

Therapy of patients diagnosed with anorexia nervosa treated at an inpatient ward – specificity, rules and dilemmas

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Summary

Aim. The article presents methods of therapeutic work with female patients diagnosed with anorexia nervosa at the Child and Adolescent Psychiatry Clinic.

Methods. The characterized model of therapeutic work has been worked out, corrected and extended for almost 40 years of working with patients. The currently proposed therapy bases on a complementary application of behavioral, cognitive and system approaches within the framework of a group, individual and family therapy and the contract.

Results. The article examines the specificity, rules and dilemmas of working with female patients who both deny being ill and identify themselves with the symptoms.

Conclusions. The author notices that the development of studies concerning eating disorders might be inspiring in terms of further research and presenting the patients with a wider and customized therapeutic offer.

anorexia nervosa / therapy/ adolescent ward

INTRODUCTION

Treatment of anorexic patients is very often a challenge and can be an inspiring experience for therapists and teams working in hospitals or at wards. One of the motivations for sharing my experience in therapeutic work with patients suffering from anorexia nervosa at the inpatient ward was the article describing specificity, rules and dilemmas of the therapy conducted at the Department of Child and Adolescent Psychiatry, CM of the Jagiellonian University in Kraków [1].

The rules of working with patients suffering from anorexia nervosa have a long history

at the Child and Adolescent Psychiatry Clinic of Poznań University of Medical Sciences and their beginnings were empirically worked out nearly 40 years ago when the child and adolescent ward was being formed. During the initial period the work was based on the principles of the behavioral and psychoeducational therapy which next was extended by the cognitive approach and then, during the period of the last 15 years, also by systemic paradigm [2, 3]. We neither try to evaluate the applied therapeutic approaches nor give any of them the prevailing significance. As it stems from our experience, each approach performs a significant and useful role in the therapy of patients diagnosed with anorexia nervosa [4]. However, when taking into account different stages and forms of the conducted therapy different approaches are adopted. During the initial period of hospitalization when the contract is entered we base on the behavioral approach. When the female patient's

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The article has not been aided by any grant.

stay at the ward is continued we apply the cognitive approach within the framework of the individual and group therapy. Eventually, during the final stage of hospitalization, while conducting the family therapy, we work within the scope of the systemic paradigm.

While facing various kinds of difficulties, and also very often failures when working with patients who, in most cases, show no motivation for being treated, we try to implement changes and develop a wider – in a quantitative sense and richer – in a qualitative sense therapeutic offer.

SPECIFICITY OF WORK

At the ward, which has twenty beds, patients suffering from various mental disorders, including eating disorders, are hospitalized. The anorexic patients usually form at the ward a group containing from a few to a dozen or so persons and after having been discharged from hospital they remain under the care of the outpatient clinic for at least 6 months within the limits of which the family therapy is conducted. The patients diagnosed with anorexia form a subgroup which unites quite fast although seemingly. It very often creates the so-called second life, consisting in behaviors which are contraindicated or forbidden because of health reasons and include physical exercises, using laxatives or drinking excessive amounts of liquids before planned weighing. Another manifestation of the specific functioning of the group of anorexic patients is lack of motivation to be treated the basis for which might be both the denial of being ill and the simultaneous acceptance of the symptoms [5, 6]. The clinic's personnel consist of psychiatrists, psychologists, physical therapists, occupational therapists, educators and the team of nursing personnel. The patients diagnosed with anorexia use all the forms of therapeutic activities offered at the clinic including schooling. They also take part in classes carried out only for this group of patients. Additional forms of therapeutic interactions offered only for the anorexic patients include: the behavioral contract, working with the body and the group therapy conducted solely in a group of patients suffering from eating disorders as one of the versions of a group therapy carried out for all the hospitalized patients.

The female patients diagnosed with anorexia nervosa, in spite of similarities characteristic for them, constitute a diverse group. Differences influencing the effectiveness of therapeutic interactions include both the long duration of suffering from a disorder that may cause the consolidation of the symptoms and the adaptation of the patient and her family to the illness. Another factor distinguishing the patients and influencing the effects of the therapy are the functions which can be performed by the symptoms of anorexia in the family and the dysfunctionality of families. An important distinguishing factor that influences the effectiveness of the therapy are personality factors.

The authors of studies carried out in the Department of Child and Adolescent Psychiatry at the Institute of Psychiatry and Neurology in Warsaw distinguish four subgroups of female patients differing in personality pathology which were characterized as subgroups: with perfectionist/dependant personality; with narcissistic personality with resistance; with avoidant personality and well-functioning personality [7].

The research results indicate that the distinguished and described personality traits may influence among others: general functioning, pre-illness adaptation, intensification of depression symptoms, anxiety, compulsions as well as the course and prognosis of an underlying illness.

Summing up their studies the authors notice that the patients with avoidant personality are often identified as schizoid or preschizoid and also more often need to be treated by neuroleptics [7].

On the other hand the studies concerning genetic factors and personality traits in anorexia nervosa carried out by F. Rybakowski at the Child and Adolescent Psychiatry Clinic of Poznań University of Medical Sciences indicate among others that female patients with anorexia nervosa, when compared to a control group differ in personality traits that are measured by the Temperament and Character Inventory (TCI). The TCI is a test used to rate dimensions of personality and was one of the methods used in F. Rybakowski's studies. In the TCI one may distinguish four dimensions of temperament and three scales rating "a character", i.e. character-

istics of personality which are acquired during ontogenetic development [8, 9].

Dimensions of personality distinguished in the TCI are:

1. "novelty seeking" (NS) – defined as a tendency to react actively to novel stimuli.
2. "harm avoidance" (HA) – refers to a tendency to inhibit behaviors in response to negative stimuli.
3. "reward dependence" (RD) – is described as a tendency to maintain a behavior in response to a positive reinforcement.
4. "persistence" (P) – is defined as an ability to maintain independently a given type of activity.

On the other hand, the character scales describe:

1. "self-directedness" (SD) – this dimension describes abilities of a person to control, regulate and adapt their behavior in order to adapt to a given situation.
2. "cooperativeness" (C) – refers to an ability to identify and accept behaviors of others.
3. "self-transcendence" (ST) – defines spirituality and the sense of integration of a person with the universe [8].

The author of studies points out that anorexic patients got significantly higher results in the following temperament scales: "harm avoidance" and "persistence" and a lower result in a character scale: an ability to "self-directedness". Persons with great intensification of "harm avoidance" are characterized by caution, anxiety, pessimism, nervousness, asthenia whereas persons with great intensification of "persistence" are characterized by traits such as: ambition, diligence, perfectionism, persistence in acting in spite of frustration and fatigue. F. Rybakowski indicates that according to a theoretical assumption of Cloninger temperament traits, which are revealed in an early period of life, may permanently influence the development and shaping of a character as well as possible susceptibility to mental disorders [8].

I think that subdimensions of temperament and character in a psychological model of personality which were described by F. Rybakowski

are interesting in a therapeutic context. The distinguished subdimensions of particular dimensions of temperament include among others: cognitive curiosity, impulsiveness, pessimism, fear of uncertainty, social anxiety, fatigability and asthenia, devotion, dependence, perseverance. On the other hand, exemplary subdimensions of particular traits of character are: empathy, understanding, integrated conscience, responsibility, self-acceptance, creativeness or the acceptance of spirituality [8].

The results of the described studies which allow to differentiate traits of adolescent personalities of anorexic patients may become an inspiration to search for various methods of therapeutic work that can be adjusted to the traits of persons ill with anorexia. The analysis of the presented results of studies may induce to put forward new hypotheses in the individual, group and family work in the dynamic, cognitive as well as systemic paradigm.

Forms of therapeutic work:

1. behavioral contract
2. therapeutic community
3. therapeutic work focused on the body
4. physiotherapy with relaxation
5. individual therapy
6. group therapy
7. family therapy

Behavioral contract

The contract is entered into with the parents and the patient after she is admitted to the ward by the doctor who looks after her. The contract with the patient and her family concerns among others planning parents' visits at the hospital, criteria of moving from the so-called close observation to the so-called ordinary observation, going for walks outside hospital premises, preparing meals, the possibility to participate in physical exercises, the date of a hospital pass and also weight criteria referring to discharging the patient from hospital. The first point of the contract is making an agreement with the parents on postponing their visits at the hospital and establishing with them and the patient the amount of weight gain after which parents' visits are possible. It stems from our experience that entering

into this type of a contract performs several important functions that are helpful in treatment. First of all, by the “suspension” of the patient’s meetings with her parents the ambivalent relation between her and the parents is broken off and the time of suspending their contact raises the possibility of gradual rebuilding of the relation daughter–parents without fixation about the subject of food.

Secondly, a desire to get the possibility of contacting parents quickly becomes for the patient one of the main motivations to eat meals.

Thirdly, breaking off not only ambivalent but also very often symbiotic relation between the patient and the parents creates the space for the patient to establish contact with her peers at the ward. On the other hand, the contract concerning the change of the form of observation bases on setting up another stage of an increase in body weight which allows to move from the so called “close observation”, i.e. wearing pajamas to the so called “ordinary observation” based on wearing private clothes by the patient. The aspects of the contract concerning food consist in implementing the so-called “self-preparation” of meals by the patient and the possibility of exchanging food products.

Next stage of the contract, connected with the progressive increase in body weight, refers to the possibility of participating in physical exercises conducted by a physiotherapist. The anorexic patients particularly care about this stage because on the one hand it can create for the patient a subjective “sense of returning to the past” when she exercised and moved a lot and on the other one it can give “hope” to speed up burning calories. Next stages of the contract include establishing the weight criterion connected with the first hospital pass and being discharged from hospital. The execution of the contract includes patients as well as nursing personnel. Without the help of the nursing team it would be difficult for the patients to execute successive stages of the contract.

Therapeutic community

Therapeutic community performs a particular function within the framework of work at the adolescent ward. The specificity of the adolescence period consists in the developmental need of belonging to a group, creating peer coalitions and

taking into account peers’ opinions. That is why the community at the adolescent ward may perform therapeutic functions in terms of the need of integration, identification and acceptance as well as independence, individuation and separation. In the clinic once a week meetings of the therapeutic community take place. During these meetings the council is chosen, that is the chairman and his or her deputy. Within the framework of the community patients co-decide on ways of spending time and perform different types of duties. At the meetings of the community current principles and rules of functioning are established and common problems concerning the stay at the ward are solved. Moreover, at the meetings relations between the patients and the personnel are discussed which seems to be particularly important in order to avoid the suppression of tensions or forming coalitions “against” the personnel and discussing these types of topics during the group therapy.

As it stems from the observation and experience of the author of the article functioning of the therapeutic community at the adolescent ward may be difficult for patients in some cases. These difficulties may stem from the conflict of loyalty experienced by adolescent patients which is connected with the need of belonging and identification with the peer group typical for this age. In situations where the sense of identification and belonging to a group is contradictory with personnel’s requirements or current regulations patients may experience dilemmas connected with the choice: whether to conceal collectively behaviors which are forbidden and at the same time harmful to other patients or raise them at the meeting of the community. Such dilemmas very often concern non-obeyance of one of the points of the regulations which is a ban on smoking cigarettes by the patients on the clinic premises. As far as the patients diagnosed with anorexia nervosa are concerned loyalty dilemmas are connected with harmful behaviors such as overexercising, hiding food or drinking excessive amounts of water before weighing.

Work focused on the body

Specific forms of therapies used with the anorexic patients include the therapy focused on the body. Disturbed body perception and incorrect

experience of functioning of the body schema and the body functioning are one of the symptoms specific to anorexia nervosa. Incorrect body experience may be connected with different factors including among others neurophysiological processes, i.e. perceptual and cognitive aspects. Experiencing one's own body may also be connected with psychological factors such as: the body image, comprehension of boundaries, the attitude to one's own body.

Work with the body is offered to patients during the first days of their stay at the ward. This is a method of work based on the Probst's approach and it has been used by us for fifteen years according to modifications applied by the physiotherapist working in our clinic [4, 10].

The classes are of a group character, conducted by a physiotherapist and filmed, with the patients' consent, by another physiotherapist. The classes include two stages: the first stage comprises dynamic, isometric, respiratory and stretching exercises as well as relational massage, auto massage and examining oneself in the mirror. The aim of the relational massage conducted in pairs is to experience tactile sensations and feelings both as a massaged and massaging person.

The second stage is on the other hand based on watching filmed classes by the patients. During this stage the patients together with a physiotherapist share their observations, reflections and feelings concerning the perception of themselves and other patients. This work very often causes strong emotions connected with confronting the image of one's own appearance – stemming from a disturbance of its perception - with the possibility of seeing one's body from "the perspective of" the spectator of the film.

In the therapy focused on the body, except for exercises and relational massage, visualization of the proper weight is used.

The aim of the therapy focused on the body is correcting the disturbed image of the body and shaping its realistic image as well as developing an ability to experience pleasure connected with the body.

Physiotherapy with relaxation

Physiotherapy and relaxation are forms of classes offered to the patients hospitalized in the

clinic. Relaxation is carried out from the beginning of the stay for all the patients while in the case of the patients with anorexia nervosa the introduction of physical exercises is connected with the behavioral contract concerning weight. The beginning and the scope of implementation of physical exercises are thus contracted individually and every patient knows when she can expect the possibility of taking part in physical exercises. Physical activities are carried out as morning gymnastics as well as gymnastic exercises and team sports at the gym located on the clinic premises. During the first stage of the implementation of gymnastic activities isometric and stretching exercises are offered to the anorexic patients. In the second stage more dynamic exercises are introduced and in the third stage there is a possibility of taking part in team sports at the gym. The relaxation on the other hand takes place twice a week and is conducted mainly as an autogenic training with incidental music and elements of visualization and respiratory exercises. Physiotherapy and relaxation are carried out by a physiotherapist.

Individual therapy

Individual therapy is conducted at the ward by psychiatrists and psychologists mainly in the cognitive approach. The frequency of sessions and the scope of discussed subjects are individually matched and depend both on the patient's needs as well as indications suggested by the attending physician.

In the initial period of hospitalization most frequent conversation topics raised by the patients concern the attempts to convince the personnel of "unnecessary hospitalization" and "the diagnostic mistake". The patients also put forward wishes to renegotiate the entered contract. The patient's need during individual conversations to bring up topics which only concern a subjective sense of health stems from egosyntonicity of anorexia nervosa which manifests itself among others in denying the illness and accepting the symptoms. That is why in the first period of treatment at the ward it is hard to conduct planned therapeutic interactions during individual conversations because the patients' needs make it significantly difficult or impossi-

ble to raise topics differing from their expectations. In a subsequent period of hospitalization, when the patients gradually adjust themselves to the contract, it is possible to conduct a therapy in a more planned and effective way. Within the framework of individual work discussed issues include among others: used defense mechanisms and their possible correction, issues concerning self-esteem and the level of aspiration, fears and anxieties as well as subjects that require additional work besides the group therapy. A relatively new form of individual therapeutic interactions is the cognitive remediation therapy (CTR) which has been implemented for 2 years [11].

The basis for the used method are research and observations of cognitive functioning of the patients diagnosed with anorexia nervosa as well as suggestions concerning declining flexibility along with increasing rigidity of thinking of the patients. It is assumed that the idea of the cognitive remediation therapy training is "plasticizing" cognitive functioning in order to prepare "the cognitive system" of the patient for psychotherapeutic interactions [11, 12, 13]. The set goals of the conducted training are: implementing changes in the way of thinking, motivating the patient to reflect upon her own style of thinking, perceiving the possibilities and limitations of the previous cognitive strategies. Originally, the cognitive remediation therapy allows the patient to learn new cognitive strategies and makes it easier to make decisions and plan actions independently [13].

Group therapy

Group therapy has been conducted at the ward for 20 years. During this period the authorial program has been developed and used in therapeutic work with the anorexic patients. Taking care of the process of individualization and, simultaneously, tendencies to affiliate with the peer group the conducted therapy is associated by the motto: "changes without crossing the borders" [14].

General rules of the group therapy were defined both for the heterogeneous group as well as for the homogeneous one. The aim of the therapy used in both groups of patients is working out problems in a way not to violate the borders of the developing individuation and to strength-

en constructively the process of separation. The group therapy at the ward is conducted with the use of the cognitive method along with the application of techniques such as: an attempt to change automatic thoughts and cognitive reformulation. In psychotherapy of the patients with anorexia nervosa a particular attention is paid to the change of a dichotomous way of thinking and the reformulation of convictions concerning self-esteem. We work using the so called cognitive meta-contents which constitute the interpretation of cognitive schemes and can contribute to fixing disorders [14].

Within the scope of the developed program the following aims of the group therapy have been distinguished for the patients diagnosed with anorexia nervosa: identifying the problem, confronting weight and appearance within the group, working on relations with peers, making the level of aspiration real, improving self-esteem and self-acceptance, balancing profits against losses connected with the illness, visualizing the future, analyzing plans and fears after returning home and to school [14].

While realizing the objectives of the program we begin work from the identification of the problem paying attention to what meaning the fact of being ill with anorexia nervosa has for the patient and what functions the symptoms of the illness perform in the patient's life.

During the group therapy we propose confronting the knowledge and ideas concerning weight and appearance of the patients with the opinions of peers. Despite the fact that the used confrontation does not result in the patient's unconditional acceptance of the peers' opinion it is still very often the first and important factor of the autoanalysis of perceiving one's own body.

On the other hand, work concerning relations with peers is conducted from the angle of two goals. One of the goals is activating resources or acquiring new skills within the scope of establishing and maintaining interpersonal contacts. Another one is the ability to designate the borders of one's own autonomy and independence in a group with elements of assertive behaviors.

While working upon the level of aspiration we pay attention to making the need of achievements real and adjusting it to the abilities of the patient. The patients differentiate also their own

aspirations from expectations and aspirations of their significant others [14, 15].

On the other hand, working on self-esteem is focused on cognition, appreciation and the use of resources and the expansion of the repertoire of roles the patients perform in order to improve their lowered self-esteem. The anorexic patients are characterized by lowered self-esteem and an inadequate image of their own person [16]. Within that scope therapeutic work concerns fuller perception of the image of their own person according to the performed psychosocial roles.

While working on the balance of profits and losses patients, with the help of the group, identify subjective advantages stemming from the illness. It is proposed to look for solutions concerning how to retain advantages and privileges gained through the illness but without the symptoms of anorexia. The next goal of the work concerning the visualization of the future is based on imagining "the split" from the illness and finishing the function as the ill person. Patients visualize their life in the future in two versions: in a version of being healthy and the version of being ill with anorexia nervosa. They also balance limitations and liberties stemming from being ill and healthy. Another stage of work group is the analysis of plans and fears connected with returning home. The probability of achieving goals in the determined time perspective is assessed. Thanks to the support of the group and the possibility of expanding the repertoire of psychosocial roles the patients correct their previous goals connected with achievements. The last stage of psychotherapy is summing up the therapy by the patient and saying goodbye to the patient by the group. The group gives the patient feedback concerning changes in her functioning during the therapy. The patient and members of the group also make prognosis concerning prospects of life without symptoms. The last stage of the therapy is usually looked forward to by the patients because it often provides many individual suggestions and positive reinforcements. Adolescent patients are interested in feedback and the perception of their behaviors by other members of the group. On the other hand, for the patients with anorexia nervosa, for whom, during the period of the illness, school grades are the main emotional gratification, receiving rein-

forcements not connected with school achievements seems to be a significant experience [14].

Group therapy sessions intended for the anorexic patients take place twice a week. Once a week the patients participate in the homogeneous group therapy whereas the second time a week they take part in the therapy of heterogeneous groups. The groups function in an open mode. In the conducted group therapy the following forms of work are used: conversations, psychodramas, psychodrawings, encounter exercises. The classes are conducted by one or two psychologists.

Clinical experiences of the author of the article made it possible to observe how the patients function in homogeneous and heterogeneous groups and thus enabled her to observe pros and cons of both forms of the therapy. Differences concern among others motivation for work and the involvement of the patients with anorexia nervosa, their openness as well as integration or alienation in a peer group. In homogeneous groups the patients provide each other with a lot of acceptance and understanding what makes them feel safer. This is the reason why they discuss their problems more eagerly and with greater involvement. On the other hand, heterogeneous groups show the patients a wider context of social relations and can more effectively model functioning in different social roles. Group psychotherapy of the anorexic patients provides many opportunities of therapeutic interactions with a focus on the need of belonging to a group and identifying oneself with the views of the peer group [14].

Family therapy

The family therapy has been conducted in our clinic in the system approach for several years. For many years therapists worked in a team of four people: two men – psychiatrists and two women – psychologists. The therapy was usually conducted in mixed teams which was beneficial because it allowed to reflect and model among others communication in family subsystems.

However, working in that type of a team was connected with certain dilemmas associated among others with different roles performed by

the therapists at the ward, e.g. a role of an attending physician or a psychologist dealing with diagnostic tests and conducting the group therapy. Because of limited human resources we could not separate the role of a group therapist from the one of a family therapist, thus we cared about not connecting the role of a doctor who was directly looking after the patient with the role of a therapist conducting the family therapy.

At present, as a result of changes in human resources, the therapy is conducted by one system therapist who does not perform any other roles towards the patients. On the one hand, this situation is favorable because the therapist starts the therapeutic work without knowing the patient and her family beforehand which facilitates maintaining impartiality. However, on the other one, it entails certain limitations stemming from conducting the family therapy by one therapist. Nevertheless, unassisted conducting of the therapy does not mean single-person work with the family because due to the possibility of using a see-through mirror a therapist can cooperate with observers of the session. The see-through mirror and the possibility to observe the session by the members of the treatment team, supervisors or people undergoing training have been used in the therapy since it started to be conducted at the ward. However, the possibility to observe the sessions brings certain dilemmas because on the one hand it gives a lot of advantages in therapeutic and training work but on the other one it can influence discomfort or even stress experienced by the families and as a result may limit the freedom of speaking out or openness while discussing problems. The procedure that we use involves informing the families about the method of working with the see-through mirror and the participation of observers behind the pane. Each family is asked whether they give their consent to the participation of observers in the session, they are also informed about who the observers are and have the possibility to meet the persons observing the session. What the author has observed is the fact that only in occasional cases the families did not give their consent to the participation of observers who were the employees of the clinic or interns. The families more often did not agree to have the session observed when the observers were supposed to be students.

In therapeutic work with the patients diagnosed with anorexia nervosa and their families we use different system approaches which include among others transgenerational or narrative ones and match them to the needs and problems of a particular family. The choice of a working model is a result of hypotheses that are put forward and verified one by one. Within the scope of them the illness can be considered among others in the context of bonding, delegating and the idea of making a sacrifice or as a result of a family game [3].

The family therapy is proposed to the anorexic patients at the end of their stay at the ward and just before discharging them from clinic in order to enable the family common functioning. The family comes to the sessions once a month and have the possibility to use six sessions, thus the therapy is continued after discharge from clinic for the next six months.

CONCLUSIONS

Treatment of patients diagnosed with anorexia nervosa is very often a challenge for persons taking care of them. In spite of many years' experience in treatment of anorexic patients at our ward, implementation of changes and widening the therapeutic offer there are patients who return to the clinic. It is not always possible to determine reasons of returning to hospital. But we can assume that they may stem among others from personality traits, fixed lack of motivation to be treated, family situation or functions of the illness which have been impossible to identify.

However, it is optimistic that the described model of therapy turns out to be effective in the great majority of patients both with restricting and binge eating type of anorexia nervosa. In individual and substantiated cases the used program of a therapy also requires additional pharmacological treatment. It refers mainly to patients with schizoid or prepsychotic personality traits or coexisting obsessive-compulsive or depression symptoms [7, 17].

The forms of a therapy described in the article may be questionable or raise dilemmas.

The author of the article puts forward a hypothesis that entering the behavioral contract may raise dilemmas or controversy concerning

among others the limitation of independence and autonomy of the patients diagnosed with anorexia nervosa. However, on the other hand, it can be assumed that executing the contract may provide the patient with a sense of influence and co-deciding on her situation and the duration of her stay at the ward. Executing the contract tends to be hard, especially for the nursing personnel who is directly involved in taking care of regular meals and executing other rules of the contract. Situations connected with eating and controlling may trigger off in patients a transferential and counter-transferential attitude.

Next, conducting the individual therapy implies dilemmas connected with linking the role of an individual and group therapist to the role of a doctor directly taking care of a patient, thus entering and obeying the contract. Linking therapeutic roles might be a factor that makes it difficult to retain impartiality and execute the therapy program.

On the other hand, a family therapist, not being involved in a diagnostic-therapeutic process at the ward, does not perform other therapeutic functions which is conducive to retaining impartiality. It does not, however, make family therapy free from other kinds of dilemmas and doubts, not only in the context of work pertaining to the content but also didactic and organizational one. To sum up, the therapy of anorexic patients is work requiring both a complementary application of different methods and cooperation of members of the treatment team along with simultaneous lack of motivation and cooperation of the patient.

The therapy of patients diagnosed with anorexia nervosa also requires particular attention to avoid violating the patient's dignity when struggling with the egosyntonic illness.

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It is our great pleasure to invite you to attend the 14th ESCAP Congress which will take place in Helsinki, Finland in June 2011. The congress will be organized by the Finnish Society for Child and Adolescent Psychiatry in close co-operation with ESCAP Board. The scientific program will include a broad range of various themes relevant to child and adolescent psychiatry and allied disciplines. The congress intends to cover both medical, psychological, sociological, nursing and educational perspectives on a highest possible level. The joint challenge of professionals working with children who have special needs is to be informed about recent research and how to integrate research into policy and practice. The ESCAP 2011 will be the opportunity to learn and share the most recent knowledge and to meet colleagues from various countries – the possibility to learn, debate and develop. You are cordially invited to Helsinki in June 2011!

Kirsti Kumpulainen, Professor of Child Psychiatry, Congress co-President

Tuula Tamminen, Professor of Child Psychiatry, President of ESCAP

Jorma Piha, Professor of Child Psychiatry, Congress co-President

Ruud Minderaa, Professor of Child and Adolescent Psychiatry, Chair of International Scientific Advisory Board

Invited speaker:

Celso Arango (Spain)
David Coghill (United Kingdom)
James Hudziak (USA)
Miri Keren (Israel)
James F. Leckman (USA)
Marja Makarow (Finland)
Johan Ormel (Netherlands)
Eija Palosaari (Finland)
Andre Sourander (Finland)
Eric Taylor (UK)

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More information about:

Registration fees, cancellation policy, abstract submission please visit website:
<http://www.escap2011.fi/>