this issue:

Table of contents	2
News from the Association	3
Scientific Events	8
Theme: Eating Disorders	
Article	9
Literrature review	13
Program, Resources	20
Publication	29
Program:GAP	31



HAPPY NEW YEAR

WINTER FUN!

PRO-TEEN

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TABLE OF CONTENTS

News from the Association

Two CAAH founder's departure 3

President's 1998 report 3

Scientific Events

Assesment and Management of Substance Use Disorders During Adolescence 8

Imagine my future 8

Main theme for this issue:

EATING DISORDERS

Presence of this icon indicates that content refers to the main theme.

Article

Anorexia Nervosa: Self Sabotage in Adolescence 9

Literature Review: Outcome of Adolescents with Anorexia Nervosa 13

Programs, Resources

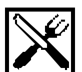
ANAB Quebec 20

NEDIC 20

Eating Disorders Clinic for Preadolescents and Adolescents IWK Grace Health Center 21

The Eating Disorder Program 25

BC's Children' Hospital 27

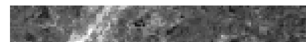


Publication

Books, manuals and videos 29

PROGRAM : GAP

Working with teens in Schools: Moving From a



News from the Association

Two CAAH founders' departure

We would like to mention the departure of two members of the CAAH's board of directors : two nurses, Cheryl Littleton and Lise Audet.

Lise Audet has been retired since 1997. This fall, she announced that she was leaving her position on the CAAH's board of directors. Lise is one of the CAAH's founders. She was part of the team that wrote our constitution and signed the incorporation request. Lise always believed in this young organization and gave of her time and efforts to further develop the CAAH. She was part of the scientific committee and organization of many conferences and workshops since 1994.

Lise has worked with teens for many years. She has developed innovating programs, has always sought out to improve her expertise and is remarkably open-minded. Most importantly, she has always defended adolescent's rights to services and good care. She certainly was an asset to the nursing profession. Lise is a woman filled with ideas, creativity, energy and integrity. Our organization benefited greatly by her presence.

Lise also surrounded herself with active professionals. In 1997, she developed the CAAH's Quebec section. This committee, which she brought so much energy to, continues on the same path by combining actions, ideas and fun.

Personally, as President, I am losing a trusted colleague and valuable partner. Her optimism and hard work has helped me through difficult times. This fall, we learned that Lise was having health problems. As I write these words, we are happy to say that the worst seems to have past and we wish her all the best.

Lise has an endless amount of energy as she has shown through her work both with the CAAH and adolescents. Good luck Lise and, once again, thank you.

Cheryl Littleton, a nurse from Toronto and one of the CAAH's directors, passed away in February of 1998. She was also one of the CAAH's founders. We acknowledged her contributions in an earlier publication.

In conclusion, Lise and Cheryl were pioneers both for the CAAH and adolescent medicine. We are deeply indebted to both of them.

President's 1998 report

In 1998, we continued the CAAH's administrative consolidation. Membership is slowly increasing. The publicity from our national Conference drew new members. The 1998's Meetings were completely managed by our organization. We received a contract from *the National Clearinghouse on Population Health* newly developed by Health Canada to study Canada's youth health information network. This contract was granted by the intermediary of the Canadian Pediatric Society. A 278-page report was produced in May 1998.

Administrative organization and activities

Bank of members

The computerized data bank of members has improved and we have corrected certain details to avoid errors. We can produce status sheets of the bank of members more effectively.

Budget management

We must improve our accounting procedures. We are paying GST-TVQ taxes since February 1998 which increases our expenses.

Postal list for Promotion

We have continued to develop this list for Quebec. It is almost completed (private and public schools, CEGEPs, school boards, CLSCs, public health department, pedopsychiatric units, Youth Centres, psychologists, Youth houses, CALACS, CAVACs, police services, old members). We must incorporate universities to the list.

We have also developed a similar list for Ontario's public health, district and community health services, mental health services, school boards, public and private schools, universities, psychologists and drug addiction services. This list will be completed in 1999.

For all other provinces, we have listed school boards and public health services as well as universities. We must further develop this list.

Conferences and Scientific Meetings

We have finalized our Conferences' organizational procedures. We no longer require an external firm. Thus, it allows us to save money and to hire someone full time to work on different activities of the CAAH. Organizing this year's Conferences was easier since we were able to re-use the computerized tools that were developed in 1997. We are presently writing our Conferences' organizational procedures.

Website

We have developed our web site. It is still in an early stage but the main structure is up and running. We are looking forward to completing this promising Website.

Members

En 1998, we have increased our membership, from **863 to 931**. This is largely due to the promotion of CAAH through mailing of brochures for the fall meeting. The state of membership in november 1998 is as follows (see table)

This year, 65% of our members havre paid their dues. The 67 members of 1996 will not renew and be deleted, but 50% of the 175 members from 1997 will probably renew in 1999 after several reminders.

We are loosing members each year. Many retire or are not working with adolescents anymore. Also, many organizations were taking a membership for many professionals and are renewing for one only.

There are more members in Quebec because more promotion of CAAH was carried on in that province (many regional meetings). We are beginning to publicize CAAH in other provinces, with mailing lists that are being developped for that purpose.

Eighty one percent of the members are women; 60% of the members want to receive their correspondance and journal in French, 31% in English, while 9% want both.

41% of the members have a single membership ; thus 59% are in a group membership. This include about 50% of total membership who have an institutional/group membership (130$ for up to 7 members). It is only 20% of the members who pay themselves their dues, the majority having their dues paid by their institution or organization.

1996 (deleted in december)	67 (7%)
1997	175 (19%)
1998 (registered and paid in 1998)	604 (65%)
1999 (registered and paid since september 1998)	85 (9%)
TOTAL	**931**

Type of Work (more than one choice)	
Clinical Intervention	557(60%)
Teaching	269 (29%)
Prevention / Promotion	530 (57%)
Health Education	348 (37%)
Coordination	88 (9%)
Group Animation	251 (27%)
Community Work	151 (16%)
Public Health	162 (17%)
Research	77 (8%)
Administration	103 (11%)
Documentation, library	31 (3%)
Benevolant	21 (2%)
Media	20 (2%)
Street Work	16 (2%)
Program Development	139 (15%)
Others	21 (2%)
Not Available	90 (9%)

Professions of members	
Nurses	300 (32%)
Family Medicine	124 (13%)
Doctors: specialist	83 (9%)
Social Workers	112 (12%)
Psychologist	47 (5%)
Teachers	12 (1%)
Counsellors	25 (3%)
Psycho-educator	31(3%)
Community Workers	26 (3%)
Sexologist	8 (1%)
Coordinator	36 (4%)
Dentist	4 (0%)
Librarian	18 (2%)
Dietitian	10 (1%)
Others	84 (9%)
Not available	69 (7%)

Work Place (more than one choice)	
CLSC	309 (33%)
Private office	81 (9%)
School	239 (26%)
Public Health Department	120 (13%)
District Health Services	14 (2%)
Hospital	172 (18%)
University	41 (4%)
Community Organization	72 (8%)
Youth Homes	14 (2%)
Youth Protection (CPEJ, DPJ)	15 (2%)
Custodial Facilities	22 (2%)
Government Organization	15 (2%)
Others	23 (2%)

Membres par provinces	
Québec	661(71%)
Ontario	172 (18,5%)
British Columbia	41 (4,5%)
Nova Scotia	10 (1%)
Alberta	28 (3%)
Saskatchewan	5 (0,5%)
Manitoba	10 (1%)
Newfoundland	1
New Brunswick	2
Yukon	1

Fields of Interest (more than one choice)	
Parents/adolescents Relationships	671 (72%)
Adolescent Development	590 (63%)
Behavior Problems	623 (67%)
Suicide, Suicide Attempt, Depression	498 (53%)
Violence	564 (60%)
Drugs Use and Abuse	599 (64%)
Sexuality, Pregnancy, Contraception	585 (63%)
STD and AIDS	519 (56%)
Sexual Abuse	538 (58%)
Anorexia Nervosa, Bulimia	467 (50%)
Nutrition, obesity	347 (37%)
General Health: growth, skin, ortho, sport	428 (48%)
Psychosomatic Diseases	411 (44%)
Handicap, Chronic diseases	323 (35%)
Learning Disorders	409 (44%)
Rights, Laws	383 (41%)
Not Available	90 (9%)

PRO-TEEN

We have a new team. We mentionned Martin Benny's contributions in September's edition. Martin has been a valuable asset to the journal for the past 3 years. We are receiving a few more articles from our members. The journal's layout has changed and we have removed several sections which makes it easier to edit. Our journal tends to be more thematic in content.

Conferences and workshops

The Adolescent Division of the Sick Children Hospital of Toronto presented the CAAH's first regional Ontario Conference in February 1998 under the theme of " drug abuse " ; with more than 120 participants. We had a Quebec regional Conference in Montreal in May 1998. The theme was " Male oriented interventions " and it attracted more than 340 participants and speaker-workshop leaders. The 5th annual National Conference attracted 305 participants and speaker-workshop leaders under the theme of " Eating Disorders ". An Ontario regional Conference is planned in Ottawa on May 14th 1999. The theme will be " drug abuse ". In addtition, " Speaking out during adolescence " will be the theme highlighted in a Quebec regional Conference the 7th of May 1999 in Montreal.

Quebec Section

The " Quebec section " committee has been in function for a year; its members have developed May 1998's conference program. We must mention Lise Audet's contributions to the committee. She helped develop this committee and conducted the meetings throughout the year. Other members include Danièle Bouchard, a Nurse, Micheline Proteau, a Nurse-sexologist, Ginette Ducharme, a Nurse, Pierre Chartrand, a Community worker, Yves Lambert, Family medicine, Martin Benny, a Doctorate psychology student, Mélanie Gagnon, a Psychology student and, since October, Danièle Delorme, a Social worker as well as Jean-Yves Frappier.

It would be important that similar committees be created in other provinces.

Committees

Advocacy

This committee has recently been re-established adue to the return of Dr. Katherine Leonard after a year working abroad.

Finances

Registration fees will increase slightly in 1999.
In 1998, we had an approximative revenue of 60,000 for expenses of about 57,000$.

Budget: 1997 Audited Report			
Revenu	**$**	**Expenses**	**$**
In bank	4,254$	Administration Support	21,400$
Registration 1997	11,420$	Entry of Data	3,490$
National Meeting	45,460$	Equipement (maintenance)	80$
Regional Meetings	22,700$	Taxes and permit	92$
Others	2,000$	Journal	12,897$
		Office expenses	1,477$
		Mailing	235$
		Bank Account	1,543$
		Travel (board)	1,175$
		Amortissement	885$
		Professional Honorarium	863$
		Colloque National	30,749$
		Québec Regional meetings	7,886$
Total	81,580$		83,345$

Conclusion

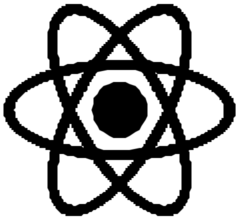
If the CAAH wishes to maintain and develop activities, it must find additional funding such as 1998's federal contract. The CAAH should be in contact with other national associations pertaining to youth. It is especially important that the CAAH be developed in other provinces.

We remain a young organization and there is still a lot to do. You can help us and your participation is important.

Happy New Year.

Jean-Yves Frappier
President

Scientific Events



Assessment and Management of Substance Use Disorders During Adolescence

Second Ontario Regional Meeting of CAAH
Ottawa, May 14 1999

A group of professionals from diverse backgrounds, under the coordination of Dr. Suji Lena, is preparing the program of this meeting. It will be an occasion for participants to discuss with other professionals, to be familiar with resources and acquire new knowledge. The preliminary program has the following presentations outlined:

Neuro-biology-neuro-chemistry-neuro-physiology, new developments in addictive disorders.
The process of addiction.
What's special about the management of addictive disorders in adolescents.

Worshops and panel suggested are:

Resources : access ; how to use them which resource for which client ?
Assessment process and tools
Early intervention program in school
How to manage dropping out of program
Measures that works to keep drugs off the school
Nurses and drug abuse.

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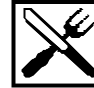
Article



Anorexia Nervosa: Self Sabotage in Adolescence

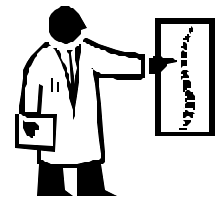
Jean Wilkins. MD
Professor of Paediatrics
University of Montreal,
Adolescent Division
Ste-Justine Hospital

Adolescence is a time to find oneself and create an identity. For many adolescents, it is a time when the physical clashes with the psychological. As doctors, we need to look at anorexia from a biopsychosocial perspective, and discover why this disease is so important to these troubled teens.

Twenty or 25 years ago, we could not talk about anorexia nervosa in adolescence because of the rarity of the disease. In the 80's ---and more in the 90's---any adolescent-medicine programs in North America were overrun by female teenagers who had lost weight, were amenorrheic, and who professed to be happy to be like that Anorexia nervosa empowers its victims by giving them the ability to destabilize any relationship ---including their relationship with their doctors.

When the adolescent medicine program at Sainte-Justine Hospital started in 1974, anorexic teenagers were admitted to our ward, so we were in close contact. The team felt that our approach ---more oriented towards the endocrinologic aspect of the disease--- was not giving us a complete picture. So, we decided to get involved in the disease from a biopsychosocial perspective. This new viewpoint meant taking the time to sit down and discover why this eating disorder was so important to these teens. It became evident fairly early on that anorexia nervosa empowers teenagers; therefore, we had to avoid confrontation. The risk in confronting such teenagers is that they may become more resistant and more closed to any intervention.

The first step in treating teens with anorexia is to establish a good therapeutic alliance with the patients by respecting their realities and their rhythms of change, which are very slow because of their absolute denial of their thinness. To be successful, we had to look at anorexia nervosa as a developmental problem ---something like an impasse at this specific moment in life. Adolescence itself is a complex biopsychosocio-cultural period. It is my perception that anorexia nervosa is a chronic disease that begins in adolescence and has different manifestations throughout life.



Why during adolescence?

Why anorexia during the teen years? Perhaps anorexia manifests in adolescence because these are the years of a person's greatest metamorphosis. The body changes dramatically, with the teenager almost doubling in weight and increasing in height by 20% between 10 to 18 years of age. The female teenager particularly has many changes to accept and integrate. For many very young adolescents, anorexia nervosa reflects an incapacity to accept and integrate pubertal changes.

From another standpoint, perhaps, anorexia may begin at this crucial time because adolescence, psychologically, means setting distance between oneself and others while developing one's own identity. Adolescence requires the developmental tasks of separation and individuation ---tasks well defined by Erikson and Blos --which anorexics cannot perform. Because of this inability to develop, teenagers may start to control their food intake and realize that, for the first time, they can be "somebody" by doing this. The patient "wins" by losing weight, by controlling her appetite and by limiting her food intake. This control over what the patient is doing provides him or her with such a sense of strength and good feelings that getting the patient to quit is very difficult. Often, control over appetite fills a person's emptiness; losing this sense of control forces the patient to confront the emptiness, which is immediately followed by a sense of sadness and impending disaster. How

can a teenager give up a pleasure (control) for something unknown, uncertain and likely to bring about pain?

Perhaps the teen years are so volatile for anorexics because these teens are influenced by society's cultural pressures. In the last two decades, thinness has been associated with success. The medical community has talked about things like body mass index and weight percentiles, but has forgotten to talk about genetic weight, the weight people actually are and the weight that gives people their own particular appearance. Weight has been discussed as something one can easily control; this is not realistic. I often meet girls who started their eating disorders after being told by their doctors to watch their weight.

How does self-sabotage begin?

I believe that anorexia nervosa manifest differently according to the stage at which it occurs. Being anorexic at age 12, 13 or 14 may be different than being anorexic at age 17, 18 or 19. The difficulties of accepting puberty changes, developing autonomy and finding out which one is (often impossible) can play different roles in the genesis of this disorder. The intensity of each contributing factor may vary according to the different stage of adolescence. Garner and Garfinkel's theory provides a dynamic comprehension of the disease; the contribution of the biologic, psychologic and sociologic components is well accepted in their theory. I expand on this theory by considering anorexia nervosa as an activity of " self sabotage " (autosabotage).

Anorexia nervosa is a difficulty of maturation, a major problem in the process of separation/individuation; it is similar in some manifestations to what we see in other " self-sabotage " behaviours (e.g., drug abuse, dropping out of school, etc.). Anorexia nervosa may assume features of an addictive disorder. We have found many similarities between the anorexics we are seeing today and the drug users of the late '70s, including the following: the conduct of self sabotage, the pleasure this disease fives victims, the denial of any problem, the reluctance to consult, the non-compliance to prescription and the limitations of interventions because victims are not ready to let go of the disease.

It is important to know the complexities of this disease before meeting with the anorexic teenager; if ones do not know these complexities, intervention can actually harm patients and their families. The patient may decide to leave the clinic, making his or her situation worse. We must prevent this from happening.

The first clinical visit

Any unexpected hospitalization should be prevented if possible. If a patient is going to be admitted, the admittance must be negotiated beforehand and be part of a therapeutic strategy known to the patient. Try to set the first appointment as soon as possible after the first call is made to the clinic, usually by the patient's mother. After a recent review of 205 consecutive calls requesting an appointment for anorexic treatment at our clinic, we found that 83% of calls came from parents (usually from the mother), 20% from a professional and 7% from the teenager herself. When one knows how anorexia develops, one begins to understand that the parents' decision to reach out and ask for help is something that has been contemplated for weeks. Because the anorexic is usually a brilliant child, is successful at school and has thoughts about food that seem " healthy ", parents often wait, hoping to see a change in the child's behaviour. The change that parents so desperately seek, however, does not happen; the anorexic teenager just eats less and less. By the time the parents make the call, they have already done their best; the teenager needs help immediately. Our clinic tries to give these families an appointment within three weeks; if you exceed this time, do not be surprised to see the parents and their anorexic teenager in the emergency room.

At the first visit, try to ensure that things go easily; adapt to the teenager and her situation. Recognize that the call for the appointment came from the family and not the teenager ---her presence was probably negotiated between them, and we do not know what they discussed together ---it is therefore important to limit the number of professionals who meet the teenager during the first visit. The nurse who took the original call will meet the patient and collect any information. After this is complete, the pediatrician is introduced to

the teenager, explains his or her role and performs a physical examination. The first physical examination is usually a partial one, unless the teenager responds positively to key questions. The most important part of the examination is sensitizing the teenager to the physical repercussions of her disease; explain that part in detail, showing and explaining findings to her (e.g., why her skin is so dry, her hands cyanotic, her blood pressure low, her heart rate low, why she is constipated, etc). Touch her fingers to illustrate her slow recirculation time; this usually impresses the teenager. Until witnessing such a demonstration, the teenager has not realized all the physical repercussions of anorexia on her body. After talking with the teen, explaining findings and discussing these things with the parents, one's diagnostic impression is usually given. Explain why you are sure of your diagnosis using the Diagnostic Statistical Manual of Mental Disorders IV criteria as a guide, since anorexia nervosa must be an objective diagnosis and not a diagnosis of elimination. Making or confirming the diagnosis is the major goal of the first visit. For the teenager, this is probably the first time that somebody outside the family is telling her that something is wrong with her behaviur.

After explaining why the teenager is found to be anorexic, give your first prescription. One of the main objectives of the first visit is to create a positive alliance with the teenager, so it is wise to be cautious with an " anorexic prescription ". Ask the teenager to think about why she developed the disease. Why is anorexia such an important part of her life? Do not let the teenager leave before giving her a brief explanation of the disease and some of its causative factors. Ask parents to keep their daughter out of the kitchen and to excuse her from meal preparation. Parents should be warned that this is difficult to do and often proves to be an impossible task.

To accomplish all of this and do it correctly takes at least one to one-and-a-half hours. In our setting at Sainte-Justine, compliance with keeping the second appointment and subsequent others is between 90% to 94%. We believe that this success rate is due to the care and time taken with the initial visit. The second visit comes one to three weeks after the teenager's first visit, according to the assessment of her physical state and the situation within the family. The priority is the teenager; she is the one who is sick and needs attention.

A chronic condition with different stages

Anorexia is a chronic condition that evolves through different stages. The actions or interventions of the physician must be different and appropriate for each of these stages.

<u>Stage I: Restricting Food Intake</u>

This is the phase when the teenager decides to lose weight and does; it is the period between the beginning of her diet and the first appointment at the clinic. This phase usually lasts between four to six months. It is very difficult to establish a therapeutic alliance with affected teens during this period. The teenager is actively anorexic and her mind is taken over by thoughts of losing weight and controlling her body. Family members feel helpless, totally impotent; it is the same for physicians. It is important to avoid conflicts during this period, although most of the time, that seems impossible.

I usually tell the anorexic teenager that her situation resembles a hockey game in which she is shooting at her own net. I explain that if she wants to win, she must shoot at the other net. I then assure the teenager that I will not go on the ice to withdraw the puck or handle her hockey stick for her. This is clear from the beginning.

As a clinical safety margin, the teenager must have a heart rate of over 50 beats per minute to be followed as an outpatient. Usually, one has the security of such a margin.

<u>Stage II: The Stagnation</u>

The teenager's weight hits rock bottom; she cannot lose any more, but she is not ready to gain weight. This can be a long period filled with a great deal of frustration. The teenager promises to gain weight but does not. This phase is one in which it is important to prevent your intervention or prescription from creating iatrogenic effects. For example, the teenager may drink a lot of water to increase her weight, with the resultant risk of hyponatremia and convulsion or rapid gastric dilatation.

During this phase, the importance of the anorexic

behaviour will slowly decrease. The teenager's mind will revolve less and less around the preoccupation with food and weight control. This is a time for clinicians to develop a respect for the teenager. If you must, adapt your approach, try to get the teenager to quit her anorexic habits as soon as possible, on her own and for herself.

Stage III: Regaining Weight.

After a while, the teenager becomes " incompetent " in her rigid eating control; this is a terrible period for her. The patient cannot " control " herself anymore, she experiences bulimic episodes, she gains weight and she no longer feels successful; this is a terrible feeling for her. The patient hates herself; she is not happy and may feel depressed even while all the people in her environment are happy. The family may believe that the disease is over and that the ex-anorexic patient is now a normal, happy teenager, but this is not the case. . The ex-anorexic is suffering; she does not know who she is. Feelings of emptiness and failure become more apparent and take up a lot of space in the patient's mind; she will cry, and may experience suicidal thoughts.

Physically, the patient is improving in this phase, but psychologically she is worse; this is one paradox of anorexia. It must now be explained to the parents that because their daughter is improving physically, she is going through another crisis that must be managed. During this phase, the time between appointments should be shorter. These frequent visits seem strange to family members, who are relieved that " the worst " is past.

This is a very difficult stage. Doctors may not have the ability to control the speed or direction of the patient's weight-regaining phase. Perhaps it is more important to recognize and try to prevent bulimic episodes. This part of the disease is a tough challenge.

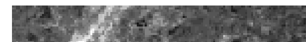
Stage IV: Confronting the Reality of Life

The teenager is now physically " corrected "; her menses may not have come back yet but she probably does not see this as a major problem. The patient's weight is near normal, with or without bulimic episodes. Bulimic episodes, if present, are less intense, less severe and less frequent. Now, however, the patient is 18, 19 or 20 years old and is beginning to experience difficulties in choosing a life path or career. The patient may be doing well at school but does not know which discipline to go into at university; she may have difficulty establishing relationships with others, especially boyfriends.

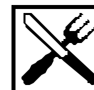
It is the physician's job to remind these patients that anorexia nervosa is as much a problem of identity as weight, and that to pursue a life after adolescence requires one to develop an identity. This is often the anorexic patient's major psychological defect, and the reason she will face different problems after anorexia " leaves " her life.

Conclusion

To treat anorexia nervosa, one must understand its evolution; this can guide the physician to the most effective and efficient manner of intervention. The best approach is one that can be adapted to the different stages of the disease process. In a period of budgetary restriction, it is important to find better ways to introduce each of the professionals involved in a team approach. The pediatrician, family physician and nurse practitioner all have a specific and major role to play during stages I, II and perhaps III. The psychologist and/or psychiatrist begin to play a more useful role during stages III and IV. The complexity of the adolescent anorexic and this disorder creates a need to regularly review one's approach to this disease, examine it and continuously adapt it. Anorexia needs to be discussed openly. Nobody has the exact answer, but we can stimulate our thinking though discussion.



Literature Review: Outcome of Adolescents with Anorexia Nervosa



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Introduction

Anorexia Nervosa most frequently affects young girls. According to the APA (1994), the prevalence in adolescents is estimated at 0.5 to 1%. These findings could be even higher in certain sub-populations. In 1979, Dally and Gomez estimated that 10% of brilliant young girls of upper socio-economic backgrounds would present a moderate episode of anorexia. Many questions arise on the possible recent increase in prevalence of this illness. We may want to question whether the increase is really due to an increase of incidence in the population or to a better understanding and screening of the illness.

For the last several years, the comprehension models of Anorexia have been modified to concentrate more on adolescent issues. During this period, developmental factors are a key issue. Anorexia confronts each characteristic of adolescence. Anorexia nervosa outcome studies are important for gathering scientific data as well as developing comprehension models. Furthermore, prognostic factors and treatment can only be improved if we truly understand adolescents with eating disorders and their evolution.

Methodological problems of outcome studies

Since the early 80's, the number of publications on outcome of anorexic patients have multiplied. Today, there are approximately one hundred articles on the subject. However, the disparity of methods makes the results difficult to compare. In 1988, HSU suggests the following criteria for a good anorexia outcome study:

Use of precise diagnostic criteria and exclusion of atypical cases.
More than 25 subjects.
Minimum of 4 year follow-up following the beginning of the illness.
Less than 10% subjects lost to follow-up
Direct contact with at least half of the subjects
Use of several well defined standardized instruments.

In 1996, in the event of a review of several articles on anorexia beginning at adolescence, HSU still notes methodological problems, which we review here.

Instruments

Certain scales have been specially developed to study the outcome of anorexic patients. In 1975, Morgan and Russell used a general outcome score pertaining to weight and menstruation during follow-up. General outcome is defined as:

Good outcome:	if weight is maintained at 15% of ideal body weight and menstruations is regular.
Intermediary:	if weight has reached 15% of ideal body weight (but not consistently) or abnormal menstruation.
Poor evolution:	if weight is inferior to 15% of ideal body weight and has never been reached and amenorrhoea persists.

The " Global Clinical Score –GCS " validated by Garfinkel in 1977 allows us to categorize anorexic patients' outcome based on other criteria defined by Morgan and Russell in 1975. GCS will be used in most studies. It takes in account the evolution of :

Weight compared to the ideal body weight (depending on age, height and sex)
Menstruation
Eating habits
Social adjustment
Education or employment

From these items will result a global score allowing to categorize the outcome of patients who have an eating disorder. The global score is the sum of these 5 items, from 0 to 23 (A score inferior to 8 will be considered a " good evolution ").

Types of studies

Retrospective. For practical reasons, many studies are in part retrospective, with baseline charac-

teristics collected from medical files. Among related methodological problems: missing data in files, diagnostic criteria not evaluated by the same person.

The patient's age at the beginning of the illness may also be a confusing data. For some studies, the beginning date can be either the beginning of amenorrhoea, the beginning of treatment, or hospitalization. One might ask if this was a deliberate choice of the authors or if it depended on reliable data that they were able to obtain.

Prospective. The Herpertz-Dahlmann study in 1993 on associated depression is characteristic of a prospective study where patients are evaluated with the same instruments during the entire follow-up process. The Göteberg team (Rostam-Gillbers) published several articles on a cohort.

Population studied

Each study only looks at its recruited population and extrapolation is sometimes difficult. As an example, a specialized center who cares for patients whose previous treatment failed, will treat the most difficult cases and is barely comparable to a primary care center.

Diagnostic criteria

It is necessary to have standardized criteria for clinical studies. However, classification always reveals imperfections that force modification as in the DSM. As a result, DSM criteria have evolved and this evolution, over the last few years, has complicated the comparison of recruited groups in different studies. The DSM-III-R would introduce the notion of 25% difference of expected weight for height and age, and then the DSM-IV would bring it down to 15%.

Criteria A of the DSM-IV related to weight loss could be used as an example to show the difficulty of an objective and uniform measure from one study to another. " Impossibility to maintain their weight at 85% of the expected weight. " The expected weight varies with age and height. The expected weight calculation methods are not always specified in studies. As criteria, Steinhausen 1991 used weight, which was 20% above standard weight for an age group. Thus, he does not consider their height. By this method, he must obtain an overestimation of anorexia diagnostic for the weight criteria among taller girls and an underestimation among shorter girls.

Subjects lost to follow-up

In all studies that needed to relocate former patients, the difficulty to find all of their population is an important problem. Steinhausen notes in his literature review of 1991 that lost cases in studies go from 0 to 27% with an average of 24%. Groups of patients, both found and lost must be compared to eliminate significant differences in the intake data. Therefore, the data remains exploitable even though it might not be entirely satisfying.

Other bias

The methodological problems of these types of researches can be resolved while others appear. Therefore, Kreipe 96 raises the problem of an increase of oral contraceptive prescriptions to limit the risk of osteoporosis; the rate of regular menstrual cycles will differ in future studies. This criteria is usually cited as an evaluation aspect of outcome and is even included in certain scores as the " Clinical Global Score ".

General Results

The first studies and a number of those who followed were mostly published by teams of psychiatrists and the subjects were adolescents and young adults. In the 1990's, research related to adolescents was published either by psychiatric teams or by adolescent medicine teams.

In 1988, HSU chose 5 studies from a literature review; (Morgan and Russell 1975, Hsu 1979, Morgan 1983, Hall 19874, Burns and Crisp 1984) all of which could satisfy the rigorous methodological criteria that he defined. In these studies, the global outcome, according to Morgan and Russell's criteria went as follows:

Good outcome: 36% to 58%
Intermediate: 19% to 36%
Poor outcome: 20% to 34%

In 1991, Steinhausen published a literature review that analyzed 22 articles published from 1981 to 1989. According to the Global Clinical Score, he found the following outcomes:

- Good outcome: 25% to 75% (avg. of 50%)
- Intermediate: 1% to 47% (avg. of 30%)
- Poor outcome: 5% to 30%

(avg. of 20%)

Results of adolescent psychiatric teams

Table 1. Results From Six Pedopsychiatric Teams.						
Authors	**Bryant-**	**Bryant-**	**Higgs**	**Gillberg**	**Smith**	**Steinhausen**
Year	1988	1996	1989	1994	1993	1993
Subjects	30/44	18/22	23/27	51/52	23/34	26/26
Boys/Girls	23%	27%	30%	16%	0	0
Age at On-	11,7	12,1	8 to 16	14,3	15,5 at	?
Time of Follow-up from Onset	8,9	5,5	7,3	6,7	6,6 from diagnosis	4 to 8 from diagnosis
Death	(2) 6%	0	0	0	0	0
Good	58%	56%	30%	47%		
Intermedi-	6%	28%	30%	39%		
Poor Outcome	29%	17%	39%	14%	43% had an eating	35% had an eating

Table 2. Results of Follow-up Sudies of Psychiatric Teams						
Authors	**Hamley 85**	**Jenkins 87**	**Walford 91**	**Jeammet 91**	**Herpertz 95**	**Gillberg 96**
Country	England	UK	Ireland	France	Germany	Sweden
Number of	21	21	15	129	39	51
Number at	18 / 85%		15	113 / 88%	34 / 88%	0
Mean age at	11,5 y	15 y	12,3 y	16 y	16,2 y	16 y
Age at on-	11,5 y	14,1 y	11,9 y			
Time of	8,7 y	4 y or +	5,6 y	11,7 y	8 y	5 y
Good Outcome	50%	50%	46,6%	54%	44% 58%	41%
Intermedi-	33%	19%	26,6%		33%	35%
Poor	17%	19%	26,6%		23%	24%

Studies on Follow-ups by Adolescent Medicine Teams

In 1985, Nussbaum published the first study on anorexic patients follow-up treated by adolescent medicine teams. In this specialty, the treatment modality requires the implementation of a multi

disciplinary team: physicians, pediatricians specialized in adolescents, nurses, dietitians, and psychologists or psychiatrists. Until now, 4 studies have been published, which are the following (see table 3).

Kreipe 1996 notes that the results of the first three studies were better than the researches related to adolescents and young adults treated in psychiatry. The hypotheses evoked by Kreipe are: 1) age difference; 2) the smallest interval of time between the onset of the illness and the beginning of treatment; the access to care was not stigmatized by mental illness; 3) the type of treatment.

Results by themes

Eating habits

In 1977, Garfinkel found 7% of obesity. Jeammet did not find any evolution towards obesity.

Restrictive

Jeammet found a 10 to 15% transition to chronicity. In 1993, Steinhausen, on a short and mid-term study described 4 types of possible evolution with regards to anorexia:

Acute:
short duration of the illness, a few months, then continuous remission (36%)
Simple chronicity :
remission after a few years (20%)
Chronic with exarcerbation :
relapses (34%)
Persistent chronicity :
(10%)

Table 3. Results from Adolescent Medicine Teams

	Nussbaum 1985	Kreipe 1989	Steiner 1990	Kreipe 1996
Number of patients	63	49		38
Response Rate		89%		92%
Time of Follow-up	27 months	80 months	32 months	69 months
Mean age at follow-up		22,7 years		22,5 years
Weight at onset in % of ideal	41,8%	72,1%	80%	81%
Weight at follow-up in % of ideal weight	92%	96,1%	93%	97,9%
Return of men-	84%	80%		94%
Good evaluation GCS	72%	86%	71%	88%

After 20 years of evolution, Ratnasuriya 1991 noted that among those who had evolved well, half testified to having a restrictive diet regularly and one third testified to eating irregularly.

Bulimia

The cross over between anorexia and bulimia after four years of evolution is 8% according to Van der Ham in 1994, 9% according to Steinhausen in 1993, 8% at three years and 11,7% at 7 years for Herpertz-Dahlman in 1995, and after 20 years of evolution, Ratnasuriya 1991 found that 15% were bulimic. In 1997, Steinhausen noted that the frequency of bulimia during the evolution is less important for younger ones. According to studies, the occurrence of bulimia varies from 0 to 45% (more or less complete clinical picture).

Mortality

According to certain studies, mortality at mid-term, from 4 to 14 years is at 0 to 6 % (Crisp 1992). On a more extensive follow-up (20 to 35 years), the raw data is 17 to 20%. In 1988, Patton was the first to bring this raw data to a standardized mortality ratio, therefore taking into account the expected mortality rate for a given age category. The rate he found was 3.3%, which compared to a standardized mortality rate shows a 6-time increase in mortality rate among anorexic patients. In 1991, Steinhausen noted a decrease in the raw mortality rate compared to the previous review of literature that he had published in 1983. (1991, an average of 4.4 %; 1983, an average of 10%). Jeammet 91 noted that the causes of death are essentially a direct consequence of malnutrition or suicide, and that the lethal risk is primarily with chronic forms. Many studies find mortality rates nil with follow-ups from 3 to 6 years.

Menses

The return of a regular menstrual cycle is directly evaluated in the Global Outcome Score. Many studies report rates over 65% of return of menstruation at 3 years.

Psychosocial Adaptation

Hamley 1985, for a young group, finds that 62% have a good professional or academic integration, and 43% have sexual relationship difficulties. The study of Jeammet is representative: 55% of women are satisfied regarding their personnel life (sexual, family, and relationships). At a professional level, the outcome is satisfying in 74% of cases. However, in view of the usual exceptional academic performances of these girls during anorexia, we could expect a greater professional accomplishment.

Psychiatric comorbidity

The psychiatric comorbitity varies from 36% to 62% according to 4 studies. In Jeammet's study, 20% are considered by the clinician as having a normal mental state, 5% have a good or fair mental functioning, but 45% still have psychiatric symptoms. The most frequently found diagnosis is anxiety and affect disorders. Herpertz –Dahlman 1993, quoted several studies that found depression rates ranging form 20 to 40 % among patients affected by poor eating habits, and often, depression is linked with poor prognosis. In his sample, 9% were diagnosed with major depression associated with anorexia. In 1993, Smith found that 60 % of female patients still had poor eating habits, anxiety symptoms or associated depression. Concerning addictive behaviors, Ratnasuriya 91 noted that 7% had abused of alcohol. Jeammet 91 noted that 8% of patients considered themselves dependent on alcohol or drugs.

Psychic Functioning

Alexihtymia

Jeammet (1991), as well as other clinicians, noted in a prospective study that insight was diminished; only 24 % of patients followed-up presented a good insight. Other authors attempted to demonstrate a correlation between anorexia and alexihtymia. Alexihtymia is defined as a incapability to assess one's emotions. Bourke et al (1992) studied a population consisting of 48 anorexic women at different stage of their illness and compared the T.A.S. scores (Toronto Alexihtymia Scale) within those of a control group. They found 77% of Alexihtymic individuals among the anorexic and 6,7% among the control group. Rastam and Gilberg (1997) published a study about young adults (average age of 22), having been treated for anorexia nervosa during their adolescence. They did not bring forth any significant differences between the anorexic and the control

group on the T.S.A scores. However, among the highest scores they found more anorexics.

Prognostic Factors

Age at the onset of anorexia

There have been contradictory results with respect to prognosis in terms of age at illness' onset. According to studies, an early onset beginning means adolescence compared to adulthood, or simply an onset before the age of 11. In his sample, Morgan 1983 did not find any correlation with regards to age at the beginning. In 1988, Bryant-Waugh found a less favorable prognosis if the illness started before age 11, while studying a group of 30 children with a follow-up at 7 years. But in 1996, the same team, with a group of 18 children with a follow-up at 3 years did not confirm these findings. Walford 91, with a small sample and an average age of 12 years observed a worse outcome among the youngest, having started their anorexia before the age of 11. In 1995, Herpertz did not find any correlation with the age at the onset of anorexia. Steinhausen 1997, in his literature review writes that five studies did not find any influence of age at the onset and one describes a less favorable prognosis if anorexia begins before the age of 11. While studying a population of various ages, Ratnasuriya (1991) noted a less favorable prognosis associated with a later beginning, onset over 18, when compared to the 11-15 year olds. This variable is a predictive factor, still important after 20 years of evolution.

Family structure and dynamic

Morgan 1983 found that difficult family relationships and hostility on the family's part towards the patient are more often correlated with a less favorable prognosis. In 1988, Bryant–Waugh showed a negative influence on the prognosis in situations of disruptive family life, single parent household, remarriage. These results were not confirmed however by the same authors in 1996. In 1991, Ratnasuriya noted that disruptive family relationships are more often associated with a less favorable prognosis after a twenty-year follow-up. In 1996, Herpertz did not find any correlation with regards to divorced parents.

Weight

Among the factors that seemed to correlate with prognosis in many studies, we must mention weight. The minimum weight reached during the illness (Jeammet 92, Herpertz 95) or low BMI (body mass index) at admission (Herpertz 95, Steinhausen 93, 97) would be indicators of a less favorable prognosis. Comparing the subjects with eating disorders at 7 year follow-up, with those no longer ill, Herpertz 95 came with some significant results: Minimum lower weight: (32 Vs 41); Low BMI at admission (13.7 Vs 15).

Hebebrand 1997 studied the influence of the BMI on the prognosis at 5 years of 272 women whose average age was of 16,7. He found that patients with a low BMI at the onset of anorexia have a lower BMI at the time of the follow-up. The cut-off was a BMI of 13. The correlation between the BMI at the onset and at the time of the follow-up was significant, even when ignoring the deceased patients.
For the:
BMI<13 the mortality rate is 11%
BMI > 13 the mortality rate is 0.6%

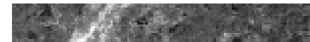
A BMI inferior to 13 means a poor prognosis. The authors concluded that even for a BMI <15, the risk of death increased. A BMI superior to 13 would be related to an increased duration of the illness; long duration of the illness before the onset of treatment is also a factor for a less favorable prognosis.

Hospitalization

According to certain studies, the duration and the number of hospitalizations are associated with an unsatisfying outcome. (Jeammet 92, Steinhausen 83, 87). Herpertz-Dahlmann 93 did not confirm these findings.

Personality Problems and Depression

Ratnasuriya 91 noted a less favorable prognosis if personality disturbances already existed, in a follow-up study at 20 years. Steinhausen 1997 found a less favorable prognosis if depression was present. Smith 1993 noted a less favorable prognosis if there was evidence of depression at the time of diagnosis.



Vomiting

For several authors, vomiting would be a sign of a poor prognosis (Jeammet 91, Garfinkel 77). Kreipe 96 found a persistence in auto vomiting for 18% of the study group and 2/3 of those patients had a CGS > 8, the outcome score ranking them in the intermediate or poor outcome. These results were significantly different from the rest of the group studied. Morgan 1983 did not find any correlation between vomiting and prognosis. Steinhausen 1997 did not find a significant difference between the restrictive and purgative sub-types; for younger subjects, 3 studies show correlation between bulimia or purge and a poor prognosis.

Mid-term evolution

In 1992, Ratnasuriya published an outcome study with a 20 years follow-up of a population he had already studied after a five-year delay. He noted that a good outcome score at five years is a good predictor of a good outcome score after twenty years.

The Outcome of Bulimic Patients

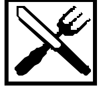
Few studies have been published on the outcome of Bulimia Nervosa, and even fewer for long term outcome.
In 1994, Van der Ham published a prospective study that included 25 anorexics and 25 bulimics. At 4 years, the outcome according to Morgan Russell score was good in 59% of Bulimic and 36% of anorexics. It was poor in 8% and 12 % respectively. These results do not show a significant statistical difference. In 1986, Toner and Garfinkel compared the outcome of a group of anorexics and bulimics to a control group. They did not find any difference in their general outcome. However, there is a higher rate of alcohol and drug abuse as well as smokers among bulimics. Bulimics as well as anorexics had a higher percentage of anxiety disorders than the control group. Here are the results for 17 studies with follow-ups ranging from 6 months to 6 years. (Kell 1997)

The estimated mortality rate for all the studies was 0.3 % even though this number cannot be considered absolutely exact considering the amount of subjects lost to follow-up; it would seem that this rate is lower than for anorexics. Crossover rates towards anorexia are between 0 and 7%. Relapse rates are between 26 to 43% for studies, which had follow-ups, ranging from 6 months to 6 years. Among the many studies, an obvious prognostic factor could not be found.

		BN at Follow-up	BN partial at Follow-up	Remission
Follow-up< of 1 y	6 studies N=7 to 75	6 studies 36% to 86%	1 study 28%	4 studies 28% to 33%
Follow-up 2 to 6 y	12 studies N=5 to 19	9 studies 20% to 60%	5 studies 9% to 29%	10 studies 13% to 69%
Follow-up at 10 y	1 study N=44	9%	89%	52%

Table 10. Review of Follow-up of Bulimics, Kell 1997

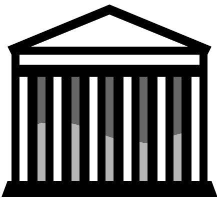
Programs, Resources



ANAB Quebec

Association for Assistance to Persons Suffering from **A**norexia **N**ervosa **A**nd **B**ulimia

ANAB Quebec provides assistance to those affected by an eating disorder through:



l public information evenings held in conjunction with the Douglas Hospital's Eating Dis order Unit.

l support groups that meet throughout Greater Montreal for people who suffer directly.

l Coping Courses that offer practical advice for family and friends.

l Images, our quarterly newsletter full of current information, relevant articles and suggestions for helpful readings.

l education and prevention projects with local schools and businesses as well as conferences at local high schools, CEGEPs and universities.
l a helpful and sympathetic ear to those who call.

ANAB Quebec
114 Donegani Blvd.
Pointe Claire, QC
H9R 2W3
TEL: (514) 630-0907
FAX: (514) 630-1225

BANA
Bulimia Anorexia Nervosa Association

Clinical treatment center for Eating Disorders : services, information, advocacy.

300 Cabana Rd east, Windsor, Ontario N9G 1A3
TEL : (519) 253-6638
FAX : (819) 969-0227
(Web): www. Bana.ca

NEDIC

National Eating Disorders Information Centre

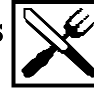
200 Elizabeth St, 1-211, College Wing, Toronto, Ontario M5G 2C4
TEL : (416) 340-4188
FAX : (416) 340-4156
e-mail : fmain@porhost.toronto.on.ca

Dietitians of Canada Eating Disorders Network

Chairperson : Mary Losier-Roderick,
138 Meadowbank Ave, Saint John, NB E2K 2C8
TEL : (506) 658-0827
FAX : (506) 648-6345

Representatives in each provinces.
Newsletter published by Nancy Saunders (e-mail saunders@rocler.qc.ca ; FAX : (450) 829-4278

Eating Disorders Clinic for Preadolescents and Adolescents IWK Grace Health Center for Children, Women and Families



The Eating Disorders Program at the IWK-Grace Health Center was developed in 1995 by our multidisciplinary team including Dr. Joanne Gusella, Clinical Psychologist, Dr. Doris Hirsch, Psychiatrist, Ms. Judy Ashley, Nurse, Ms. Katherine McPherson, Social Worker, and Ms. Lisa Parkinson, Dietician, and Dr. Mike Smith, Pediatrician. In 1996, our Eating Disorder Clinic received official designation as a specialty clinic within our Mental Health system, with a mandate to serve pre-adolescents and adolescents in Nova Scotia, New Brunswick and Prince Edward Island. Specifically, we provide a comprehensive assessment of eating disorders and comorbid conditions: 1. First opinion psychological, medical and nutritional assessment and treatment services where these services do not exist in the local community, or where the patient is in moderate to severe starvation, or there are physical complications arising from eating disordered behaviors; 2. Second opinion assessments, and consultation to other health professionals on request. Our Eating Disorders Clinic can be accessed by calling our Central Referral system (902-464-4110) which triages all calls received for mental health services for children and adolescents. After an initial comprehensive assessment, a decision is made as the whether the patient is best treated as an inpatient or an outpatient. Over the next year, we will see in the range of 125 children and adolescents, approximately 10% will be inpatients, and the rest will be a outpatient. Although we do see male patients, 99% of our patients are female adolescents. In this article, I will summarize our Eating Disorders Clinic program for pre-adolescents and adolescents (Gusella et al., 1997).

Treatment Philosophy.

Our treatment philosophy is guided by developmental theory, which has been articulated by Strober and Yager (1985). Anorexia has its onset in the adolescent years and is associated with the fear and confusion regarding the process of growing up (i.e., the maturation of the body, the task of individuation and identity development, taking on more adult responsibilities, achieving acceptance from peers, intimate partners, or important role models). A developmental perspective also extends to the treatment of young people who develop Bulimia Nervosa; binging and purging can be seen as playing a role in meeting the adolescent's needs for comfort, security, friendship in the face of insecurity about growing up, going to a new school or university, having intimate relationships. Above all, our treatment program for adolescents is tailored to their developmental level and experiences by making use of concrete, hands-on materials, interactive, and activity based approaches to learning (e.g., art, poetry and journal writing, magazines and videos, role-plays, food models, puppets, humour, body work). It is also geared to their developmental needs for maintaining connections with family, school and friends. Within this age group, there is general consensus that best practice involves a multidisciplinary team approach offering a combination of medical, nutritional treatment along with family therapy, and individual and group therapy as needed. Given that there are many pathways to developing an eating disorder, it follows that our treatment approaches include an integration of approaches which have been shown to be effective with adolescents or with adults, including cognitive-behavioral (Wilson, Fairburn & Agras, 1997; Garner, Vitousek, Pike, 1997), psycho-educational and group psychotherapy approaches (Davis& Olmsted, 1992; Cramer-Azima, 1992); narrative approaches (i.e., "externalizing the problem"; Manley, 1995; White, 1989), and motivational "stages of change", and decision making models (Franko, in press; Prochaska et al., 1994).

Inpatient Program

Children and adolescents may require admission to the general 17-bed inpatient Psychiatric Unit, if: 1. They are medically or psychiatrically unstable; 2. They are suffering from extreme malnutrition (weight loss at or exceeding 25% of ideal body weight); 3. They need an intensive supportive environment to promote weight restoration; 4. They

need supplemental feeding or nasogastric feeding to initiate weight gain; 5. Outpatient treatment has been ineffective.

The purpose of inpatient admission is to: 1. Restore physical health (i.e., weight to 90-95% of Ideal Body Weight, and stable vital signs); 2. To develop a therapeutic relationships; 3. To reduce anxiety related to weight restoration; 4. To establish regular eating patterns (3 meals a day and snacks); 5. To begin to separate "anorexic or bulimic" thinking from healthy, rational thinking; 6. To interrupt the cycle of binging/vomiting, 7. To encourage communication of thoughts and feelings, and to begin to discover the role that the eating disorder plays in their life; 8. To prepare the patient to generalize their healthier lifestyle, to the transition back home. Average length of stay is 3 months.

A comprehensive medical assessment is performed to 1) estimate the degree of starvation 2) determine the degree of physiological compromise 3) evaluate for other diagnoses.

Specific Treatment/Inpatient program

- Ideal weight range is decided upon by dietician in consultation with the treatment team, and patient's concerns regarding food issues are to be discussed with the dietician
- Sessions with dietician to develop a plan for gradual weight restoration with a goal weight gain of 1.0 to 1.5 kilograms per week
- development of an individual program by members of the treatment team with input from the patient which will allow the patient to have an increase in activity level based on weekly weight gain and vital signs. The program is described to the patient in logical terms. If her body is in a state of starvation, it will not have enough energy to spare for daily activity, therefore, she will need to lie in bed or have minimal physical activity. As her body becomes healthier and well nourished she will be able to increase her physical activity in a gradual fashion as outlined in her program.

- Individual sessions "as needed" with the attending psychiatrist and resident
- family sessions with the assigned social worker and resident
- Individual sessions "as needed" with the psychologist who uses cognitive-behavioral techniques to reduce anxiety related to weight gain and reduced exercise, and cognitive restructuring to challenge - "anorexic" or "bulimic" thinking
- Individual sessions "as needed" with the occupational therapist to work on issues of self-esteem, body image, fitness program
- School in hospital with Child Life Teacher and then integration back to own school when patient is ready and able to
- Pharmacological therapy will be used and monitored as needed
- At discharge, the patient's weight should be restored to 90- 95% IBW and maintained for a one to two week period; the patient should be showing more responsibility in selecting a meal plan and eating a variety of foods; binge and vomit cycle should be under control.

Day Patient Service

The day patient service is operated on an "as needed" basis by inpatient staff with consultation from the Eating Disorders Team to provide the children or adolescents with more structure and support in the transition from a highly structured inpatient unit to their home environment.

Outpatient Program

A comprehensive history and assessment of the current problems is obtained through semi-structured interviews with the family, and individual, and through standardized self-report measures completed by the adolescent, parents, and teacher. The assessment includes developmental, medical, family, social-emotional, and school history, weight and growth history, eating attitudes and behaviours, and current stresses. As well, the adolescent is given a physical examination, nutritional evaluation, and laboratory tests are ordered "as needed". A treatment plan is developed with the family's input, and may include individual, family therapy, group therapy, parent support group, and/or nutritional therapy. Outpatient treatment may be provided by our Eating Disorders Team or through a health professional in their local community.
Individual Therapy sessions with treatment team members. The purpose is:

- To develop therapeutic relationship(s)
- To explore their motivation through "stage of change"(i.e., readiness for change); pros and cons of recovery from the eating disorder;
- To restore physical health by monitoring and facilitating a healthy weight gain
- To normalize eating habits
- To monitor any medications prescribed
- To monitor associated medical complications
- To help patients understand how their eating disorder developed (e.g., low self-esteem, weak communication styles, need for an identity, need for control, need for independence from family, need for rigid, safe secure habits, fears of growing up and taking on responsibilities, emerging sexual issues)
- To use cognitive-behavioral (and/or insight oriented) therapies to help them replace destructive "anorexic thinking patterns" with constructive, helpful thoughts through self-monitoring, challenging beliefs
- To explore past and present internal and external stresses and to learn new ways to cope with these
- To promote behavior change toward a healthier lifestyle including normalized eating, fitness, social and family relationships

Family Therapy. The medical, psychological and social impact of illness places heavy emotional stress on individuals and their family. The child or adolescent with an eating disorder has a significant impact on family functioning, and family dynamics may be influential in maintaining the disorder. The social worker has a role in providing a clearer picture of the predisposing and precipitating factors in eating disorders, and in proposing systemic interventions. Through assessment of structure, roles, and patterns, within the context of the family life cycle, the therapist focuses on changing dysfunctional patterns of family behavior and increasing the stability of the family environment.

Groups Psychoeducational Groups. The clinical psychologist, and a psychology intern on the team co-lead an eight to ten week group for girls with Anorexia and/or Bulimia Nervosa between 15 and 18 years of age. While the group is based on a cognitive-behavioral approach including psychoeducational concepts (Davis & Olmsted, 1992), it also encourages the therapeutic processes by fostering group cohesion, universality, installation of hope, and interpersonal learning (Yalom, 1985). The purpose is to provide members with an opportunity to communicate in a group of peers, to foster peer support, and to allow members to gain a better understanding, and control over their eating disorder. In essence, our aim is to provide these girls with a supportive context in which they came move forward in their "stage of recovery"(i.e., from Pre-Contemplation, or Contemplation, toward the Action Stage). This is a closed group for up to eight members. It is held weekly, after regular school hours for 1 1/2 hours each session. Along with an open check-in with each girl, and review of their weekly goals, we provide the girls with a "theme" at each session to provide a format for discussion.

The themes include: 1.What is my goal in this group? How can I benefit? 2. How ready am I to change? Is the eating disorder more of a friend or more of a foe, to me? (E.g., what are the pros and cons of recovering), 3. What can I learn from others who have recovered? 4. What messages do I pick up from media, friends and family about weight and shape? Why do people eat and stop eating? (e.g., exploring the physical, emotional and social reasons that guide our decisions to eat and to stop eating), What is healthy eating? 5. How do I communicate? (e.g., passive, assertive, aggressive), 6. Where do I get my self-esteem? (E. g., look at overvaluing weight and shape, explore other sources of feeling good about self), 7. What do I say to myself? (E.g., exploring to separate "anorexic and bulimic" thinking from healthy, rational thinking), 8. How do I see, feel and think about my body? (I.e. exploring body distortion and dissatisfaction), 9. Who are my supports? 10. What have I learned and where do I go from here? The girls are given individual folders to hold their "recovery work" and handouts are given at each session to amplify the concepts learned in the session. At the end of the group, the girls complete post-assessment questionnaires and evaluate their group experience. Individual reports are then written, in age-appropriate language, in order that each girl have a record of her progress in group, and insights from the group experience.

Parent Support Group. This open support group for parents combines a mutual support with and educational approach. The group is facilitated by our team nurses, and runs biweekly. The format is

informal and guided by the parents' current concerns and and interests. We are in the process of evaluating the benefits of this group.

Building Partnerships for Health Promotion

We have developed a partnership with Public Health nurses who are affiliated with the schools in Nova Scotia. Through this partnership, we have been able to provide treatment groups for students with eating disorders within a few schools. There is an increasing demand for the provision of interactive-learning experiences, for Grade 6 12 students regarding the issues of healthy eating exercise and healthy body image, and the prevention of eating disorders. We widely distribute our Eating Disorder Clinic pamphlets, and respond to all requests to write articles in high school and community publications, in order to educate students and the public at large about the warning signs of an eating disorder and how to get help. Our Eating Disorders Clinic provides consultation to Mental Health Centers and Hospitals, as well as health professionals throughout the Maritime provinces. Locally, we work with the QE11 Health Center Eating Disorders Clinic when one of our young people is transitioning to the adult system.

Teaching, Training and Research Mandate

Our Eating Disorders Clinic has a role in training other health professionals to assess and treat children and adolescents with eating disorders. We have delivered half and full-day workshops for health professionals, as well as Continuing Medical Education programs for physicians. Our Eating Disorders Clinic is also active in the training of Psychiatric and Pediatric esidents, Psychology interns, and students in dietetics and social work

By evaluating our treatment services, we are learning from our young patients, what has helped them to recover from their eating disorder, and what has not been helpful. After participating in the group, girls indicate on self-report, that they would chose to be a healthier size and shape than they did prior to the group. They also reported that the group allowed them to "find out that I'm not alone", and to share their thoughts and feelings (Gusella & DeWolfe, 1997). We are currently examining whether their "stage of change" (Prochaska et al., 1994) prior to the group experience can help predict treatment outcomes.

This year, Dr. Joanne Gusella, along with her co-investigator, Dr. Erica vanRoosmalen were awarded a grant from the Social Sciences and Humanities Research Council to implement and evaluate a school-based intervention model to deal with the issues of unhealthy weight regulation, body image, nutrition and healthy lifestyle in junior high school students. The project will be complete in 3 years.

If you are interested in learning more about what we do, or have some insights to share with us about your programs, you can reach me at the following addresses: Dr. Joanne Gusella, Psychologist and Team Leader, Eating Disorders Clinic, IWK-Grace Health Center, Halifax, NS, Canada, B3J 3G9; Fax: (902) 428-8736; Phone: (902) 428-8409; e-mail, jgusella@is.dal.ca.

References

1 Cramer-Azima, F.J. (1992). Adolescent group treatment. In Harper-Guiffre, H. and MacKenzie, K. Roy (Eds) Group psychotherapy for eating disorders (pp. 233 - 241). Washington, D.C. - American Psychiatric Press.

2 Davis, R., & Olmsted, M.P. (1992). Cognitive-behavioral group treatment for bulimia nervosa. Integrating group psychoeducation and psychotherapy. In H. Harpre-Guiffre and K.R. MacKenzie (Eds). Group psychotherapy for eating disorders. Washington, D.C. - American Psychiatric Press.

3 Franko, D. (in press) Ready or not? Stages of change as predictors of brief group therapy outcome in bulimia nervosa.

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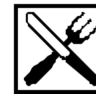
13 Wilson, G.T., Fairburn, C.G., Agras, W.S. (1997). Cognitive-behavioral therapy for bulimia nervosa. In D.M. Garner & Paul E. Garfinkel (Eds.) Handbook of treatment for eating disorders. Second edition (pp. 67 - 93). New York: Guilford Press.

The eating Disorder Program
Hospital For Sick Children Toronto, Ontario



Debra K. Katzman, MD, Head of Eating Disorder Program

The Eating Disorder Program at the Hospital for Sick Children (HSC) is a multidisciplinary program co-directed by the Division of Adolescent Medicine Department of Peadiatrics (Debra K. Katzman, MD) and the Department of Child Psychiatry (Rose Geist, MD). Since 1993, our multidisciplinary program has created a multifaceted child and adolescent eating disorder program, which includes clinical (inpatient, outpatient, consultative), research, educational and networking components.

The Clinical Program

There are five major goals of our clinical Program. They include medical stabilization, weight gain, eating rehabilitation, social integration, and the identification and treatment of comorbid psychiatric disorders. The patient population consists of young people less than 18 years old who have an eating disorder. The average age of our patient population is 14.8 years old. We have children as young as eight years old in our Program.

Inpatient Program

The inpatient component of the Program is designed to diagnose and provide treatment to young people in a multidisciplinary setting. The inpatient ward consists of nine beds. Three beds are equipped to care for medically unstable patients and 6 beds are designed for medically stable patients. The unit is in operation 24 hours a day, 7 days a week. The front-line staff consists of registered nurses that are involved in the day to day milieu treatment of patients.

Children and adolescents with anorexia nervosa are admitted to our inpatient ward when weight loss has been so prolonged or so rapid that life-threatening medical complications must be averted, or when weight loss continues despite outpatient treatment. Those adolescents whose growth and development may be retarded are also admitted. These criteria recognize that early hospitalization for younger adolescents who do not yet

have a chronic form of the disease may prevent the multiple hospitalizations and medical complications that are found in the young people suffering from this illness.

Patients with bulimia nervosa may also require in-hospital treatment at the HSC for some of the same phenomena as those with anorexia nervosa, as well as for intractable binge/purge cycles, dehydration, electrolyte disturbances, cardiac dysrhythmia, and gastrointestinal bleeding or dysfunction. Hospitalization serves to break the binge-purge cycle. Adolescent patients with bulimia are generally hospitalized for a shorter length of time than those with anorexia nervosa, since they usually do not require weight gain.

The goals of our program require the collaborative medical and psychosocial treatments of the multidisciplinary team for a successful outcome to occur. Treatment on the inpatient unit involves educational programs (school), group therapy, milieu therapy, psychotherapy and psychoeducation programs for the adolescent, parents and family.

Outpatient Program

The outpatient component of the Program is a multidisciplinary clinic designed to diagnose and treat young people with eating disorders. The outpatient component also provides consultation and treatment recommendations to referring physicians and allied health care providers. The eating disorder assessment is conducted by all members of the Eating Disorder Team. Patients referred to the Eating Disorder Program are assessed by Adolescent Medicine, Child Psychiatry, Psychology, Social Work and Nutritional Services. Those who refer patients to our Program include pediatricians (community and hospital-based), psychiatrists (community and hospital-based), and family physicians (community and hospital-based). Treatment in the outpatient Program includes medical intervention, individual therapy, family therapy and education. The treatment aims to involve the parents and the rest of the family as treatment allies. The parents/family are included in the treatment initiatives. Thus, a major goal of our treatment is to increase the therapeutic alliance with the patient and family, one of the major variables related to a successful outcome.

Consultation Program

In addition to the inpatient and outpatient component there is also a consultative arm to the service. Consultation is provided to other Divisions in the Department of Pediatrics.

Research

Our multidisciplinary team is committed to the ongoing development of an academic/teaching program for adolescents with eating disorders. Group members continue to seek funds, which will allow the advancement of knowledge into the etiology and treatment of child and adolescent eating disorders. Our group is committed to help develop evidence-based care and health outcomes research. Currently there are numerous research studies being carried out in the Eating Disorder Program at HSC. In addition, The Eating Disorder Program at the HSC provides research-training opportunities for medical students, residents, fellows (pediatric, psychiatric and family practice) and students of other allied health professions in the area of child and adolescent eating disorders.

Education

The Eating Disorder Program at the HSC provides education of medical students, residents, fellows (pediatric, psychiatric and family practice) and students of other allied health professions in the area of child and adolescent eating disorders. We currently have pediatric fellows and residents, psychiatry residents, clinical clerks, nursing students, social work students, nutrition interns, research assistants and students learning in our program. Our group members continue to participate in national and international meetings and present original research and workshops in the area of adolescent eating disorders.

Child Health Network

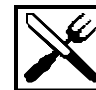
The Eating Disorder Program at the HSC actively supports an outreach component to health care workers, medical centers and agencies in the community. The Ontario Ministry of Health has been instrumental in this accomplishment as as result of six years of funding to the Ontario Community Outreach Program for Eating Disorders. In collaboration with OMH and The Toronto Hospital-

General Division, we continue to train multidisciplinary hospital and community teams throughout Ontario to work more effectively with young people suffering from these disorders. In addition, our group has offered intensive training to a number of strategically located centers in the province.

For further information regarding our program please contact :

Heather Brown
The Eating Disorder Program
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario
M5G 1X8
Phone : (416) 813-7195
Fax: (416) 813-5392

BC's Children' Hospital
Eating Disorders Program for Children and Adolescents



Ronald Manley, Head
Jorge Pinzon, paediatrician

The B.C.C.H. Eating Program is the tertiary provincial resource program for child and adolescent patients with eating disorders and their families. The Program reflects our philosophy of an interprofessional team approach to the delivery of health care for this patient population.

Program Description

The mandate of the Program is to provide leadership in the areas of clinical services, education, family-focused child and adolescent health promotion, and research and outreach activities in the area of eating disorders. The clinical responsibilities of the interdisciplinary team include assessment and treatment services for children and adolescents with anorexia nervosa and/or bulimia nervosa and related eating disorders. The outreach component of the Program supports and integrates services together with locally based treatment resources throughout the province.

Referrals are received by the program from all regions of British Columbia. Patients receive comprehensive evaluations, and referring agencies receive a report of the assessment findings and recommendations. The assessment results and options for treatment are discussed with patients and families.

Scope of Services

The Eating Disorders Program team has designed a number of innovative programs to better deliver a high quality of health care to patients with eating disorders and their families, with interprofessional collaboration being the cornerstone of the Program.

Intake Service : All referrals to the Eating Disorders Program are made through the intake service, which is provided by nursing staff and who review referrals prior to scheduling an assessment. One a referral is accepted, patients referred to the Program receive medical (pediatrician), nursing, nutritional (dietitian), psychosocial/psychiatric (psychologist or psychiatrist), and family (social worker/psychiatrist) assessments. Patients also receive an eating disorder diagnostic interview by one of the psychologists or trainees under their supervision. These assessment are used in determining the most appropriate services for the patient and her/his family. At a triage meeting, the team meets to determine the assignment of patients to the most appropriate component of the program, this being based upon patient and family treatment needs and in consideration of the ability of local communities to meet the needs of the patients and their families.

Day Treatment Program : The Day Treatment Program is for patients with a moderate to severe eating disorder who requires intensive treatment. It operates five days per week with space for up to ten patients. Treatment is primarily group-based and there is an emphasis on managing patients in this program rather than with inpatient hospital care. The overall goals of the program include normalization of the patient's eating behavior, weight restoration when applicable, and treatment of the patient's psychosocial needs the latter including a strong family-focused component. Our teacher supervises the patient's school program during morning hours, and serves as a link between the patient's community school for ongoing exchange of information related to their educational program. Patients receive daily meals and snacks with staff support, and they participate in group therapies in the afternoons. All disciplines are involved in the Day Treatment Program, and there is a strong emphasis on patient and family education. The nurse clinician meets with patients and families for several pre-care sessions prior to their joining the Program. Patients stay in the Day Treatment Program for varying lengths of time depending upon their treatment needs and individual achievement of goals.

Outpatient Program : The Outpatient Program provides ongoing medical and dietary assessment and management of patients as well as family and individual psychotherapy. Outpatients also receive nursing support, counseling and education. The services offered are oriented towards helping individuals to gain increased control over their eating difficulties, address problems with self-image and family dynamics, and provide aftercare and relapse prevention for individuals who have undergone more intensive treatment in the Day Treatment or Inpatient programs. The Outpatient Program includes a Parent Support Group.

Inpatient Program : The inpatient program is located on the Adolescent Care Unit at BC's Children's Hospital. The primary goal are medical stabilization and nutritional rehabilitation, provision of psychological support, family counseling, and to prepare patients and families for further treatment within the program or community. An interdisciplinary team, which includes specialized inpatient nursing staff, is involved in helping patients to restore normal metabolic functioning and healthy eating patterns. Patients may be transferred from programs in all regions of the province. Inpatients may begin to attend the Day Treatment Program once they are medically able to do so.

Additional Provincial Services

The Eating Disorders Program at BC's Children's Hospital also provides a range of outreach services, these including community education and training of staff in local eating disorders programs. A telephone consultation service is available to health care professionals who are treating children and adolescents with eating disorders. On invitation from communities around the province,staff may travel to assist in the development of local assessment and treatment services.

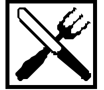
The Program plays a major role as a teaching center. Health care professional trainees from all disciplines, including staff from other agencies, receive specialized training within the Program under the supervision of staff members. The staff provides workshops, seminars, and lectures to a wide variety of groups on understanding eating disorders in children and adolescents as well as aspects of assessment and treatment.

The Program supports research projects in the area of eating disorders as well as promoting the ongoing evaluation of treatment services. Our goal is to ensure that eating disorder patients and their families continue to receive the highest possible standard of care and to increase our understanding of these disorders in children and adolescents.

The BC's Children's Hospital Eating Disorders Program liaises with the Provincial Eating Disorders Steering Committee, the St. Paul's Hospital Eating Disorders Program, and the Eating Disorders Resource Center of British Columbia.

For more information :
Eating Disorder Gate
D4, BC's Children's Hospital, 4480 Oak Street,
Vancouver, BC, V6H 3V4
Tel : (604) 875-2200
Fax: (604) 875-2271

Publication



Prevention of Eating Disorders

Suggested readings by :

Gail McVey, Ph.D.
Ontario Community Outreach Program for Eating Disorders

Books

Adderholdt-Elliot, M. (1987). Perfectionism : What's bad about being too good?. USA : Free Spirit.

Elias, M.J., Tobias, S.E. (1990). Problem-solving/ Decision-making for social and academic success. Washington : National Education Association.

Hipp, E. (1995). Revised and updated Fighting invisible tigers : A stress management guide for teens. USA : Free Spirit.

Schmitz, C.C., & Hipp, E. (1995). Revised and updated Fighting invisible tigers : A stress management guide for teens (Workbook). USA : Free Spirit.

Manuals

The Body Image Coalition of Peel. ***Every Body is a Somebody***. An active learning program to promote healthy body image, positive self-esteem, healthy eating, and an active lifestyle for adolescents (1996). An active learning program to promote healthy image, positive self-esteem, healthy eating and an active lifestyle for female adolescents. Every body is A Somebody provides information and strategies on ways to promote positive body image among teenage girls. The manual has six chapters, each providing background information for the facilitator and lots of activities and worksheets to use with teen participants. The topics included in the manual are :

. Media, Family and Friends
. Self-Esteem and Body image
. Set-Point : The Body's Resistance to Dieting
. Healthy Eating and an Active Lifestyle
. Stress Management
. Relationships

To order : Please make cheques ($29.00) payable to : Body Image Coalition of Peel and mail to

Mary Turfryer
Body Image Coalition of Peel
C/O Peel Health
199 County Court Blvd.
Brampton, Ontario
L6W 4P3
Tel : (905) 791-7800 ext. 2565

Friedman, S.S. (1994). ***Girls in the 90's***. A program to help girls safely navigate the rocky road through adolescence and avoid pitfalls such as eating disorders and the preoccupation with food and weight. Salal Books, 101-1184 DenMan Street, Vancouver, B.C., V6G 2M9

NEDIC (1989) ***Teachers's Resource Kit : A teacher's lesson plan kit for the prevention of eating disorders (Ages 9-12)***

Department of Public Health, Hamilton/ Wentworth Health (1995). ***Getting there is half the fun.*** An active learning program on positive self-image, healthy eating, and active living for pre-teens (grade 6) (Teacher's Guide). " Getting There is Half the Fun! " is a teaching kit of 12 lessons, each containing background information for teachers and student worksheets. There are also take-home materials for parents or guardians and a colourful interactive poster. This resource was developed as part of the Healthy Lifestyles Model Program, funded by the Public Health Branch of the Ontario Ministry of Health. Its purpose is to make the Vitality! message, with its concepts of healthy eating, active living, and positive self-image, relevant to pre-teens. It was developed primarily for teachers, and was written to complement grade 6 curriculum in health, language arts, physical education, and science. Teachers, as well as other professionals and adults working with children, will enjoy using this resource!
Cheque or money order ($20.00) should be made payable to :

Regional Municipality of Hamilton-Wentworth
And sent to :
Nutrition and Physical Activity Promotion Program
Hamilton-Wentworth Department of Public Health Services
P.O. Box 897
Hamilton, Ontario L8N 3P6

Red Deer Regional Health Unit (1993). ***The best you can be***. Body image, healthy eating and healthy weight (Nutritional Resource Manual).
The Best You Can Be helps educators and health professionals address the issues of body image, healthy eating and healthy weight. A wide variety of ready-to-use activity sheets and project ideas are included to help meet teaching objectives and complement Provincial Education Curriculum Guides. Student activities in the Body Image section focus on self-acceptance, self-esteem, external factors that influence body image, the healthy weight concept, and the prevention of eating disorders. Student activities in the Healthy Eating section focus on skill development in food selection for overall and lifelong health. Healthy Eating promotes variety, nutritional balance and food choices which reduce the risk of heart disease, certain cancers, and osteoporosis. Comprehensive Background Information Includes the Following Topics :

. Body Image
. Canada's Guidelines for Healthy Eating
. Obesity in Children
. Canada's Food Guide To Healthy Eating
. Eating Disorders
. Healthy Weight Concept
. Functions of Nutrients
. Osteoporosis
. Nutrition and Your Heart
. Diet and Cancer

Mail to : Red Deer Regional Health Unit, Nutrition Program
2845 Bremner Ave, Red Deer,
Alberta, T4R 1S2
Phone : 341-2160

Manual for	Price :
Grade 1-3 :	$ 28.00
Grade 4-6 :	$ 28.00
Grade 7-9 :	$ 28.00
Grade 10-12 :	$ 28.00
Pkg. of 4 :	$ 100.00
Shipping (per manual) :	$ 2.00

Videos

Get Real (1995). A Canadian video on dieting, peer pressure, coping skills, self-esteem and body image (35 minutes). Produced for adolescent women, the half-hour program promotes a healthy lifestyle, healthy body image and positive self esteem. The program is divided into three segments – MEDIA PRESSURE, STAYING TRUE TO ME and SELF ESTEEM. GET REAL provides young women with an empowering and supportive message and is an excellent tool to stimulate discussion. GIRL COOL – A role model guides the viewer through a decision making process regarding topics like dieting, body image, self esteem, peer and media pressure and coping skills. THE GIRL GROUP – is a group of five young women sharing their thoughts and feelings about these timely issues in a candid way. The audience will be able to identify with the Girl Group because the discussion not only validates their voices and feelings, it also serves as an excellent spring board for dialogue. THE EXPERTS – provide helpful information and practical coping skills to empower young women through the rocky road of girlhood. GET REAL was produced by Heidi Gerber of Transfusion Pictures with the Eating Disorder Program at the Hospital for Sick Children.

Take Another Look (1994). A Canadian video on media and peer pressures adolescents encounter as they become aware of their changing bodies (22 minutes).

Famine Within (1990). Film on the contemporary obsession with body shape and size among North American women (120 minutes or 60 minutes versions).

The three videos distributed by :

McNabb & Connolly/Weston Woods
60 Briarwood Ave
Port Credit, Ontario
L5G 3N6
(416) 278-0566
Fax : (416) 278-2801
Email : mcnabb.connolly@CIMtegration.com

Working with teens in Schools: Moving From a Pathology to a Competency Model

Jan Wiedman, MSW, RSW, ACSW
Clinical Social Worker
Adolescent at Risk Program

Maureen Johnston, B Ed.
Jr. High Teacher/School Counselor

Lionel Dibden, MBBCh, FRCP (C)
Program Director
Adolescent at Risk Program

Introduction

Edmonton is located in the Capital Health Region of Alberta. The region has a population of just over 750,000 people. There are about 53,000 people aged 10 - 14 years and 50,000 aged 15 - 19 years. The school system has separate (Catholic) and public school boards, which have a mixture of 'free standing' Junior High Schools (grades 7 to 9 inclusive) and schools where these grades are attached to elementary schools.

The ***Group Awareness Program*** (GAP) started as a collaborative community project involving the personnel of the Adolescent at Risk Program of the Misericordia Community Hospital, Caritas Health Group, and the counselor from each of two local Junior High Schools. Although differences existed in the two initial locations, a synopsis description of what the Group Awareness Program has become, follows.

Program Description

The Group Awareness Program (GAP) is designed to offer participants an opportunity to experience personal growth through a group process. Within a safe and healthy environment, participants are encouraged to attain their unique potential, and to increase their capacity to experience successes in their lives.

The GAP began operating at one Junior High School at the beginning of 1995 and was initially offered to Grade 9 students. At the beginning of the next school year, it was decided to offer a year seven and year eight group. A mixed grade level group was commenced at another Junior High School in the Fall of 1995.

Driving the need for the GAP was a number of students requiring psycho-emotional assistance who were not accessing this service in the community. Youth who attended the GAP were experiencing difficulties such as depression, family violence, poverty, suicidal ideation, body image issues, low self esteem, separation and loss, eating disorders, relationship difficulties, limited problem solving abilities, sexual assault, at risk for school failure or dropping out, parent-teen conflict, etc; etc.

The group is held weekly for 60 to 90 minute sessions during class time. The preference is for the group to be co-led by a school counselor and 2 trained group psychotherapists (one male and one female). The primary purpose of the therapists in group is to ensure safety for all members; to role model healthy and efficacious behavior; to nurture; to support; to challenge distortions; to be the targets of the transference of group members; and to offer interpretations aimed at providing group members with insights into their worlds and behavior.

Adolescent Development and Adolescent health care

The philosophy of Adolescent Healthcare requires an integrative approach to healthcare, health promotion and negative outcome prevention, which is consistent with the successful com-

pletion of the main tasks of adolescent development, namely: becoming a complete, competent adult with a clear sense of one's own identity and values and being comfortable pursuing an intimate sexual relationship of one's own choosing in an independent fashion.

Adolescent Healthcare is seen as an integrative disciplines which has as its foundation the principle that physical, mental, emotional, spiritual and social health are inseparable. There is considerable advantage to having pediatricians specializing in this discipline as group therapists as they are able, on a weekly basis, to monitor all dimensions of the health of the adolescents they are serving, and to intervene medically when necessary.

Why Have Group and Why in a School?

It is an efficient and effective use of resources to see several students with similar issues at one time.

Group is the preferred modality when working with adolescents as the peer group is all-important at this time of development.

As the school counselor is significantly involved in identifying students with difficulties, having the group in the school allows for ongoing support outside of the group. Since many students present with similar issues, it is a more efficacious use of the counselor's time to deal with them in a group.

It is believed that the school environment, and more specifically the peer environment, offer a greater likelihood that positive changes in participants' day-to-day functioning resulting from the group can be consolidated.

It is also believed that locating the group in the school ensures that potential barriers between the school and community service providers can be avoided through direct access.

School is a place where adolescents gather naturally. Holding group in school depathologizes presenting problems and allows more opportunity to tap into the natural resilience and inherent competencies of these students.

Prerequisites for Group Membership

In order for students to benefit from the group experience, participants need to have a "core of health"; they need to have the capacity to develop insight; they need to be able to function in a group setting; they need to have the capacity for reciprocity; and they need to be able to maintain group confidentiality.

Goals of the GAP

To provide a safe, supportive and nurturing environment where participants are allowed to explore their difficulties and those of their peers and generate insight.

To provide participants with the opportunity to observe and practice healthy, pro-social interpersonal interactions.

To provide alternatives to stereotyped roles and behavior, which may be negatively impacting identity formation.

To assist participants in establishing healthy personal boundaries.

Desired outcomes of the GAP

Improved physical, mental, emotional, social and spiritual health, including appropriate modulation of affect.

Improved school attendance and academic performance.

Increased ability to cope.

Increased ability to trust others appropriately.

A Teacher/Counselor's Perspective on the GAP and its Efficacy

Because at schools teachers are dealing with the "whole" child, staff needs to be cognizant that the adolescent does not attend school in a vacuum. The student brings with him or her the outside world he or she lives in. Outside of school, students engage in social and familial relationships that are a part of their world. Formal schooling

which occurs for 5 1/2 hours a day represents only a portion of a student's existence. Therefore, there is an overlap of the social and familial aspects of a student's world with the school's educational goals for the student.

On occasion, some students experiencing trauma in their lives may need to temporarily set aside our/their educational goals to allow them to recover from and work out the trauma without the added stress of attending and performing adequately at school. To experience success at school, students must be in class; follow the class rules; focus on class material; and put in the required effort to complete required assigned tasks.

For some students, what goes on for them both inside and outside of school interferes with their chances of experiencing success at school. Teachers can help spot some of these students, hopefully early on before problems become entrenched, by being vigilant to the following:

Warning Signs

Attendance
sporadic due to crises which they "must attend to"
suspensions for inability to follow school routines

Hallway
out of class time
student requests to leave class to "sort out" situations with friends
inability to follow staff requests to be in class to do the work necessary for success in school
leaving the school building, after signing out or not, to continue to solve or work on situations with which they feel powerless to cope
numerable "trauma calls" to the school counselor to intervene in their problem situations

Home
the family indicates that there are medical, social, mental and/or emotional problems at home
the family indicates that the student is reacting to past or ongoing trauma

Sometimes, these warning signs indicate a picture where the student is experiencing severe problems and is in dire straits. For some, school may cease to be the best place for them unless and until there is intervention to alleviate the crisis and support them at school. Alternate school placement, intense therapy, and/or alternative living arrangements may be options to consider in these situations.

For students with difficulties who are able to continue on at school, group therapy at school may be the option of choice.

The GAP

Many group members have serious problems in their lives. Their problems are not remote. Their problems affect how they perform and behave in the classroom. In many cases, their problems have been longstanding and perhaps chronic.

Crises can lead to change. The GAP allows members to learn that they are not alone; that there are credential group leaders who will guide the group in its work; and that there are some things that they are able to change and some they are not. The leaders will ensure the group members' protection as far as is possible. What is said in-group is confidential, except when the member may be in danger or when a leader is subpoenaed to court on a matter relating to the member.

We want to empower members to capitalize on the strengths, innate capacities and resilience that they possess to become strong and successful adults.

In the classroom, group members are to follow the class rules and instructions like any other student. Group members require compassionate understanding, not sympathy. They are often angry and fragile individuals who have little regard for or faith in the "big people" in their lives. However, they are still accountable for their behavior. Some of their families are willing to keep the school informed of crises at home - others are not.

Group members are best supported by not "buying into" any manipulation strategies. They may use manipulation or "acting out" effectively as a method of coping in their dysfunctional or stress-filled lives. As teachers, we must try not to personalize the behavior and understand that it often has nothing to do with us but everything to do with what is going on in their lives.

Sometimes, group members have an unrealistic im-

age of the "importance" of certain events or situations in their lives. This may be due to the fact that they see the world through distorted lenses. The intention of the leaders is to assist members to see the world as it really is and to operate in a healthier, more grounded manner.

Frequently, things are brought to the surface in-group and there may be "spill over" into the hallways and classrooms. This is normal and to be expected. Teacher feedback as to how group members are coping is helpful.

By and large, group members are young persons who need to be nurtured and encouraged by the healthy role models in their lives. Saying things like "your smile brightens my day"; "when I see you happy, I know that this is going to be a great class"; "thanks for helping me with ...."; etc., provides the kind of recognition, acknowledgement and affirmation which these students require even more than other students.

Always mindful of the confidentiality of group, attempts are made to keep teachers informed of situations that require careful vigilance, or successes to be celebrated. Teachers make known to the GAP leaders those classroom situations that assist group members to maximize their potential.

Initial GAP Evaluation

The importance of the ongoing evaluation of the GAP is recognized. Over the last academic year (Sept/97 to June/98), an attempt was made to evaluate the efficacy of the GAP. The instrument used was THE PIERS - HARRIS CHILDREN'S SELF - CONCEPT SCALE, developed in 1969 and published by Western Psychological Services, Los Angeles, CA.

The Scale was administered to all group members at the initial group session in Sept/97 and the final group session in June/98. Unfortunately, there were only 5 original group members who completed the Scale in June/98. The results are depicted below in Table 1.
As Table 1 reveals, there was a positive change for the 5 students over the period of time from the beginning to the end of group on the variables measured.

This attempt to evaluate the GAP was a preliminary one. For the next academic year (i.e. Sept/98 to June/99), the GAP will be evaluated at all 5 school sites where it is operating. The instrument that will be used for this evaluation attempt will be THE BASC (SELF - REPORT, TEACHER RATING SCALES AND PARENT REPORTING SCALES) developed in 1992 and published by American Guidance Service, Inc. in Circle Pines, MN.

Conclusion

The philosophical perspective of the resilience and competence of youth, the pragmatic consideration of fiscal efficiency, the 'goodness of fit' of a peer group modality and adolescents and the provision of service by a healthcare/education team, in a school location, seems to have come together as a effective intervention for some youth in the form of the ***Group Awareness program.***

Further evaluation, in a more controlled form, will hopefully show effectiveness, which can be stated with greater conviction than is presently possible.

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Adolescent At-Risk Program
Junior High School
Piers-Harris Self-Concept Scale
Pre and Post Group Mean
Outcome Measures
(n°5)

70
60
50
40
30
20
10
0

T-Scores

Pre-Test
Post-Test

Behavior
Intellectutal and School Status
Physical Appearance and Attributes
Anxiety
Popularity
Happiness and Satisfaction
Total Score

Scales

Key to T-Scores cutofs:
+50 Average
49-40 At-Risk
-39 Clinically Significant

Renewal 99

For those who receives a membership renewal form, please fill it and send it with your contribution as soon as possible.

Please send us your comments and suggestions. They are greatly appreciated for the continuous improvement of the Journal. It is important for those who are editing PRO-TEEN.

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