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An Occupation-Based Program for the Dual Diagnosis of an Eating Disorder and Post-Traumatic Stress Disorder

by

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of the

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for the degree of

Master's of Occupational Therapy

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Approval Page

This Scholarly Project Paper, submitted by Tessa Larson and Dana Rome in partial fulfillment of the requirements for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

_____
Faculty Advisor

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Date

Permission

Title: An Occupation-Based Program for the Dual Diagnosis of an Eating Disorder and Post-Traumatic Stress Disorder

Department: Occupational Therapy

Degree: Master's of Occupational Therapy

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Acknowledgements

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Abstract

The purpose of this project was to develop an occupation-based occupational therapy program for the dual diagnosis of an eating disorder and post-traumatic stress disorder for use in an outpatient setting. A literature review was conducted to identify the challenges associated with the assessment and treatment of eating disorders and post-traumatic stress disorder. The literature supports the need for occupation-based interventions, especially in the areas of self-care, meal planning and preparation, sleep and rest, leisure, and various life skills. Guided by the Model of Human Occupation in conjunction with cognitive behavioral therapy techniques, an occupation-based program guide was developed. The guide provides structure for group and individual sessions for clients in the occupational areas of self-care, general life skills (management of stress, time, the home, or finances), meal planning and preparation, sleep and rest, leisure, and social exploration. The product is unique in that each activity provides the client with the opportunity to reflect on feelings, beliefs, habits, routines, and self-perception related to occupational performance. This program will guide occupational therapists in the treatment of clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder with the goal of improving quality of life through education and practice of life skills strategies in the context of daily occupations.

Chapter I

Introduction

A high prevalence of post-traumatic stress disorder has been identified among clients diagnosed with an eating disorder (Brewerton, 2007). Approximately 25% of women and 8% of men diagnosed with an eating disorder are also diagnosed with post-traumatic stress disorder (Striegel-Moore, Garvin, Dohm, & Rosenheck, 1999). Occupation-based interventions are needed with this population in the areas of self-care, meal planning and preparation, sleep and rest, and leisure, along with various life skills (Gorde, Helfrich, & Finlayson, 2004; Lock & Pépin, 2011). All areas of occupation, as outlined in the Occupational Therapy Practice Framework (AOTA, 2008), are negatively impacted. Both diagnoses experience physical and psychosocial limitations. Decreased engagement in social, occupation, and work areas are commonly seen and cognitive impairments such as decreased memory and attention coupled with feelings of worthlessness or guilt further combine to decrease engagement or socialization (Lock & Pépin, 2011). The process of occupational therapy treatment for both diagnoses are similar as interventions utilized include individual and group treatments targeted at developing healthy coping skills and managing present symptoms (Gorde, Helfrich, & Finlayson, 2004; Lock & Pépin, 2011).

The product developed is an occupation-based occupational therapy program to be used in an outpatient setting. This product was designed to guide the treatment of the dual diagnosis of an eating disorder and post-traumatic stress disorder. The Model of

Human Occupation is a suitable model for treatment of the dual diagnosis of an eating disorder and post-traumatic stress disorder because of its focus on habits, roles, and the motivation for occupational performance (Kielhofner, 2008). The Model of Human Occupation was utilized to guide the development of this program and was chosen because of the focus it places on a client's behaviors and the motivation and habits which are underlying these behaviors. All daily activities are performed in an environment which has an impact on occupational performance.

Cognitive behavioral therapy is useful as a framework for changing thoughts in order to develop positive feelings and actions (National Association of Cognitive Behavioral Therapists, 2007). The Model of Human Occupation and cognitive behavioral therapy are useful in the formation of habits that support occupational performance. Effective habits reinforce a normal schedule leading to increased occupational performance and decreased fatigue which protects the client from other effects of stress (McColl, 2002). Additionally, while there is limited research on the evaluation, assessment, and treatment of clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder, it has been found that cognitive behavioral therapy is often utilized to highlight the impact that irrational thought processes have on behaviors and feelings. This theory was integrated into the product in order to encourage self-reflection and focus on the adaptation of maladaptive behaviors.

This document is broken into five chapters. Chapter two includes the literature review which provides information regarding the diagnoses of an eating disorder and post-traumatic stress disorder including lifetime prevalence in the general population, the criteria for diagnosis, and deficit areas. Also discussed is the occurrence of the dual

diagnosis and correlations between the two disorders. Occupation-based intervention is described in relation to how these interventions support and promote recovery. Additionally, the Model of Human Occupation is discussed in detail, including how it can be utilized to guide treatment and why it is appropriate for use with this dual diagnosis population. Chapter three provides an outline for how the literature review was used to inform the development of the activities and how the program was set up for use in an outpatient setting. Chapter four is the final product which includes three main sections: referral, evaluation, and activities. The activities section is further separated into five areas of focus: Self-Awareness, Life Skills, Meal, Self-Care, and Leisure and Social Exploration. The activities within these sections were developed to have a cognitive behavioral focus as well as occupation-based aspects so that the client can easily transfer the skills learned into their own lives and recovery. Finally, chapter five summarizes the product development, the strengths and limitations of the product, and areas for further implementation and development.

Chapter II

Literature Review

Eating Disorders

An eating disorder is marked by an extreme disturbance in the habits related to eating. A person may have extremely reduced intake or consume vast quantities of food. Eating disorders have biological, behavioral, and social components which make them a multifaceted disorder and difficult to approach in treatment. It is common for an eating disorder to occur in combination with psychiatric disorders, such as mood or anxiety disorders and substance abuse (National Institute of Mental Health, 2009).

There are three categories of eating disorders: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified. Anorexia nervosa is characterized by refusal to maintain a minimally accepted weight while bulimia nervosa consists of recurrent episodes of binge eating followed by inappropriate behaviors to prevent weight gain (American Psychiatric Association, 2000). Both disorders are accompanied by a skewed perception of body shape or size. In addition, eating disorder not otherwise specified is a third category for those whom do not meet criteria for anorexia nervosa or bulimia nervosa (American Psychiatric Association, 2000).

Eating disorders are common with statistics showing that more than ten percent of women may suffer from some form of an eating disorder within their lifetime (American Psychiatric Association, 2000; Kloczko & Ikiugu, 2006). The Adolescent Medicine Committee ranks eating disorders as third among the most common chronic illnesses

affecting the adolescent female population (Kloczko & Ikiugu, 2006). The female to male ratio of the diagnosis of an eating disorder is 10:1 (Singlehurst, Corr, Griffiths, & Beaulieu, 2006; American Psychiatric Association, 2000). While eating disorders most commonly impact women, "men and boys account for an estimated 5 to 15 percent of clients with anorexia or bulimia an estimated 35 percent of those with binge eating disorder" (National Institute of Mental Health, 2009, p. 3). The National Institute of Mental Health (2009) reports males and females are equally impacted by binge eating disorder. While males experience similar signs and symptoms as their female counterparts, they are less likely to be diagnosed with anorexia nervosa which is commonly perceived as an exclusively female disorder. Males account for one in four cases of anorexia nervosa in the preadolescent population (National Institute of Mental Health, 2009). Eating disorders most commonly occur within the adolescent and young adulthood years of life, although development during childhood or later adulthood is possible (Lock & Pépin, 2011). In the late adolescent and young adulthood years many environmental changes are seen as this marks the time when many people enter into a new level of education. The change of environment, whether into high school or a collegiate level establishment, can bring on new demands and greater expectations increasing the risk for the development of an eating disorder (Lock & Pépin, 2011).

The etiology of an eating disorder is often complex and multifactorial and can stem from social and societal demands, negative self-perception, and daily pressures with familial and cultural influences (Kloczko & Ikiugu, 2006, Lock & Pépin, 2011). Environmental stressors and genetic or biologic components can also play a role in the development of an eating disorder. One biologic component currently being studied is the

role of serotonin because of its contribution to the development and maintenance of the cycle of eating disorders. Serotonin dysregulation is brought on by a variation in the levels of serotonin present in the body, as well as a change in how serotonin is used by the body. This can impact the development of an eating disorder (Lock & Pépin, 2011). Dieting is a component of most eating disorders and contributes to further decrease serotonin levels, which in turn increases the symptomology of eating disorders. Variations in serotonin levels influence personality traits commonly seen in those with an eating disorder, such as impulsivity and perfectionism. History of a traumatic experience, like abuse, can also be a contributing factor in serotonin dysregulation (Lock & Pépin, 2011).

Genetic components have also been identified in the vulnerability for the development of an eating disorder. Children are at greater risk for development if they have a parent who has dealt with an eating disorder. Twin studies have shown a genetic connection of an increased risk in the development of an eating disorder. Bulimia nervosa was found to have an occurrence rate of 26% in monozygotic twins where both develop the disorder and even higher rates in anorexia nervosa of 35% (Lock & Pépin, 2011). Also, family dynamics have an impact on the development of an eating disorder as characteristics of abuse, violence, excessive control, rigidity, or protectiveness seen in a parent, as well as perpetual negative views of appearance or dieting are examples of unhealthy dynamics.

Societal components and pressures to be thin can further influence the development of an eating disorder. The media often promotes images of thin women and Western society reinforces these ideals by placing an emphasis on being thin. Thinness is

associated with happiness and being successful, while being heavy is looked upon as laziness, which can lead to being looked over or alienated in society (Lock & Pépin, 2011). If an individual has low self-esteem, societal pressures can influence body dissatisfaction and trigger feelings of inadequacy, leading to the development of an eating disorder. Early in the progression of an eating disorder, changes in an individual's body are often commented on as a positive development by those around them. This reinforces attitudes towards and behaviors associated with the eating disorder. An individual may establish ways to continue the weight loss and develop obsessive thoughts about maintenance of their appearance, which furthers cognitive distortions of their body (Lock & Pépin, 2011).

Predisposing factors contribute to an individual's vulnerability for the development of an eating disorder. Personality characteristics, including presence of an anxious or insecure personality, influence the development of secure attachments and individualization (Lock & Pépin, 2011). Low self-esteem, negative self-image, and lack of meaningful relationships are significant factors which lead to a susceptibility to an eating disorder (Lock & Pépin, 2011). All of these factors influence an individual's development and the impact of an eating disorder differently.

Anorexia Nervosa. Anorexia nervosa is a complex and multifaceted condition in which a person demonstrates a skewed perception of their body image or self-concept and an intense fear of weight gain (American Psychiatric Association, 2000; Kloczko & Ikiugu, 2006; Lock & Pépin, 2011). This disorder is identifiable by emaciation, the result of a pursuit for thinness, and refusal to maintain a minimally acceptable weight (National Institute of Mental Health, 2009). Associated with a reduction of food intake and even

restriction of diet to a few foods, anorexia nervosa is a disorder in which control over food and eating becomes an obsession. A person often partakes in counting calories, exercising excessively, or isolating themselves to permit eating behaviors to continue (American Psychiatric Association, 2000; Lock & Pépin, 2011; National Institute of Mental Health, 2009).

There are two significant subtypes within the diagnosis of anorexia nervosa which are determined by whether purging behaviors are present or absent. The restricting subtype of anorexia nervosa presents as weight loss achieved through the restriction of food intake, the use of dieting pills, and/or exercise. The binge-eating/purging subtype is characterized by the regular occurrence of food binges, purging, or the co-occurrence of both. Individuals that binge on food are seen to utilize methods of weight loss including purging through the use of laxatives, diuretics, enemas, self-induced vomiting, or through increased exercise (American Psychiatric Association, 2000; National Institute of Mental Health, 2009). While consumption of large quantities of food is a common characteristic of the binge-eating/purging subtype, not all individuals binge eat. Individuals may be observed to purge regularly after eating, regardless of the quantity of food consumed (American Psychiatric Association, 2000). Individuals with anorexia nervosa are divided fairly evenly between the two subtypes with each accounting for roughly half of anorexic individuals (Lock & Pépin, 2011).

Anorexia nervosa is believed to occur more frequently within industrialized societies due to the availability of food, as well as the perceptions that are held by members of these societies about thin figures correlating with beauty (American Psychiatric Association, 2000). The onset of anorexia nervosa is rarely observed to occur

prior to puberty though it is believed that onset in early adolescence may have a better prognosis than an onset which occurs later in life (American Psychiatric Association, 2000). Since development of anorexia nervosa generally occurs during adolescence, it can be difficult to distinguish development of this disorder from typical growth and development patterns (Lock & Pépin, 2011).

The lifetime prevalence of anorexia nervosa is about 0.5% among females and has demonstrated an increase from past decades (American Psychiatric Association, 2000). Peak age of occurrence for this disorder is between 15 and 19 years of age with the typical span of onset being 14 to 25 years of age. Onset in an age after adolescence is beginning to be more common and as many as 5% of those with newly developed anorexia nervosa are older than 25 years (Lock & Pépin, 2011). Death is a severe consequence of this disorder and, compared to the unaffected population, individuals with anorexia nervosa have been found to have a lifespan that is an estimated 25 years shorter (Lock & Pépin, 2011).

Many physical complications are observed in relation to anorexia nervosa as a direct consequence of restricting food intake and/or purging behaviors (American Psychiatric Association, 2000). Common complications include heart irregularities, bradycardia, abnormally low blood pressure, hypothermia or a lower than average body temperature, lethargy or excess energy, cognitive slowness, constipation, abdominal pain, edema, permanent changes in bone density or osteoporosis, hair loss or development of lanugo, and dry skin (American Psychiatric Association, 2000; Kloczko & Ikiugu, 2006; Lock & Pépin, 2011). In postmenarchal women, amenorrhea is experienced following extreme weight loss, while in young girls the start of menstruation will become delayed

(American Psychiatric Association, 2000). For those with associated purging behaviors, there may also be evidence of anemia, decreased renal function, osteoporosis, and dental enamel erosion from acid encountered through vomiting (Kloczko & Ikiugu, 2006). While the majority of health problems will improve or resolve once a person begins to follow healthy eating habits, some have lasting effects on health. Osteoporosis is an irreversible complication commonly seen as a result of poor nutrition (Kloczko & Ikiugu, 2006).

Anorexia nervosa commonly presents with a lack of insight, misperception, or denial of the disorder, decreased self-perception and body image. During an assessment period, it can be beneficial to include family members or outside sources, as the client may be an unreliable historian. Utilizing sources other than the client can help a clinician gather information regarding the amount of weight loss, the length of the illness, and the individual features of this disorder (American Psychiatric Association, 2000). Features making this diagnosis difficult to treat include ambivalence of the client and self-destructive and manipulative behaviors all of which hinder the building of a therapeutic relationship between the client and the therapist (Orchard, 2003).

Bulimia Nervosa. Bulimia nervosa is defined as recurrent episodes of binge eating followed by inappropriate actions in order to prevent weight gain. A binge episode consists of the consumption of large quantities of food in a short length of time with the individual experiencing a lack of control in their eating (American Psychiatric Association, 2000). These behaviors must occur two times a week for three months to fit the criteria for this diagnosis. Bulimia nervosa is believed to take origin within a person who experiences dissatisfaction with their body and has an unrealistic concern about the

size and shape of their body (Kloczko & Ikiugu, 2006). This dissatisfaction can lead to low self-esteem, feelings of helplessness, and a fear of becoming fat. The lifetime prevalence of bulimia nervosa is about 1 – 3% among females (American Psychiatric Association, 2000; Henderson, 1999). An intense fear of becoming fat leads to unhealthy eating habits, which often include obsessions related to the consumption of food, weight, and/or physical shape and participation in excessive exercise. Misperceptions of body image and shape continue even after the weight is lost (Kloczko & Ikiugu, 2006)

Physical complications related to bulimia nervosa include dental malformations, dangerous fluctuation in body fluids and minerals, inflammation of the stomach and esophagus, and possible sudden death. (Kloczko & Ikiugu, 2006)

Eating Disorder Not Otherwise Specified. Eating disorder not otherwise specified is a category within the DSM-IV-TR for dysfunctional behaviors in eating that do not fit within the diagnostic criteria for either anorexia nervosa or bulimia nervosa (American Psychiatric Association, 2000). Individuals that have symptomology similar to anorexia nervosa, such as a recent, significant weight loss, but present with a weight in the normal range or a lack of amenorrhea would fall into the category of eating disorder not otherwise specified (American Psychiatric Association, 2000).

In addition, if an individual fits most criteria for bulimia nervosa but binge eating episodes occur less frequently than the diagnostic criteria dictates or the individual utilizes unhealthy strategies to maintain weight after consistently consuming small amounts of food without the occurrence of a binge episode, he or she falls into the category of eating disorder not otherwise specified. Individuals in this category may also

be seen chewing and spitting out great amounts of food while not swallowing the food (American Psychiatric Association, 2000).

Binge Eating Disorder. Binge eating disorder is a recently identified disorder. Found in the DSM-IV-TR (American Psychiatric Association, 2000) as a proposed disorder warranting further study, binge eating disorder falls within the category of eating disorder not otherwise specified. Binge eating disorder is defined as episodes of binge eating with associated impaired control of food intake. With this disorder, the individual has significant distress related to the episode but behaviors to prevent weight loss are not present, making binge eating disorder a separate disorder from bulimia nervosa (American Psychiatric Association, 2000). While inappropriate coping behaviors, such as the use of laxatives, exercise, and self-induced vomiting may be used, these strategies are not employed consistently following the consumption of food. Under the criteria for binge eating disorder, a binge eating episode is defined in the same manner as the criteria for bulimia nervosa (American Psychiatric Association, 2000). In order to follow proposed criteria for binge eating disorder, episodes of binge eating must occur two days a week for a minimum of a six month duration. In a variation from bulimia nervosa criteria which defines binge eating by the number of episodes, individuals with binge eating disorder may have difficulty defining episodes, so it is suggested criteria be based on the number of days in which binge eating occurs (American Psychiatric Association, 2000).

An individual with binge eating disorder is observed to have impaired control of eating habits, often eating far beyond the feeling of being full or when he or she is not hungry (American Psychiatric Association, 2000). There is a positive correlation between

the frequency of binge eating disorder and degree of obesity in an individual (First & Tasman, 2004). Accompanying the disorder, an individual often has embarrassment over the amount of their eating, leading to social isolation and eating alone. Also observed in those with binge eating disorder are negative beliefs or emotions about themselves, including feelings of disgust, guilt, depression, and concerns about their weight and shape (Singlehurst, Corr, Griffiths, & Beaulieu, 2007). Unlike anorexia nervosa and bulimia nervosa, the population affected by this diagnosis includes a greater percentage of men (First & Tasman, 2004). Some studies have indicated that the occurrence ratio of women to men is 1:1.5 as compared to the 10:1 ratio associated with anorexia nervosa and bulimia nervosa (First & Tasman, 2004) while the National Institute of Mental Health (2009) states that men account for approximately 35 percent of those with binge eating disorder. The difference in occurrence ratios demonstrates the need for further research.

Since little research has been done on binge eating disorder, there is limited information on the impact the disease has on function in daily life (Singlehurst, Corr, Griffiths, & Beaulieu, 2007). An individual's self-cares may be neglected, struggles may be evident with productivity, and leisure can become limited (Singlehurst, Corr, Griffiths, & Beaulieu, 2007). These areas may suffer as individuals with binge eating disorder hold very high expectations for themselves, in addition to negative views about their abilities. These beliefs may make individuals feel as if they can't reach future goals or are worthless in their productivity in all areas of life (Singlehurst, Corr, Griffiths, & Beaulieu, 2007). Negative or skewed self perception may make them feel unlovable or inferior to others. Individuals with binge eating disorder may also fear they are being

manipulated by those around them, which can lead to isolation (Singlehurst, Corr, Griffiths, & Beaulieu, 2007).

Singlehurst, Corr, Griffiths, and Beaulieu (2007) investigated binge eating disorder through the use of self-administered questionnaires and diaries. Many participants reported engaging in activities as a distraction from their dysfunctional eating habits including exercise (attending the gym, swimming, walking, and meditating). Other participants reported using support groups and hobbies (Singlehurst, Corr, Griffiths, & Beaulieu, 2007). Preoccupations with food and eating, as well as body image have a negative impact on engagement in occupation and relationships. Specifically, poor body image seemed to be exacerbated on days in which binge eating occurred (Singlehurst, Corr, Griffiths, & Beaulieu, 2007). Participants reported feeling as if they were an embarrassment to those in their life, leading to isolation and lack of participation in social events. One participant reported that binge eating disorder was "an isolating disease. I did not want to see or spend time with anyone. I used to send my partner out so I could sit and eat in peace" (Singlehurst, Corr, Griffiths, & Beaulieu, 2007, p. 498) while another said "I avoid eating out and seldom invite people to my home for meals. I like to eat in private" (Singlehurst, Corr, Griffiths, & Beaulieu, 2007, p. 498). Many participants reported receiving recurrent negative comments from family and friends, which increased their avoidance of occupations and impacted the relationships they formed. These cycles have negatively impacted the emotional, social, and sexual well-being of the participants (Singlehurst, Corr, Griffiths, & Beaulieu, 2007).

Preoccupation with food is another aspect of binge eating disorder that directly impacts occupational engagement. Many decisions made by an individual relate to an

activity and the environment that allows access to food in a manner which is comfortable to them. Singlehurst, Corr, Griffiths, and Beaulieu (2007) reported that individuals avoided situations not related to food and instead planned daily activities around the presence of food. This preoccupation with food leads to loss of functional skill because of disrupted participation in previous occupations (Singlehurst, Corr, Griffiths, & Beaulieu, 2007).

Prognosis. One of the most important factors towards recovery from an eating disorder is the duration of the illness. There appears to be a better prognosis associated with a younger onset of an eating disorder. Recovery from anorexia nervosa is viewed to be more difficult when the individual additionally struggles with a comorbid psychological disorder (Lock & Pépin, 2011). Similarly, bulimia nervosa has a poorer prognosis when other psychological diagnoses are present, such as depression, mood disorders, or substance abuse, as well as the presence of impulsive behaviors which are not seen in anorexia nervosa. Another factor impacting successful resolution of an eating disorder is the significance that each person places on their weight loss. Having a high value for weight loss can negatively impact the desire to change. In addition, the more treatment an individual has received in the past negatively contributes to an individual's recovery due to poorer outcomes with a longer duration of illness (Lock & Pépin, 2011).

In anorexia nervosa, approximately 40 – 50% of individuals will recover fully and maintain a healthy weight, 30% will demonstrate improvement in their disorder but will still experience fluctuating weight and menstruation, and 20% will continue to have severe symptoms in which a healthy weight is never reached (Lock & Pépin, 2011). Of those individuals who continue to have severe symptoms, 5 – 20% will ultimately die

from the disorder. Bulimia nervosa has similar statistics with approximately 50% of individuals recovering fully, 30% demonstrating improvement, and 20% with persistent and severe symptoms (Lock & Pépin, 2011).

Problem Areas. There is limited research on the impact of an eating disorder on daily activities. Individuals with an eating disorder generally face problems in all areas of their daily routines and lives. Main areas that may be impacted include the areas of self-care, productivity, and leisure (Singlehurst, Corr, Griffiths, & Beaulieu, 2006; Henderson, 1999). The occupation of work may also be impacted by an eating disorder as undernourishment and preoccupation with food can lead to diminished concentration or health problems that limit participation. Decreased energy also impacts the participation in social activities with others as well as impairs interest and engagement in leisure activities (Kloczko & Ikiugu, 2006). Eating disorders can also create the desire for isolation from family and friends in order to keep eating habits secret or maintain control over situations (Kloczko & Ikiugu, 2006; Singlehurst, Corr, Griffiths, & Beaulieu, 2006).

Treatment of an Eating Disorder. Treatment of an eating disorder must be holistic and address the relationship between the physical, cognitive, and emotional aspects of the disease (Kloczko & Ikiugu, 2006). Treatment is offered in a variety of settings, including inpatient, outpatient, partial hospitalization, and community-based settings. Severity of the disorder and related health concerns dictate which setting will be appropriate for a client's treatment. The treatment of an eating disorder generally takes a multidisciplinary approach with physicians, nursing, psychologists, occupational therapy, physical therapy, and family member involvement (Lock & Pépin, 2011). Treatment often includes support groups, individualized therapy treatment focused on symptom

management and body acceptance, stress management, and the development of life skills (Lock & Pépin, 2011).

When treating a client with anorexia nervosa, there are three main focuses for team members to consider and address: body weight, psychological concerns, and present behaviors or thoughts. In multidisciplinary settings, treatment often includes psychological and medicinal treatment (National Institute of Mental Health, 2009). Medical staff, such as physicians and nurses, are involved with overseeing the medical treatment and stabilization of clients with health concerns. Physicians may prescribe selective serotonin reuptake inhibitors (SSRIs) or other antidepressants to address comorbid diagnoses. Physicians may also oversee the initial evaluation of an individual, admit them into the hospital for treatment, and order therapy services. A dietician or nutrition specialist is generally involved in addressing and creating meal plans for an individual to follow in order to reach a healthy weight (National Institute of Mental Health, 2009). An occupational therapist may be involved in monitoring weight gain or loss through the use of the body mass index (BMI). This measurement tool uses calculations related to weight and height to determine a BMI score demonstrating where a client falls along a spectrum that spans from underweight to obesity (Sadock & Sadock, 2008). In order for occupational therapy to be effective, it is important for a therapist and client to build trust in one another, which supports communication and cooperation crucial to the development of a healthy lifestyle (Kloczko & Ikiugu, 2006).

Post-Traumatic Stress Disorder

Post-traumatic stress disorder is an anxiety disorder that occurs following a traumatic experience. Sadock and Sadock (2008) define post-traumatic stress disorder as

"a condition marked by the development of symptoms after exposure to traumatic life events. The person reacts to this experience with fear and helplessness; persistently relives the event; and tries to avoid being reminded of it" (p. 258). Mulvihill (2005) defines post-traumatic stress disorder as "an acute response to a catastrophic stress in which the person has an intense emotional response such as panic, terror, grief, or disgust" (p. 117). Post-traumatic stress disorder can result from traumatic experiences such as any form of abuse, witnessing a crime, or being involved in a severe accident. Individuals may have symptoms of post-traumatic stress disorder but must meet specific criteria in order to receive the diagnosis.

The American Psychiatric Association (2000) outlines criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) for the diagnosis of post-traumatic stress disorder. According to the criteria, the individual must be exposed to a traumatic event and present with a response of intense fear, helplessness, or horror. Individuals also persistently re-experience the trauma through recollections, dreams, feeling as if the event is recurring, or increased symptomology when exposed to aspects similar to the traumatic event (American Psychiatric Association, 2000). There must also be repeated avoidance of stimuli related to the traumatic event such as avoiding thoughts, feelings, places, or people, experiencing an inability to recall certain aspects of the trauma, decreased interest in meaningful activities, or a feeling of doom towards the future (American Psychiatric Association, 2000). The occurrence of symptoms of persistent increased arousal, such as difficulty falling asleep, irritability, difficulty concentrating, or an exaggerated startle response must also exist (American Psychiatric Association, 2000). Symptoms must last more than

one month and have a considerable effect on social, occupational, or other areas of functioning for a diagnosis (American Psychiatric Association, 2000).

The symptomology of post-traumatic stress disorder often limits participation in activities of daily living, work, or social activities. This limited participation may cause increased symptoms and negative effects on successful function in daily life. Symptoms or effects of post-traumatic stress disorder may include feelings of guilt, rejection, or humiliation; hallucinations; illusions; and impaired memory or attention (Sadock & Sadock, 2008). Other symptoms include "impulsivity; distractibility and attention problems; emotional numbing; social avoidance; dissociation; sleep problems; aggressive play; school failure; and regressed or delayed development" (Mulvihill, 2005, p. 120).

The lifetime prevalence of post-traumatic stress disorder in the normal adult population is approximately 8% (American Psychiatric Association, 2000). Mulvihill (2005) reported that "75% of the population has experienced severe trauma, but only 7.5% have suffered PTSD" (p. 118). Repeated exposure to traumatic experiences causes sensitization of the nervous system causing the nervous system to be activated by decreasingly intense stimuli (Mulvihill, 2005). A traumatic experience is defined as exposure to an extremely stressful situation (Mulvihill, 2005). This may include violence, abuse, or a life-threatening illness or situation.

Many factors predispose an individual to the development of post-traumatic stress disorder. Bisson (2007) discussed predisposing factors of post-traumatic stress disorder, including a previous psychiatric disorder, lower socioeconomic status, lack of education, minority status, previous trauma, presence of a family psychiatric history, female gender, the severity of the traumatic experience, lack of social support, and life stress. Many of

these factors cause individuals to be susceptible to or at an increased risk of being exposed to a traumatic experience that leads to post-traumatic stress disorder.

One major predisposing factor for post-traumatic stress disorder is being exposed to childhood trauma. Mulvihill (2005) looked at childhood trauma and the resulting post-traumatic stress disorder. He defined childhood trauma as "a form of an extreme stressor, including events such as natural disasters, motor vehicle accidents, life threatening illnesses and associated medical procedures, physical abuse, sexual abuse, domestic or community violence, kidnapping, or death of a parent. These events pose an actual or perceived threat to the child and thereby activate an extreme stress response" (p. 117). Childhood trauma has a major influence on the development of post-traumatic stress disorder and can play a large part in treatment of the disorder and related symptoms. Kjorstad, O'Hare, Soseman, Spellman, and Thomas (2005) found that symptoms of post-traumatic stress disorder had negative effects on social behaviors during play. Children often had difficulty controlling their levels of aggression and temper, as well as had a decreased frustration tolerance (Kjorstad, O'Hare, Soseman, Spellman, & Thomas, 2005).

Another predisposing factor for the development of post-traumatic stress disorder is the presence of domestic violence. Gorde, Helfrich, and Finlayson (2004) studied symptoms of trauma in domestic violence victims and they also looked at deficits in life skills within this population. The participants were separated into three groups based on their living situation: an emergency shelter, a transitional program, or a community group. All three groups were asked to rank their top four priorities for themselves and their top two priorities for their environment. The priorities these three groups had in

common included: financial management, participating in leisure activities, and having a place to live and perform self-care tasks. In addition, the emergency shelters and community groups both identified working toward goals as being important to them. Self-expression was identified as a high priority for the transitional housing and community groups. Self-care was also identified as an importance by the emergency shelter and the transitional housing groups. Other high priorities for the emergency shelter group include taking care of others and having a place to be productive through work, study, and volunteerism. The transitional housing group identified "places where I can go and enjoy myself" and "people who support and encourage me" as a high priority, while "having the opportunity to do things I value and like" was a priority of the community group (Gorde, Helfrich, & Finlayson, 2004, p. 700). These findings show a need for post-traumatic stress disorder treatment that addresses fulfilling the basic needs of food and shelter, as well as securing a source of financial income and participation in leisure activities.

Women and children who have experienced domestic violence or another form of trauma often develop symptoms of post-traumatic stress disorder that impact their function in daily life. Gorde, Helfrich, and Finlayson (2004) support the need for life skills training for women who have experienced domestic violence or another trauma or related post-traumatic stress disorder. Due to the lack of housing in this population and symptoms related to exposure to trauma, individuals who experience domestic violence often have a high level of distress. An unstable living situation may also increase symptoms of distress related to a previous traumatic experience (Gorde, Helfrich, & Finlayson, 2004). The women expressed numerous deficits in life skills and a need for

interventions to restore function in daily life (Gorde, Helfrich, & Finlayson, 2004). Life skills training is used to increase knowledge, self-esteem, and independence in daily life.

Individuals with post-traumatic stress disorder often have difficulty functioning in their everyday life. Problem areas for those with post-traumatic stress disorder often include self-care, work, or leisure activities, cognition, or psychosocial aspects of the individual (Reed, 2002). A wide variety of treatment interventions are available to relieve symptoms of post-traumatic stress disorder. Brewerton (2007) proposed that the most effective treatment options for post-traumatic stress disorder include cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT). Both of these treatments have proven to be effective in the treatment of post-traumatic stress disorder. These interventions are also effective when used together. Brewerton (2007) reported that certain aspects of each intervention seem to be more effective than others, depending on the needs of the client.

The National Association of Cognitive Behavioral Therapists (2007) defines CBT as a brief form of treatment based on the idea that thoughts affect feelings and actions. The client is usually involved in approximately 16 structured and educational sessions that assist in the development of rational thinking patterns (National Association of Cognitive Behavioral Therapists, 2007). Cognitive behavioral therapy has proven to be effective in the treatment of post-traumatic stress disorder symptomology. Ehlers, Clark, Hackmann, McManus, and Fennell (2005) developed a CBT program for the treatment of post-traumatic stress disorder. They found that cognitive behavioral therapy reduced symptoms of depression, anxiety, and disability related to post-traumatic stress disorder. The program focused on reliving and thinking through the trauma, identifying triggers

and coping with re-experiencing the trauma, and allowing themselves to re-experience the trauma without experiencing anxiety or other symptoms (Ehlers, et al., 2005; Blanchard, Hickling, Devineni, Veazey, Galovski, Mundy, & Buckley, 2003; Foa & Rothbaum, 1998; Gillespie, Duffy, Hackmann, & Clark, 2002). Follow-up at 6 months with this program showed that the participants had maintained their recovery well (Ehlers, et al., 2005).

One form of cognitive behavioral therapy treatment is trauma-focused CBT, a program often used with children who have been in an abusive situation or experienced some form of trauma. Deblinger, Mannarino, Cohen, Runyon, and Steer (2010) define trauma-focused CBT as "a treatment approach that incorporates separate individual sessions for the child and the non-offending parent along with conjoint parent-child sessions" (p. 68). This type of treatment can be used in the adult population as well. Bisson (2007) reported that trauma-focused CBT is the most researched intervention in the treatment of post-traumatic stress disorder. Treatment generally includes telling a narrative about the trauma and exposure to the trauma (Deblinger, et al., 2010). Other interventions included in trauma-focused CBT involve education on relaxation strategies and occurring symptoms and strategies to relieve symptoms related to the trauma. Cognitive restructuring is another method used in trauma-focused CBT and involves identifying cognitive distortions and replacing irrational thoughts with more rational thoughts (Bisson, 2007).

Another form of cognitive behavioral therapy is cognitive behavioral conjoint therapy (CBCT). Monson, et al. (2011) conducted a study of CBCT which involved seven couples. One member of each couple was experiencing symptoms of post-

traumatic stress disorder. The CBCT interventions consisted of fifteen 75-minute sessions where the clients were educated about post-traumatic stress disorder, skills to increase function in relationships, and strategies to reframe thoughts about the traumatic experience and their relationship (Monson, et al., 2011). All six clients saw improvements in their condition and only one client met the criteria for post-traumatic stress disorder after completing 15 sessions of CBCT. Participants also reported increased satisfaction in their relationship and decreased symptoms of depression (Monson, et al., 2011).

Dialectical behavior therapy (DBT) stemmed from cognitive behavioral therapy and is based on the idea of changing thoughts in order to change feelings and actions. Therapy is based on four modules: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness (Sanderson, 2008). Clients participate in individual and group sessions and the length of treatment varies from several months to one year depending on the number and length of sessions each week (Sanderson, 2008).

Emotional debriefing is another intervention method used with clients diagnosed with post-traumatic stress disorder. Debriefing includes having the client describe the events of the trauma, their thoughts about the trauma, and their reaction to the trauma (Sijbrandij, Olff, Reitsma, Carlier, & Gersons, 2006). Clients are asked to discuss their current symptoms of post-traumatic stress disorder and are informed of strategies for treatment of these symptoms (Sijbrandij, Olff, Reitsma, Carlier, & Gersons, 2006). Bisson (2007) looked at various studies focusing on the treatment of post-traumatic stress disorder and found that often times using one session of debriefing or having the client tell about their past trauma with no subsequent follow-up or discussion of coping skills

was not beneficial for the clients. This caused increased symptoms of distress and a decline in function due to reliving the experience and focusing on current symptomology.

Correlation between an Eating Disorder and Post-Traumatic Stress Disorder

Previous studies have found that an anxiety disorder often occurs with the diagnosis of an eating disorder. It has been shown that often the anxiety disorder occurs before the onset of the eating disorder. Results suggest that there may be a genetic predisposition between the development of an eating disorder following an early onset of an anxiety disorder (Swinbourne & Touyz, 2007). Kaye, Bulik, Thornton, Barbaich, and Masters (2004) found that approximately two-thirds of the individuals diagnosed with anorexia nervosa or bulimia nervosa were also diagnosed with an anxiety disorder, which is much higher than the prevalence rate of anxiety disorders in the general population. The researchers concluded that since anxiety disorders often began in childhood, these individuals were at an increased risk for developing an eating disorder (Kaye, Bulik, Thornton, Barbaich, & Masters, 2004).

Prevalence rates for the comorbidity of post-traumatic stress disorder and an eating disorder vary based on gender and the severity of symptoms. Striegel-Moore, Garvin, Dohm, and Rosenheck (1999) found that 25% of women and 8% of men diagnosed with an eating disorder also had a diagnosis of post-traumatic stress disorder. Brewerton (2007) found that the prevalence rates of post-traumatic stress disorder in subjects who were also diagnosed with an eating disorder compared to the prevalence rates of those without an eating disorder. Of those diagnosed with an eating disorder, the lifetime prevalence of a comorbid diagnosis of post-traumatic stress disorder occurs with bulimia nervosa in 37% of cases and with binge eating disorder in 22% of cases. The

lifetime prevalence of anorexia nervosa was not discussed. The prevalence rate of post-traumatic stress disorder in individuals who have not been diagnosed with an eating disorder is 12% (Brewerton, 2007).

Hepp, Spindler, Schnyder, Kraemer, and Milos (2007) also studied the comorbid occurrence of post-traumatic stress disorder in women diagnosed with an eating disorder. Only 1.4% of the participants in this study had a comorbid diagnosis of post-traumatic stress disorder and an eating disorder but approximately 24.5% of participants reported experiencing a traumatic event and consequently developed an eating disorder. Woodside and Staab (2006) reported that the lifetime prevalence of post-traumatic stress disorder with an eating disorder is approximately 13%. The severity of eating disorder symptoms also correlates with the occurrence of a traumatic experience (Woodside & Staab, 2006).

The occurrence of post-traumatic stress disorder with an eating disorder was also studied by Gleaves, Eberenz, and May (1998). Approximately 52% of the participants diagnosed with an eating disorder, reported post-traumatic stress disorder symptomatology (Gleaves, Eberenz, & May, 1998). Overall, an estimated 12 – 52% of individuals who have experienced a traumatic event or post-traumatic stress disorder symptomology also have been diagnosed with an eating disorder.

Many factors predispose individuals to the development of post-traumatic stress disorder and an eating disorder. Varying forms of abuse have largely contributed to the rate of post-traumatic stress disorder occurring with an eating disorder. Striegel-Moore, Garvin, Dohm, and Rosenheck (1999) concluded the high rate of post-traumatic stress disorder comorbidity in women diagnosed with an eating disorder was related to high rates of sexual and physical abuse in the female population. Gleaves, Eberenz, and May

(1998) also concluded that the severity of post-traumatic stress disorder symptoms was associated with depression, anxiety, and dissociative experiences, all of which were related to traumatic experiences.

Eating disorder behaviors may be used as a coping mechanism for the experience of a trauma. Individuals who have post-traumatic stress disorder may avoid feelings of depression, anxiety, or numbness by engaging in overeating, binge eating, or compulsive sexual behavior (Mulvihill, 2005). Individuals who struggle with post-traumatic stress disorder and an eating disorder often struggle with daily occupations such as self-care, work, leisure, and cognition (Reed, 2002). Brewerton (2007) discussed the need for a "comprehensive assessment of post-traumatic stress disorder and other comorbid disorders" (p. 294). The author suggested that this comprehensive assessment would provide practitioners with a precise, detailed treatment plan. Little research has been conducted on the population diagnosed with post-traumatic stress disorder and a comorbid eating disorder warranting the need for further research and a program for treatment of this population.

Occupational therapists have the knowledge to consider the comorbidity of post-traumatic stress disorder and an eating disorder and the physical and psychosocial factors which are affected. There are a number of commonalities between the presentations of the disorders. Post-traumatic stress disorder is a disorder in which symptoms impact daily functioning similar to that of an eating disorder. Both disorders cause decreased interest in meaningful activities, limitations in engagement in social, occupational and work areas, and often cause decreased performance of self-care activities. Cognitive impacts of these disorders are also similar as feelings of guilt, rejection, and worthlessness as well as

decreased memory are observed in these individuals. Cognitive behavioral therapy is often used as a way to target how the client's thoughts are impacting their behaviors and feelings. Previous experiences of trauma are predisposing factors for the development of both post-traumatic stress disorder and an eating disorder. Treatment provided by an occupational therapist for these disorders is also similar in nature and includes individual or group treatment, activities that allow self expression, and coping skills development to assist with symptom management.

Occupation-Based Intervention

Participation in occupations can be extremely difficult when an individual is going through stressful events. McColl (2002) discussed seven aspects of occupations that are affected by stressful situations: survival, diversion, mastery, habit, support, identity, and spiritual connection. An individual's participation in occupations supports persistence through difficult periods (McColl, 2002). Often times, it allows individuals a way to help "survive difficult times, and very often, it provides a modality for addressing the source of stress" (McColl, 2002, p. 351). Participation in occupation provides structure for individuals in order to help them to persist through stressful situations and also provides a diversion from the traumatic experience. McColl (2002) explains that engagement in occupation provides a diversion from the negative aspects an individual finds stressful. A sense of mastery and capability is necessary for occupations to be intrinsically motivating and supportive of adaption and skill mastery (McColl, 2002). The formation of habits also supports motivation. McColl (2002) reports that habits reinforce our normal schedules in a time of crisis leading to increased occupational performance and decreased fatigue, which in turn protects the individual from other effects of stress. A

source of support is vital for individuals during stressful or traumatic experiences. Social support has been proven to help individuals reach positive outcomes and experience decreased negative effects on health (McColl, 2002). Occupations provide a sense of identity so when a trauma occurs the individual is able to use their past occupations to maintain their identity. Engagement in occupation "provides the mechanism through which the past, present, and future of a person's life are integrated into a whole self" (McColl, 2002, p. 352). Through use of a holistic approach, an occupational therapist can assist the individual to look at positive past, present, and future experiences that shape their personality and unique sense of self. Lastly, McColl (2002) discusses spiritual activities as a means to cope during stressful times. Individuals may find meaning in life through spiritual activities and purposeful use of time despite difficult experiences (McColl, 2002).

Rogers (2007) discussed barriers to occupation-based intervention in medical-based settings and ways to increase the use of occupations in practice. Barriers which were discussed included 1) a lack of support from supervisors and managers; 2) worries about reimbursement from insurance companies; and 3) lack of occupation-based assessment to identify problem areas. Suggestions for occupation-based interventions included rearranging treatment areas to resemble a home, using all areas of the facility, the use of community outings when able, and creating occupation-based kits that allow for easy access to occupation-based activities, such as scrapbooking, pet care, or wrapping gifts (Rogers, 2007).

Model of Human Occupation

The Model of Human Occupation has been identified as a suitable framework for use by occupational therapists in the treatment of individuals diagnosed with an eating disorder due to its focus on habits and the motivation behind behavior (Robinson, Kane, & Leicht, 2005). In this model, the individual's occupational performance is impacted by three interrelated subsystems: volition, habituation, and performance capacity (Kielhofner, 2008). Volition is the motivation to perform occupations; habituation is the process the individual uses to perform routines; and performance capacity is the physical and mental abilities that go into occupational performance. The individual's performance in occupations is also impacted by environment or context in which the occupations are performed (Kielhofner, 2008).

Kielhofner (2008) describes volition as a "need or desire to act" (p. 13) and "an awareness of…potential for doing things" (p. 12). Thoughts and feelings in the volitional subsystem are divided into three areas: personal causation, values, and interests. Personal causation consists of the individual's awareness of their ability and effectiveness in occupational performance (Kielhofner, 2008). The values of the client are what they find meaningful and important to do (Kielhofner, 2008). Interests are activities the client finds pleasurable and fulfilling in their daily life. Kielhofner (2008) describes a process of volition that is continual. First, the client has an experience or thoughts and feelings that arise due to completion of a task. Second, the client interprets their experience by reflecting on performance of the task (Kielhofner, 2008). Third, the client experiences anticipation which Kielhofner (2008) defines as "the process of noticing and reacting to potentials or expectations for action" (p. 14). The final step is activity and occupational

choices. This includes making decisions about which activities or occupations and occupational roles to participate in on a daily basis (Kielhofner, 2008). Volition is continually present in daily life but is a process in which change can occur in values, interests, and personal causation throughout the individual's lifetime (Kielhofner, 2008).

Habituation is a "semiautonomous pattern of behavior in concert with our familiar temporal, physical, and social habitats" (Kielhofner, 2008, p. 16). Features of habituation include habits and internalized roles. An individual's habits are specific ways a task is performed within the same environment on a regular basis (Kielhofner, 2008). Activities must be repeated an adequate number of times and performed in a fairly similar environment in order for that action to become a habit. Internalized roles are a large part of an individual's identity. An individual may designate their own role in daily life or the role may be established based on social status (Kielhofner, 2008). Individuals usually have more than one role which can create conflict and increased demands leading to dysfunction in occupational performance.

Performance capacity incorporates the physical and cognitive abilities of the client. These abilities, which Kielhofner (2008) describes as objective or factual, are necessary for occupational performance. Kielhofner (2008) suggests there is also a subjective experience in performance capacity. The client's internal view of themselves, or their subjective view, along with their objective abilities, influences their performance capacity (Kielhofner, 2008). The client is able to evaluate their abilities to determine their satisfaction in the performance of meaningful daily activities. When learning a new task, an individual learns the objective components first, which are the things needed to know how to do the task, and then moves toward the subjective component and learns how it

feels to complete the task (Kielhofner, 2008). Disability or illness can have a considerable impact on the objective and subjective components of performance capacity. The client often needs to adapt their participation in occupations in order to feel a sense of success or fulfillment (Kielhofner, 2008).

All occupations occur in an environment or context. The environment includes the space in which the occupation is performed, the objects and people in the space, and the meaning of performing an occupation (Kielhofner, 2008). Environments can support performance in an occupation or create demands that are too large for the client to overcome independently. Kielhofner (2008) discusses the impact of the environment and states that it "depends on the intersection of the social and physical environment with the values, interests, personal causation, habits, roles, and performance capacities of those within the environment" (p. 89). The Model of Human Occupation emphasizes the impact of the environment on successful occupational performance and the need for adaptations in order to complete occupations.

The Model of Human Occupation looks at the volition or motivation of the individual to participate in enjoyable and meaningful occupations. Individuals with these comorbid diagnoses face difficulties identifying occupations they participate in and the motivation they have to complete healthy occupations. These individuals may have a dysfunctional sense of volition in that there is often limited internal motivation to participate in eating disorder behaviors which may stem from a past traumatic experience. The values and beliefs of the client greatly impact successful occupational performance. Values and beliefs influence self-esteem and self-confidence (Kielhofner, 2008). An individual who has had a traumatic experience may feel their values and

beliefs have been disturbed and in turn may struggle with the motivation and self-confidence to participate in necessary and meaningful occupations.

The habits, roles, and routines of individuals with the dual diagnosis of an eating disorder and post-traumatic stress disorder are considered in the subsystem of habituation. Often times the symptomology of these diagnoses greatly impact the habits, roles, and routines by causing increased stress, distraction, and fear of certain situations. These individuals may use avoidance and negative thinking to cope with stressors and symptoms of an eating disorder or post-traumatic stress disorder. Individuals diagnosed with both an eating disorder and post-traumatic stress disorder may have increased struggles with self-esteem and self-confidence due to a lack of trust in others or conflict with roles and routines. A large focus of the Model of Human Occupation is to assist the client to regain their previous habits, roles, and routines (Kielhofner, 2008).

An individual with the dual diagnosis of an eating disorder and post-traumatic stress disorder often has difficulties with performance capacity due to deficits in their physical or mental abilities. Often times, a traumatic experience has an immense impact on the psychosocial factors of occupational performance. An eating disorder also has psychosocial and cognitive effects. Individuals with these diagnoses may face challenges in performing routine daily activities. An occupational therapist can use the Model of Human Occupation to guide treatment and ensure that not only the objective component of performance but also the subjective component is satisfactory for the client (Kielhofner, 2008). This guarantees the client will be motivated to participate in a meaningful occupation.

Environmental impact on occupational participation is also considered in the Model of Human Occupation. The environment can create demands for the individual which greatly impact participation in meaningful occupations. The impact of social groups and the task being performed is also considered. Social groups can have a positive or negative effect on the individual depending on the social group's role in the individual's life. The social group may negatively impact the individual by creating increased eating disorder behaviors or exposing the individual to traumatic experiences. A social group may also have a supportive and positive effect on treatment by encouraging the individual to participate in treatment to alleviate symptoms. The tasks an individual must perform in their environment can also greatly impact experiences and behavior. The meaning and purpose of an activity is connected to the actions that make up the activity (Kielhofner, 2008). Occupational therapists can use the Model of Human Occupation with the population with the dual diagnosis of an eating disorder and post-traumatic stress disorder to guide treatment by looking closely at the impact of the environment on the individual and performance of occupations on a daily basis.

Assessment and Intervention

Assessment of the client and their performance of occupations involves obtaining information about the client's volition, habituation, and performance capacity, the impact of the environment on the client's occupational performance, and the client's ability to adapt occupations, if needed. Assessment information should be gathered through clear and concise questions. Kielhofner (2008), as well as other researchers, have developed assessments based on the Model of Human Occupation, including the Modified Interest Checklist, Model of Human Occupation Screening Tool (MOHOST), Occupational Self-

Assessment (OSA), and the Role Checklist. Many of these assessments can be administered in approximately 30 – 60 minutes making them practical for use in a variety of clinical settings.

There are numerous occupational therapy assessments based on the Model of Human Occupation which would be appropriate for use with this client population. The Model of Human Occupation Screening Tool (MOHOST) is a screening tool that uses observation and client interview in order to get a holistic view of the client. It contains a 24-item rating scale and can be completed fairly quickly (Kielhofner, 2008). The MOHOST specifically looks at volition (personal causation, values, interests), habituation (roles, habits), motor skills, process skills, communication or interaction skills, occupational performance and participation, and the physical and social environment. This assessment is intended for use with adolescents, adults, and the elderly.

Assessments that provide an in-depth look at the client's perspective of their occupational performance include the Occupational Self-Assessment (OSA) and the Role Checklist. The OSA is a self-rating assessment that can be effective with individuals diagnosed with an eating disorder and post-traumatic stress disorder. This assessment looks at occupational adaptation and the client's perception of their abilities, including the various components of the Model of Human Occupation (Kielhofner, 2008). The OSA can be used with adolescents, adults, and the elderly. Reed (2002) recommends using the Role Checklist with individuals diagnosed with an eating disorder and post-traumatic stress disorder. This assessment evaluates the client's perception of their

participation in occupations by looking at values related to volition and roles related to habituation. This assessment is appropriate for adolescents, adults, and the elderly.

Assessments also serve to provide insight into the actual occupational performance of the client. The Worker Role Interview can provide information about the client's work role and their perception of job performance and satisfaction. The Modified Interest Checklist identifies the client's leisure interests. The Assessment of Communication and Interaction Skills (ACIS) assesses communication skills in a social setting. Sleep is also an area that is largely impacted when diagnosed with an eating disorder and post-traumatic stress disorder. Sleep patterns and the impact of a lack of sleep on occupational performance should be evaluated.

Assessments can provide information about the performance capacity of the individual. This may include the symptomology that is currently impacting the client's performance. The Eating Disorder Inventory-3 (EDI-3) and the PTSD Checklist—Civilian version (PCL-C) can provide information about the current symptomology of the client and provide insight into the impact on the client's occupational performance.

Treatment is provided based on the information gathered during the assessment. In a psychosocial setting, interventions provided by occupational therapists are often done in a group setting. Interventions are targeted towards the needs of the client and should focus on the meaningful occupations of the client while looking at the client's volition to perform the occupation, habituation, roles, and routines. Performance capacity or capability of the client to accomplish the task, and the environment in which the occupation is performed in order to assist the client to function as independently as possible should be considered as well (Kielhofner, 2008).

The focus of occupational therapy treatment is often placed on decreased occupational performance in activities of daily living (ADLs) such as self-care, as well as instrumental activities of daily living (IADLs) including social and vocational activities which may be impacted by disease, disabilities or dysfunctional practices. The American Occupational Therapy Association (2008) defines activities of daily living (ADLs) as "activities oriented toward taking care of one's own body" (p. 631). Related "activities are fundamental to living in a social world; they enable basic survival and well-being" (Christiansen & Hammecker, 2001, p.156). In addition to ADLs, which are the more basic tasks a person completes, instrumental activities of daily living (IADLs) are often impacted. The American Occupational Therapy Association (2008) defines IADLs as "activities to support daily life within the home and community that often require more complex interactions than self-care used in ADLs" (p. 631). In addition to decreased performance of ADLs and IADLs, lack of engagement in social situations and poor social skills are often observed with this population so it is important for an occupational therapist to look at all aspects of life a client finds meaningful and bring in activities which are enjoyed (Singlehurst, Corr, Griffiths, & Beaulieu, 2007).

Collaboration with clients is necessary from an occupational therapy stand point for definition of the goals of treatment, the individual's characteristics, and providing the best possible treatment. Interventions provided are most effective if they address role demands and related stressors as these are often factors which can exacerbate the symptoms observed in individuals diagnosed with an eating disorder. While life skills training can be provided by a variety of disciplines, including social work, therapeutic recreation, or a counselor, occupational therapists are trained to assess the person,

environment, and activity in order to treat the individual in a client-centered manner (Gorde, Helfrich, & Finlayson, 2004).

The Model of Human Occupation has been identified as a beneficial framework of the treatment of those with the dual diagnosis of an eating disorder and post-traumatic stress disorder. This model has a focus on habits and the motivation behind behaviors and occupational performance of an individual. As discussed earlier, focus on the three subsystems of volition, habituation, and performance capacity can assist an occupational therapist in defining problem areas. The Model of Human Occupation also considers environmental factors and does not discount the impact the environment may have on function.

The volitional subsystem is the motivation of an individual to perform occupations. It also includes the person's awareness of ability and effectiveness. In the population with an eating disorder, volition to complete tasks, which they previously found rewarding, can be diminished secondary to decreased self-esteem and endurance. Lock and Pépin (2011) also suggest that five additional concepts negatively impact volition: "overvaluation of weight, shape and their control; mood intolerance; core low self-esteem; perfectionism; and interpersonal problems" (p. 130). These concepts can impact the client's initiation of tasks and with a decreased desire to act, clients are less likely to participate in occupations. In clients diagnosed with post-traumatic stress disorder, it is also common to see a decreased interest in activities and previous roles.

The subsystem of habituation is focused on the patterns of behavior of a client, including their habits and internalized roles. In the population of those diagnosed with an eating disorder, habits and roles are found to be dysfunctional. Often, an eating disorder

begins as a method for the client to attempt to cope with undesired self-perception and not meeting expectations set by themselves or others (Lock & Pépin, 2011). When an individual struggles with an eating disorder as well as post-traumatic stress disorder, they may have difficulties with participation in daily activities.

A client diagnosed with an eating disorder displays maladaptive habits in relation to eating as this activity often provokes anxiety. With post-traumatic stress disorder, a stimulus related to the trauma is avoided in order to prevent triggering anxiety and fear. Additionally with post-traumatic stress disorder, negative impact is commonly observed with sleep patterns and roles which the client may have held prior to the development of post-traumatic stress disorder. In both disorders, social participation can be impacted and is often avoided. Interest in meaningful activities becomes limited as does involvement in daily occupations, such as self-care, work, education, or leisure activities. Social participation can occur in a variety of contexts and has an immense effect on mental health. Kawachi and Berkman (2001) looked at the effects of social ties on mental health, social isolation, and the loss of social support as factors contributing to depression. The researchers found that social support can either provide a sense of self-efficacy and self-esteem or it may support dependence in the individual (Kawachi & Berkman, 2001). Often times, clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder have had negative experiences in the past with social participation and avoid these situations in order to avoid negative feelings.

The subsystem of performance capacity is related to a client's physical and cognitive abilities in relation to performance of occupations. A client diagnosed with anorexia nervosa often has diminished cognitive abilities secondary to poor nutrition,

perfectionism, and compulsive behaviors. Anorexia nervosa can also impact physical performance in that poor nutrition can lead to fatigue and exhaustion. Difficulty with concentration and initiation of a task or occupation may also be evident. When treating someone with bulimia nervosa, focus is largely placed on the behavioral disturbances, such as impulsivity and inadequate self-control related to eating habits which impact general function in daily occupations. Similar to bulimia nervosa, a large focus of binge eating disorder treatment is related to the cessation of behavioral disturbances. Other focuses include decreasing symptomology of any comorbid disorder, such as anxiety or mood problems and controlled healthy weight loss (First & Tasman, 2004).

With all eating disorders, a large problem area is related to cognition in regards to distortions in the client's sense of self, capabilities, and management of emotions. In addition, post-traumatic stress disorder also impacts cognitive abilities. It is common to observe difficulty with concentration, impulsivity, distractibility and emotional numbing. The fear and anxiety related to post-traumatic stress disorder limits participation in occupations. Persistent re-experiencing of the trauma has a significant, negative impact on ability to perform in all tasks an individual encounters. Memory can also be impacted as a symptom of post-traumatic stress disorder further limiting the cognitive performance of an individual. Additionally, due to the diagnoses experiencing similar cognitive impacts of feelings of guilt, rejection, decreased memory and attention, and feelings of worthlessness, treatment of the dual diagnosis of an eating disorder and post-traumatic stress disorder would follow a similar path to that of treatment for the diagnoses individually.

The occupational setting or environment that tasks or activities are performed in can have a large impact on the individual's volition, habituation, and performance capacity. Individuals with post-traumatic stress disorder may be sensitive to certain environments or avoid settings because of their past experiences. Those diagnosed with an eating disorder may have similar difficulties. Social interactions, activities of daily living, and daily tasks can all be impacted by the environment. When individuals struggle with aspects of their environment, they consequently struggle with the tasks necessary for function in their daily life. Occupational therapy treatment for clients with a dual diagnosis of an eating disorder and post-traumatic stress disorder will require assessment and interventions focused on the impact of the environment and adaptations to decrease difficulties with function related to people, objects, and spaces within the environment.

In summary, there is a need for a comprehensive treatment program addressing the holistic needs of clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder. The Model of Human Occupation provides the framework for this comprehensive occupation-based program, along with cognitive behavioral techniques. Participation in a program addressing the needs of this population will allow the client to learn necessary life skills and provide the opportunity for actual performance of daily activities.

Chapter III

Methodology

A literature review was conducted to gain information about the diagnoses of an eating disorder and post-traumatic stress disorder, as well as possible assessments and interventions currently used with these diagnoses. A search of various occupational therapy, medical, and psychology resources was completed. Through the literature review, a clear need exists for a program of interventions for the dual diagnosis of an eating disorder and post-traumatic stress disorder to address disturbances in thought patterns and performance of daily occupations, such as self-care, home management, work, and leisure.

A high prevalence of post-traumatic stress disorder has been identified among individuals diagnosed with an eating disorder (Brewerton, 2007). Approximately 25% of women and 8% of men diagnosed with an eating disorder are also diagnosed with post-traumatic stress disorder (Striegel-Moore, Garvin, Dohm, & Rosenheck, 1999). Therefore, the product focuses on interventions for the dual diagnosis of an eating disorder and post-traumatic stress disorder. Because of this finding, the product includes activities aimed at improving occupational performance in the areas of self-care, leisure, meal planning and preparation, and life skills needed for successful performance of daily activities.

The literature suggests the Model of Human Occupation is an appropriate occupational therapy model to guide the development of a program for the dual diagnosis of an eating disorder and post-traumatic stress disorder because of its emphasis on the volition of the client to perform occupations and in-depth analysis of habituation, performance capacity, and the environment of the client (Kielhofner, 2008). The program is intended to be used in an outpatient setting by occupational therapists. The referral and evaluation summary forms have been developed based on principles of the Model of Human Occupation in order to have a uniform method for referral and to assure other healthcare professionals understand the role of occupational therapy in the treatment of the dual diagnosis of an eating disorder and post-traumatic stress disorder. Assessments were chosen based on their effectiveness in evaluating the Model of Human Occupation components of volition, habitation, performance capacity, and the environment.

Cognitive behavioral therapy is useful in changing thoughts in order to produce positive feelings and action (National Association of Cognitive Behavioral Therapists, 2007). Cognitive behavioral therapy is based on the idea that thoughts affect feelings and actions (National Association of Cognitive Behavioral Therapists, 2007). Thus, the program encourages clients to use reflective thinking and increase self-awareness through reflection and journal questions that correlate with each session. Reflective questions assist the client in personal reflection and increasing awareness of thought patterns that affect habits and roles performed on a daily basis. The formation of habits reinforces a normal schedule which leads to increased occupational performance, decreased fatigue, and protect from other effects of stress (McColl, 2002). The product focuses on forming

or reinforcing healthy habits to increase occupational performance and decrease the impact of stress through the use of occupation-based activities.

Chapter IV

Product

An Occupation-Based Occupational Therapy Program for the Dual Diagnosis of an Eating Disorder and Post-Traumatic Stress Disorder

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Introduction to the Product

This program was developed to be used by occupational therapists in the treatment of clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder. The Model of Human Occupation was utilized as a guide for the development of this program.

A referral form has been developed and is representative of concepts emphasized in the Model of Human Occupation. This form was included for physicians to utilize as they request occupational therapy services. A framework to organize the assessments is proposed and a list of recommended evaluation and assessment tools indicating engagement in occupation, performance in occupations, and the influence of underlying components and the environment are included. An occupational therapy evaluation summary form is provided to compile all data gathered through the various evaluation and assessment tools.

This program provides sample activities that can be utilized as interventions for clients. The interventions are designed to target problems areas in occupations and engagement identified by the literature review. The authors of this program have organized the activities into categories that allow quick identification of targeted interventions. The self-awareness section outlines components that can be used throughout the rest of the activities. The following sections refer to areas of occupation that are common deficit areas with this population and include activities to facilitate client engagement in targeted occupations.

Referral

Referral

The referral form serves as a means to educate physicians and other healthcare professionals of the services occupational therapy can provide. Within this form, attention is given to areas of concern as guided by the Model of Human Occupation. The items included represent the areas of volition, habituation, performance capacity, and environment. Through the use of the form, physicians and other healthcare professionals can provide specific information about the client related to the occupational therapy services that are needed.

Occupational Therapy Referral Form

Client: _____ **Date**: _____
Diagnosis: _____
Date of Onset: _____
Primary Physician: _____
Pertinent Medical Information: _____
_____
_____

Reason for Referral to Occupational Therapy Services:

Area	Yes	No	Comments
Volition (self-confidence, interest)			
Habituation (self-care, home management, work, education, leisure, social participation)			
Performance Capacity (interpersonal skills, cognitive ability, physical ability)			
Environment (physical environment such as home, work, school, or the community, social support)			

_____ _____
Referring Health Professional **Date**

Evaluation

Evaluation

A list of suggested assessments is provided to guide the evaluation of clients in the use of this program. An occupational therapy summary evaluation form is provided at the end of the evaluation section to compile data from all of the assessments administered to the client. The occupational therapy summary evaluation form, based on the Model of Human Occupation, assists in viewing the client holistically throughout the assessment process. The areas of volition, habituation, performance capacity, and environment are addressed. When the occupational therapy summary evaluation form is filled out, a discussion with the client about changes in his or her occupational performance or participation can be beneficial to track declines or improvements in function.

The assessments discussed in this section were chosen because they are based on or focus on components within the Model of Human Occupation. The assessments are organized into categories for the Model of Human Occupation components that they address. The Model of Human Occupation Screening Tool (MOHOST) should be used as a screening tool to identify strengths and areas of concern for the client in the component areas of volition, habituation, and performance capacity, as well as the influence of environment on occupational performance.

Based on the screening results, the therapist can identify additional assessments needed in regard to client perspectives of occupational participation, performance in selected occupations, or impairment in performance capacity. Assessments that target client perspectives include the Occupational Self-Assessment (OSA) and the Role Checklist. These assessments are designed to gather information on how the client perceives their occupational performance and participation in daily roles.

Several assessments are designed to target occupational performance in the areas of work, leisure, social participation and sleep. They include the Worker Role Interview, the Modified Interest Checklist, the Assessment of Communication and Interaction Skills (ACIS), and a Sleep Assessment developed by the authors specifically for this program. The sleep assessment, while not a Model of Human Occupation assessment, was designed with the model's components in mind to address the client's sleep habits, routines, and the impact on occupational performance.

Assessments that address performance capacity include the Eating Disorder Inventory-3 (EDI-3) and the PTSD Checklist – Civilian Version (PCL-C). It is important to note that the purpose of using these assessments is not to diagnose the client, as that is the role of the physician, but rather to identify what symptoms are currently present and their impact on the client's daily life. This will assist the therapist in choosing appropriate interventions that will most benefit the client.

The occupational therapy evaluation summary form is a document created by the authors to provide the therapist with a place to summarize the findings and deficit areas identified by the assessment tools. This is a beneficial tool to utilize when determining course of treatment, interventions, and client factors.

The assessments included in this program are not inclusive to all assessments that can be utilized with this model and population. If other assessments are going to be used with this population, careful consideration should be given to how the components of the Model of Human Occupation are addressed and the benefits provided to treatment planning and program development.

Screening Tool

The Model of Human Occupation Screening Tool (MOHOST)

Authors: Sue Parkinson, Kirsty Forsyth, and Gary Kielhofner

Format: An occupation-based screening tool that utilizes observation, client and caregiver interviews, consultation with interdisciplinary staff, and chart reviews.

Purpose: The MOHOST measures occupational participation, including self-care, productivity, and leisure, with an emphasis on determining reasons why the client is not engaging in occupation.

Population: This assessment can be used with a wide variety of diagnoses in nearly all occupational therapy settings, including verbal and nonverbal clients. It is especially useful in a mental health setting.

Time Required: Observation can occur over a 2-week period or more if needed. It takes approximately 20 minutes to document the assessment findings. All areas of the assessment do not need to be completed in one sitting.

Setting: Observation should be completed while the client is performing occupational tasks, such as activities of daily living, participating in a group session, or socializing with other clients, in a formal or informal context. Client and caregiver interviews should be completed in a quiet room with very few distractions.

Materials or Tools: MOHOST assessment guide and forms

Description: The 24 MOHOST items are divided into six main categories: motivation for occupation, pattern of occupation, communication and interaction skills, process skills, motor skills, and environment. A 4-point rating scale is used to rate the client during observation. During the interview, the client rates themselves. The scale includes F (facilitates participation in occupation), A (allows participation in occupation), I (inhibits participation in occupation), and R (restricts participation in occupation). An F means the client needs no outside support to participate in an occupation and an R indicates the client is unable to manage in occupational participation despite receiving outside support.

Interpretation: Twenty items represent the client's occupational participation and four items represent aspects of the environment that impact occupational participation.

Reliability and Validity: The MOHOST provides high reliability and validity in assessing the occupational function of clients with a variety of diagnoses.

Source: Model of Human Occupation Clearinghouse
UIC Office of Publications Services (MC 291)
828 S. Wolcott Ave, Room B-4
Chicago, Illinois 60612
www.moho.uic.edu

Cost: $38.50

Sample Form: Available at http://www.uic.edu/depts/moho/assess/mohost.html

Assessments of Client Perspective

Occupational Self-Assessment (OSA)

Authors: Kathi Baron, Gary Kielhofner, Anita Iyenger, Victoria Goldhammer, and Julie Wolenski

Format: This assessment is a non-standardized self-report measure.

Purpose: This assessment is intended to be administered as part of an initial evaluation and captures the client's assessment of themselves and their ability to perform in occupations.

Population: This assessment is appropriate for older adolescents and adults in any setting who have some insight and adequate cognitive skills for reflection and planning and a desire to collaborate in setting and achieving goals.

Time Required: Approximately 30 minutes is needed for administration.

Setting: A quiet room is ideal for one-to-one administration.

Materials or Tools: The OSA self-report form and manual are needed for administration and interpretation of results.

Description: The OSA has two sections. Section 1: Myself assesses the client's perceived competence in occupations. Section 2: My Environment evaluates the perceived impact of the environment and the client's adaptation of occupations. Once the client completes the self-report form, the therapist and client discuss the answers in order for the therapist to understand the client's reasoning for the rating chosen.

Interpretation: Goals for therapy are set from a discussion with the client of the areas with greatest dissatisfaction on the self-report form. The responses of the client provide insight into occupational competence, the impact of the environment on adaptation, and the value and satisfaction as the client perceives them.

Reliability and Validity: The OSA has high interrater reliability and validity.

Source: Model of Human Occupation Clearinghouse
UIC Office of Publications Services (MC 291)
828 S. Wolcott Ave, Room B-4
Chicago, Illinois 60612
www.moho.uic.edu

Cost: $38.50

Sample Forms: Available at http://www.uic.edu/depts/moho/assess/mohost.html

Role Checklist

Author: Frances Oakley

Format: This assessment is a self-report measure. The assessment is usually completed through a therapist led interview but can be completed independently by the client.

Purpose: This assessment obtains information about client's participation in roles, the value of each role, and the client's capacity to maintain a balance among roles.

Population: Adolescents and adults; suitable for any diagnosis

Time Required: Approximately 15 minutes is needed for administration.

Setting: A quiet room is preferred for administration.

Materials or Tools: The Role Checklist self-report form and a writing utensil are needed for administration.

Description: The assessment is broken up into two parts: an assessment of occupational roles and the degree to which each role is valued. The checklist consists of ten roles including student, worker, volunteer, caregiver, home maintainer, friend, family member, religious participation, hobbyist/amateur, and participant in organizations. A category labeled as "other" is also included to allow the client to identify other roles not included in the checklist. The client indicates whether they have participated in the role in the past, are participating in the role presently, or anticipate participating in the role in the future. Then, the client indicates the value of the role and is given three choices: not at all valuable, somewhat valuable, and very valuable.

Interpretation: Responses from the client are evaluated and are used to set goals for therapy. A summary score sheet is available to evaluate the results more easily.

Reliability and Validity: The assessment was found to be a reliable and valid measure of the roles of the client but the value identified with these roles should be used cautiously in intervention planning.

Source: To obtain a copy of the assessment, contact Fran Oakley at FOakley@cc.nih.gov

Cost: Free

Sample Forms: An accessible version of the Role Checklist is available at http://www.uic.edu/depts/moho/images/assessments/Accessible%20Role%20Checklist.pdf

Assessments of Occupational Performance

Worker Role Interview

Authors: Brent Braveman, Mick Robson, Craig Velozo, Gary Kielhofner, Gail Fisher, Kirsty Forsyth, and Jennifer Kerschbaum

Format: This is a semi-structured interview and a therapist-administered rating scale.

Purpose: This assessment gathers information relating to psychosocial and environmental factors that currently impact the return to work or a specific job.

Population: This assessment can be used with clients that have had an injury, an illness of long duration, or a disability that is impacting work.

Time Required: Approximately 30 – 60 minutes are needed for administration.

Materials or Tools: The Worker Role Interview manual and rating scale form is needed for administration of this assessment.

Description: This assessment has recommended questions designed to guide the interview process. The therapist conducts the interview in a conversational manner while monitoring the responses. There are three forms of this assessment which can be utilized in order to focus on most relevant questions for the individual (longstanding illness or disability, injured workers, or need for vocational training). In addition, there is a rating scale portion to the assessment, administered by the therapist, which includes 16 items to be answered. Items are scored on a 4-point rating scale. The rating scale looks at how the factors influence the individual's potential and ability to return to work.

Interpretation: The therapist will assess the underlying capacity and skill possessed for work and the coherence with the client's statement about their own abilities. The rating is scored on a 4-point scale (strongly supports, supports, interferes, strongly interferes) representative of the client's ability or potential for returning to work.

Reliability and Validity: This assessment has high test-retest reliability, high interrater reliability, and a scale validity of 95% within a varied population of clients.

Source: Model of Human Occupation Clearinghouse
UIC Office of Publications Services (MC 291)
828 S. Wolcott Ave, Room B-4
Chicago, Illinois 60612
www.moho.uic.edu

Cost: $38.50

Modified Interest Checklist

Authors: Gary Kielhofner and A. Neville

Format: This assessment is a leisure interest inventory.

Purpose: This assessment gathers information related to client's level of interest in an activity and their recent and past level of function.

Population: This assessment is intended for adolescents and adults.

Time Required: Approximately 15 minutes or more is needed if client requires support to complete the checklist.

Materials or Tools: The Interest Checklist form is needed for administration.

Description: This assessment is a list of 68 activities in which the client identifies the rate in which they have participated in this activity in the last 10 years (strong, some, no engagement) and in the past year, if they participate in the activity currently, and if the client plans to continue the activity in the future. There are varying versions of this checklist to reflect cultural differences.

Interpretation: Patterns of responses are interpreted by the therapist as to what is an interest to the client.

Source: Model of Human Occupation Clearinghouse
UIC Office of Publications Services (MC 291)
828 S. Wolcott Ave, Room B-4
Chicago, IL 60612
www.moho.uic.edu

Cost: Free

Sample Forms: Available at http://www.uic.edu/depts/moho/images/Modified%20Interest%20Checklist.pdf

The Assessment of Communication and Interaction Skills (ACIS)

Authors: Kristy Forsyth, Marcelle Salamy, Sandy Simon, and Gary Kielhofner

Format: This assessment includes observation of occupational performance.

Purpose: This assessment gathers data about the skills the client demonstrates when communicating and interacting with other individuals in a group setting.

Population: This assessment is intended for adults with any diagnosis that may inhibit communication and interaction skills.

Time Required: Administration time varies from 20 – 60 minutes; observation time varies for 15 – 45 minutes; and rating time varies from 5 – 20 minutes.

Setting: A quiet area with few distractions in needed. Tasks are completed in observational settings including open, parallel task, cooperative group, one-on-one, natural setting, simulated life role situation, and unrelated life roles.

Materials or Tools: The ACIS rating form and observation tools are needed for observation.

Description: This assessment gathers data on the skills the client demonstrates when communicating and interaction with others during an occupation or within a social group. It is composed of 19 skills in three communication and interaction domains: physicality, information exchange, and relations.

Interpretation: Each of the 19 skills are rated on a 4-point scale (4 = skill supports ongoing social interaction; 3 = questionable skill with no disruption in social settings; 2 = ineffective skill which impacts social interaction; 1 = deficit skill which causes unacceptable delay or breakdown in social situations). A comment space is provided to allow for a more detailed look at the client's performance in social situations. The client's volition and habituation, as well as the data from the observation, should be considered when setting goals.

Reliability and Validity: The assessment has high inter-rater reliability and high validity in measurement of communication and interaction skills.

Source: Model of Human Occupation Clearinghouse
UIC Office of Publications Services (MC 291)
828 S. Wolcott Ave, Room B-4
Chicago, Illinois 60612
www.moho.uic.edu

Cost: $35.00

Sample Forms: Available at http://www.uic.edu/depts/moho/assess/acis.html

Sleep Assessment

Name: _____ Date: _____
Current medications: _____
_____
_____
_____

Check each symptom that applies to you:

_____ Non-Refreshing sleep
_____ Daytime sleepiness
_____ Increased irritability
_____ Restless sleep (tossing and turning)
_____ Waking up frequently
_____ Decreased memory
_____ Poor concentration

Sleep Habits:

Weekdays:
Normal Bedtime: _____
Normal Time to Get Up: _____

Weekend:
Normal Bedtime: _____
Normal Time to Get Up: _____

Do you sleep through the night: _____ Yes _____ No

If no, approximately how many times do you wake up per night?

_____ 0
_____ 1 – 2
_____ 3 – 5
_____ 5+

Do you find it difficult to return to sleep? _____ Yes _____ No

How do you feel when you awake? _____
_____
_____

Approximately how many days per week do you take a nap? _____
What is the average length of your nap? _____

Do you use caffeine to help you wake up? _____ Yes _____ No

How much caffeine do you consume daily?

_____ 0 – 1 drinks
_____ 2 – 4 drinks
_____ 5 or more drinks

What time of day do you consume your last caffeinated drink? _____

	Yes	No
Do you ever feel tired while:		
Reading		
Watching TV		
Driving		
Talking to a friend		
After eating lunch		
At work		
Doing housework		

What are your concerns regarding sleep patterns or quality of sleep? _____

_____

_____

_____

_____

_____

Assessments of Performance Capacity

Eating Disorder Inventory-3 (EDI-3)

Authors/Publishers: David M. Garner/Psychological Assessment Resources, Inc.

Format: This assessment is a self-report questionnaire.

Purpose: This assessment is designed to measure psychological traits and symptomology that occur in the population with anorexia nervosa and bulimia nervosa.

Population: This assessment is appropriate for use with clients with an eating disorder. Results are normed for the population aged 13 to 53 years.

Time Required: Approximately 20 minutes is needed for administration.

Setting: This assessment can be used in inpatient and outpatient settings.

Materials or Tools: The professional manual, item booklet, answer sheet, percentile profile form, referral form, and a symptom checklist are needed for administration and scoring.

Description: This self-assessment contains 91 items within 12 scales which yields a score in 6 areas (eating disorder risk, ineffectiveness, interpersonal problems, affective problems, over control, and general psychological maladjustment). There is also a symptom checklist which gathers information in relation to how frequently symptoms occur.

Interpretation: The raw data is converted into T scores. The percentile profile form is utilized to plot T scores on a graph to visually represent how the client scores among classification designed to identify those who are at risk for an eating disorder.

Reliability and Validity: This assessment has high reliability coefficients and validity levels.

Source: Psychological Assessment Resources, Inc.
16204 N. Florida Avenue
Lutz, FL 33549

Cost: $302.00

PTSD Checklist—Civilian Version (PCL-C)

Publishers: U.S. Department of Veterans Affairs

Format: This assessment is a standardized self-report measure.

Purpose: The purpose of this assessment is to screen individuals for post-traumatic stress disorder, diagnose post-traumatic stress disorder, and monitor symptom change during and after treatment.

Population: This assessment is appropriate for use with adults.

Time Required: Approximately 5 – 10 minutes are needed for administration.

Setting: A quiet room or area is needed for administration.

Materials or Tools: The PCL-C checklist is needed for administration.

Description: The PCL-C is a 17 item checklist that asks about symptoms related to stressful experiences. The checklist can be used to diagnose post-traumatic stress disorder, as well as monitor the client's progress.

Interpretation: All items are added to create a total severity score. Diagnosis can be made when at least one item is selected in questions 1 – 5, three items are selected in questions 6 – 12, and two items are selected in questions 13 – 17. This concludes that the client is experiencing moderate symptoms of post-traumatic stress disorder. Tables are available on the website for cutoff scores.

Reliability and Validity: The PCL-C has been proven to be a reliable and valid measure of PTSD symptomology.

Source: U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420
Email: ncptsd.assessment@va.gov
Request form available at http://www.ptsd.va.gov/professional/pages/assessments/ncptsd-instrument-request-form.asp

Cost: Free

Sample Forms: Available at
http://www.macmhb.org/StateWide%20Trauma%20Seminar/46%20PTSD%20Checklist%20-%20Civilian%20Version%20p.81.pdf

Occupational Therapy Evaluation Summary Form

Occupational Therapy Evaluation Summary Form

Client: _____ **Date:** _____
Diagnosis: _____
Primary Physician: _____
Reason for Referral: _____
_____
_____

Volition: (Comment on strengths and weaknesses in each area)

- **Interests:** _____
  _____
  _____
- **Values:** _____
  _____
  _____
- **Self-Confidence:** _____
  _____
  _____
- **Self-Awareness:** _____
  _____
  _____
- **Perfectionistic Tendencies:** _____
  _____
  _____
- **Other:** _____
  _____
  _____

Habituation: (Comment on strengths and weaknesses in each area, as well as the impact of roles, routines, habits, and responsibilities)

- **Self-care:** _____
  _____
  _____
  _____
  _____
- **Education:**
  - **What is the client's highest level of education?** _____
  - **What is the client's preferred learning style?** (auditory, visual, tactile)
    _____

- **Work:** _____
- **Leisure:** _____
- **Social Participation and Relationships:** _____
- **Home Management:** _____
- **Rest and Sleep:** _____
- **Other:** _____

Performance Capacity:

- **Communication and Interpersonal Skills:**
  - **Verbal/Conversation:** _____
  - **Nonverbal:** _____
- **Cognitive Abilities:** (executive function, memory, planning, organization, problem-solving, awareness, insight) _____
- **Physical Abilities:** (posture, mobility, strength, energy) _____
- **Other:** _____

Environment:

- **Physical:** (home, work, school, community, transportation, safety, finances, accessibility, comfort) _____
  _____
  _____
  _____
- **Social Support:** (family dynamics, friends, peers, colleagues, expectations, involvement) _____
  _____
  _____
- **Other:** _____
  _____
  _____

Intervention Suggestions:

_____ **Cognitive Behavioral Therapy** (CBT techniques, irrational beliefs, coping skills)
_____ **Life Skills** (Stress Management, Home Management, Anger Management, Assertiveness)
_____ **Meal Planning, Preparation, and Consuming a Meal**
_____ **Self-Care** (Dressing, Exercise, Body Image)
_____ **Leisure**
_____ **Rest and Sleep**

_____ _____
Occupational Therapist **Date**

Activities

Activities

The activities in this program provide skills that apply to the daily occupations of the clients. The suggested assessments will assist you in guiding treatment by identifying areas for growth in each client. A variety of possible assessments have been chosen to objectively examine the actual performance of occupations, the client's perspective of their performance, the underlying components influencing performance, and the impact of the environment.

The examples provided are not an exhaustive list of the interventions that can be done with this population. Activities may be added or adapted to fit the needs of the clients. Individual variables may make some groups more applicable or enjoyable for certain clients. Some of the activities are designed to be individual activities, while others are done in groups to promote social interaction, peer support, and combat isolation, which are behaviors commonly seen with these diagnoses. The self-awareness activities are developed to be introduced first in the program because the activities in the following sections are based on principles learned in the first section. The self-awareness section introduces the concepts of cognitive behavioral therapy, reflection, and journaling. Following the self-awareness activities, it is recommended that the life skills information be completed or addressed prior to the groups about life skills, meals, self-care, and leisure and social exploration as this section includes education for the clients on skills needed for function in daily life.

Reflection questions are provided for each group session to guide you in challenging the client's personal beliefs or self-concept. These questions also allow the

clients to analyze previous experiences and consider the impact of current habits or routines on function in daily life.

Journal questions are included for self-reflection following each group session. The client is asked to write journal entries following each session in a notebook. Journal responses are not shared with any other person. The client is encouraged to keep their journal private to support increased self-reflection. The client will meet with you each week to review the journal assignment and discuss any concerns and progress in the program. The client is encouraged to disclose pertinent information but does not need to share their reflection from the journal. In the event that more pertinent issues need to be addressed, you will meet with the client more often as needed.

Self-Awareness

Self-Awareness

Activities in this section focus on orienting the client to occupational therapy, the layout of the program, and the basic concepts of cognitive behavioral therapy (CBT). Orientation to the basic concepts of CBT provides the client with a foundation for participation in activities reflective of occupational areas. Through participation in activities the client will be directed to reflect and modify thinking and participation patterns to improve self-awareness, self-confidence, and body image.

Activities are intended to be 60 minutes in length but may be adjusted as needed. Activities may be completed in any order but a suggested activity sequence is:

1. Occupational Therapy: This is a group activity focused on teaching the client about occupational therapy.
2. Express Yourself: This is a group activity to inform clients about the benefits of journaling and self-expression.
3. Cognitive Behavioral Therapy: This is a group activity focused on educating the client about CBT and techniques used to replace negative thoughts.
4. Isn't That Absurd: This is a group activity focused on educating the client about irrational beliefs, helping the client to identify their irrational beliefs, and learning to replace irrational beliefs to increase self-esteem.
5. How to Deal: This is a group activity focused on educating clients about coping skills and their benefits. Clients are also able to identify effective coping skills to use in stressful situations.
6. Reflect on This: This is a group activity focused on methods of reflective thinking which helps clients recognize their thought patterns, beliefs, and

understanding. Clients are encouraged to take an in-depth look at the origin of these thought processes and the impact on their daily life.

Each group has a reflective component as well as suggested journal questions for further self-reflection following each activity. This will assist the client in developing the skills learned and support integration of the skills in daily life. Journal questions are provided for each session and assist the client in reflection of personal thoughts, feelings, behaviors, habits, and the impact of the environment of daily activities has on performance. Clients do not need to answer every question but are encouraged to write on a daily basis following each session in order achieve the benefits of self-reflection. Clients should be reminded that all journal entries are confidential unless permission is given for reading. Journal writing can be done in any format that is comfortable for the client, such as a letter written to them.

Several assessments guide the activities in this section of the program. The Occupational Self-Assessment (OSA) provides information about the client's perception of their ability to perform in occupations and the impact of the environment on occupational performance. Clients will assist the therapist in identify areas of deficit. The therapist can then choose groups relating to occupational therapy, journaling, cognitive behavioral therapy, irrational beliefs, coping skills, or reflective thinking based on the client's needs.

The Assessment of Communication and Interaction Skills (ACIS) involves observation of the client in a social setting in order to gather information about the skills the client demonstrates when communicating and interacting with peers. Results of this

assessment may influence the therapist to involve the client in groups related to cognitive behavioral therapy, irrational beliefs, coping skills, journaling, or reflective writing.

The Eating Disorder Inventory-3 (EDI-3) and PTSD Checklist—Civilian Version (PCL-C) obtain information about the client's current symptomology. Symptomology can greatly impact the client's function in daily activities. The results of this assessment may indicate a need for group sessions involving cognitive behavioral therapy, education about irrational beliefs or coping skills, or journaling and reflective writing.

Occupational Therapy

- **Objectives:**
  - Clients will be oriented to the occupational therapy program at your facility.
  - Clients will be introduced to and provided with background information about occupational therapy.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition

- **Introduction:**
  - Introduce clients to occupational therapy:
    - Occupational therapy promotes a healthy lifestyle by helping people to perform meaningful and purposeful occupations or daily activities.
    - Occupational therapy: "The practice of occupational therapy means the **therapeutic use of everyday life activities** (occupations) with individuals or groups **for the purpose of participation in roles and situations in home, school, work-place, community, and other settings.** Occupational therapy services are provided for the purpose of **promoting health and wellness** and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the **physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in every-day life activities that affect health, well-being, and quality of life**" (American Occupational Therapy Association, 2008).
    - Discuss your view of occupational therapy in your facility.

- **Activity:**
  - Have the client change a habit, such as sitting on their non-dominant hand while filling out the Occupational Therapy worksheet *(Handout 1)* or writing with their non-dominant hand.
  - Ask the clients: How did it feel to change your writing habit?
  - Tell the clients: Throughout this program, some things may feel awkward or different, but in order to make the healthy changes you need, you will need to continue to do them in order to learn effective coping mechanisms

and healthy habits that will continue throughout your life. As you perform these new things, they will become more comfortable and familiar.
    - Your patterns of behavior have guided your life and affect how you see yourself. You will need to focus on changing these patterns of thinking and doing in order to improve your self-confidence, body image, and self-awareness.
    - This program will focus on doing activities and then reflecting on your thinking patterns related to how you do things and how you feel about yourself related to doing.
    - Note: As you go through the program, have the clients look back at this worksheet *(Handout 1)* to see how their motivation, habits, performance, and environment have changed.

- **Reflection Questions:**
    - Facilitate discussion of the following questions:
        - What are some things that you hope to learn or begin to do again that you may have stopped doing?
        - What have you done with OT in the past that has helped you return to activities that you enjoy?
            - What impact has it had on your life?
        - What have you discovered about yourself and your habits from completing this worksheet?
            - What are some of the factors impacting your daily activities?
            - How have your environments influenced your performance?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal. Encourage them to write as much as they want. Clients do not need to answer every question. Self-reflection should be encouraged. Clients should be reminded that all journal entries are confidential unless permission is given for reading.
        - If you have previously had therapy, what kinds of things did you learn during the course of therapy in the past?
        - What are your goals for your time in this program?
        - Reflect on their responses on the Occupational Therapy worksheet *(Handout 1)*, including, motivation, habits, performance capacity, and the environment.
            - What would have your answers looked like in the past?
            - How would you like them to look like in the future?

Handout 1

Occupational Therapy

Occupational therapy promotes a healthy lifestyle by helping you to perform meaningful and purposeful occupations or daily activities. It includes the therapeutic use of everyday life activities to help you get back to participating in home, school, work, the community, or other settings. Occupational therapy looks at physical, cognitive, psychosocial, sensory, and other aspects of performance that affect health, well-being, and quality of life.

This program looks at the motivation behind your symptoms, your habits, your abilities to perform in daily activities, and the environments in which you perform daily activities.

1. What motivates you to perform daily activities?

2. What positive habits do you have that enable you to complete daily activities?

3. What negative habits get in the way of your participation in activities you value?

4. Do you have any limitations in performing your daily activities?

5. Reflect on the environments where you perform your daily activities. How does your physical or social environment impact your participation in valued activities?

Express Yourself

- **Objectives:**
  - Clients will learn the benefit of self-expression through the use of a journaling medium.
  - Clients will be provided with a method for self-expression and a place to express concerns, thoughts and beliefs (through the use of journals).
  - Clients will be able to utilize journaling as a method of stress reduction, personal understanding and growth, problem solving, and reflection.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Explain to the clients that:
    - Journaling is an activity that provides you with an emotional outlet.
    - Utilizing one or two topics to guide journaling can assist with helping you to recognize unhealthy or unproductive behaviors that are impacting function.
    - Through further reflection, you can identify how or why these behaviors began and what is holding them in place.
    - Focused journaling on a specific topic allows a way to track how you feel about a situation and how you reacted.
    - Journaling may allow you to connect with others, share ideas, and develop a mutual understanding while eliminating anxieties.

- **Activity:**
  - Explain to the clients that journaling will be an integral part of their therapy sessions. It will be used following each session to help them assess their thoughts, beliefs and habits. Set guidelines for the use of journaling in conjunction with other activities. Journaling will be a method of reflection and a way to facilitate the client to consider their current habits and thought processes that are impacting their life.
    - Suggested guidelines for journaling are:
      - Privacy will be upheld and others will not look at journals that do not belong to them.
  - Each client will meet with the therapist to discuss how the process of journaling is going at predetermined times. The focus of these meetings

might be reflection on reactions brought up in groups, feelings about treatment and recovery, and what has been learned about skills, habits, socializing or themselves. During these meetings there should be an element of self-disclosure as making it mandatory to share journal reflections may make the process less effective. Provide non-judgmental comments and probing questions for the client to consider and think deeper about their reflections. You will explain to the clients the benefits of journaling and the specific purpose of its use in their treatment. For Journaling can target the volitional process of each client and help them recognize their own needs, feelings, and the habits that they have in everyday tasks.

- Explain to the clients that journal questions are provided at the end of each activity or session done in treatment.
    - These questions are provided as a sample of what may be used in practice and are in no way an exhaustive list of what may be appropriate. Individual differences would dictate a change in what would be best to target treatment as you work to support the client in self-reflection and expression.
    - Clients do not need to stick rigidly to the questions provided as they are there only to guide journaling and outline a topic on which the entry should be focused.
- Lead the group through a practice journal activity. Give clients a topic such as how has therapy been going so far and what they hope to accomplish or explore their feelings on this topic and current habits related to journaling or self-expression. Have the clients focus on what they dislike or how they handle their situation as they consider this topic.
    - Follow-up with asking the clients if they have any questions or concerns about how to utilize this technique in their daily lives.

- **Reflection Questions:**
    - Ask the clients:
        - What is your experience with journaling?
        - Has it been beneficial in the past?
        - Do you feel journaling will be beneficial in assisting you to get to know yourself, your thoughts, and your habits?
        - What benefits do you see in journaling daily?
        - What is the value of journaling for yourself and your recovery?
        - How do you feel in regards to utilizing the technique of journaling?
        - What do you or don’t you find helpful?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - Please write a journal entry on what you hope to gain from this therapeutic process and what you foresee as barriers to your success as well as supports you have in place.

Handout 2

Descriptive Words for Journaling

A
Absurd
Active
Ambitious
Anti-social
Arrogant
Awkward

B
Beautiful
Boastful

C
Candid
Capable
Charitable
Cheerful
Clever
Clumsy
Common
Complacent
Confident
Critical
Cynical

D
Decent
Determined
Dishonest
Disturbed
Dominant
Dramatic
Dull

E
Eccentric
Efficient
Elegant
Enthusiastic

F
Firm
Flexible
Foolish
Frail
Friendly

G
Gifted

H
Helpful
Homely
Honorable
Humorous

I
Ignorant
Impressive
Indulgent
Insightful
Insignificant
Intelligent

J
Jovial

K
Kind

L
Lazy
Likeable

M
Melodramatic

N
Natural
Nice

O
Objective
Odd

P
Patient
Persistent
Petty
Polite
Precise
Profound
Purposeful

Q
Quaint
Quiet

R
Rational
Realistic
Reasonable
Reckless
Relaxed

S
Self-centered
Self-indulgent
Sensible
Shallow
Significant
Strong-willed
Stubborn
Sullen
Superficial
Symbolic

T
Talented
Thin
Thoughtful
Timid
Trivial
Trustworthy

U
Unintelligent
Unkempt
Unpolished

V
Vain
Vivacious

W
Weak
Witty

Cognitive Behavioral Therapy

- **Objectives:**
  - Clients will be introduced to and provided with background information about cognitive behavioral therapy
  - Clients will learn cognitive behavioral techniques and the effects of negative thinking on self-confidence and body image.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Performance Capacity

- **Introduction:**
  - Cognitive behavioral therapy is often used to reframe thinking about how you feel and what you do.
  - Give clients the Cognitive Behavioral Therapy handout *(Handout 3).* Discuss each of the bullet points to introduce the concepts of cognitive behavioral therapy.

- **Activity:**
  - Certain techniques are used in CBT to help the client to reframe thinking about how they feel and what they do. This can have a positive effect on self-confidence and body image by effectively changing the client's automatic thoughts, beliefs, and actions.
  - Give clients the CBT Techniques handout *(Handout 4).* Assign 1 – 2 techniques to each client and have them explain the technique and provide an example of a situation when they could use this technique. Allow other clients to help explain if any client has difficulty. Be sure to discuss each technique in detail with the clients and explain how it can be used to reframe thinking.
  - Discuss with the clients: Do you think the CBT techniques will be helpful in dealing with your current symptoms?
  - Throughout this program, future activities will be referring to these cognitive behavioral skills and techniques. Suggest that the clients try the techniques at home to become more comfortable with them and, ultimately, integrate them into their daily life.

- **Reflection Questions:**
  - Which cognitive behavioral therapy techniques covered today can you start to immediately use?

    - Which would you like to learn more about?
    - What kind of activities can you start to use these techniques in today?
    - How can these techniques be beneficial to you?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What habits do you have now in regard to your thinking that you would like to change?
        - Have you used CBT techniques in the past? If so, were they helpful?
        - Which technique holds the most promise to you for changing your identified impaired thinking patterns?
        - Have you been able to practice any of the techniques? Which one?
        - How did you feel after using the technique?

Handout 3

Cognitive Behavioral Therapy

Cognitive behavioral therapy or CBT is often used to reframe thinking about how you feel and what you do. There are many different forms of CBT that have the same basic characteristics:

- CBT is based on the idea that **thoughts cause feelings and behaviors**, not external factors, like people, objects, or events. The benefit is that you can change the way you think in order to feel better or act better, even if the situation or circumstances do not change.
- Treatment with CBT is fairly **brief** and **time-limited**. Homework assignments allow this type of therapy to be completed in 16 – 20 sessions. You and your therapist decide when it is appropriate to end therapy.
- A **positive relationship** between you and your therapist is essential. You must have a good, trusting relationship with your therapist in order to learn the CBT and life skills throughout the program.
- CBT is a **collaborative effort** between you and your therapist. Your therapist will seek to learn about your life and goals and help you to achieve those goals. Your therapist's role is to listen, teach, and encourage you, while your role is to express concerns, learn, and implement that learning.
- CBT involves **asking questions**. Your occupational therapist will often ask questions about why you have certain feelings or how you came about a thought or conclusion. Examples include "How do I really know those people are laughing at me? Or "Why do I think those people are laughing at me?"
- CBT is **structured** and **directive**. Specific goals are set for each session. Specific techniques are taught to help you focus on your goals.
- CBT has an **educational focus**. It is assumed that most emotional and behavioral reactions are learned. The goal of therapy, then, is to unlearn unwanted reactions and to learn a new way of reacting to situations. This helps you to understand how and why you are doing well and to understand what to do to continue doing well.
- CBT techniques are **based on facts**. Often times we upset ourselves about things that are out of our control when, in fact, the situation isn't like we think. CBT encourages you to look at your thoughts as things you can change or modify so your thinking is consistent with how the situation really is.
- **Homework** is a central feature of CBT. Achieving goals takes a lot of time and effort. Homework assignments will be used throughout treatment, mostly in the form of worksheets or journaling, in order encourage you to practice the techniques you have learned.

Adapted from: National Association of Cognitive Behavioral Therapists, (2007).

Handout 4

CBT Techniques

Reversal Activity: An activity that helps to reverse the mood or behavior that occurs as a consequence of a negative thought. Potential activities include coping mechanisms, self-care activities, enjoyable or gratifying activities, distraction exercises, motivating activities, and goal-oriented activities.

Positive Imagery: A brief or more involved meditation exercises such as imagining a difficult event and then imagining oneself coping effectively with that event.

Thought Stopping: This technique involves teaching yourself to actively clear your mind of verbal messages or visual images that are negative or painful.

Benefit-Finding: Finding examples of how a life event has been associated with positive changes or positive outcomes in your life.

Fast-Forwarding: Guides you to think about or picture yourself at a future point in time that is different from the present time.

Planning for the Future: Anticipating expected changes in symptoms and planning for how to deal with those changes.

Treatment Decision-Making: Working through the decision making-process in regards to treatment.

Problem-Solving: Dealing with practical issues that result from the disability through brainstorming and choosing a solution to a problem.

Self-Advocacy Training: Empowering yourself to act in your own best interests when interacting with healthcare professionals, employers, friends, family, partners, and others.

Distraction and Meditation Techniques: Used to deal with thoughts causing painful emotions. These techniques can help you to relax and focus on something positive instead of worrying about the negative aspects of daily life.

(Kielhofner, 2009)

Isn't That Absurd

- **Objectives:**
  - Clients will discuss automatic thoughts and the irrational beliefs that often occur in everyday life.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Explain to the clients: Today we will be continuing to talk about cognitive behavioral therapy. Often times we have irrational or unreasonable beliefs because of an event that has occurred in daily life. This causes us to tell ourselves negative things and tends to decrease our self-confidence and body image.
  - Ask the clients: What is a belief?
    - A belief is a habit of mind in which trust, confidence, and assurance are placed in a person or object.
  - Irrational beliefs are messages you send to yourself that have a negative impact. Often times, these messages start at a very young age and are difficult to counteract.
  - Irrational beliefs can be about you or about others. Some examples of irrational beliefs include:
    - I am worthless.
    - I should never burden others with my problems.
    - No one cares about anyone else.
    - There is a loser in every fight, so avoid fights at all costs.

- **Activity:**
  - Give clients the Irrational Beliefs handout *(Handout 5)* and discuss the main points. Have the clients take turns reading off of the worksheet. Within the group, have each member share a belief that they tend to experience.
  - Ask the clients:
    - What are some of the drawbacks to the beliefs that you shared?
    - What are some benefits to changing our irrational beliefs?
      - Help us to become productive, realistic problem solvers
      - Understand ourselves better
      - Reduce emotions of fear, guilt, or hurt

        - To forgive ourselves and others for mistakes
        - To gain a sense of purpose
    - How can you practice changing your irrational beliefs?
        - Which irrational beliefs do you use? Reflect on the irrational beliefs you have and strategies to counteract them.
        - Choose one belief and try to catch yourself thinking about it. Replace it with a positive thought instead. For example, when you think "I'm fat" instead tell yourself something positive such as "I have a nice smile" or "I am wearing nice clothes today."

- **Reflection Questions:**
    - How often do you find that you use irrational beliefs? What are one or two in particular?
    - In what situations do these irrational beliefs come up?
    - How do you feel as a result of having these beliefs?
    - How can you challenge these beliefs that you hold? What is not true about these beliefs?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - Since the discussion, have you been able to catch or replace any irrational beliefs?
        - How have you been able to replace negative thoughts with more positive or neutral thoughts? How did it feel to have this change in your thought process?
        - What have you learned about the reality of your beliefs?
        - Consider situations that have a negative impact of your life. Are there any irrational beliefs behind your reactions to these situations?
        - How can you strive to challenge your beliefs in the future? How do you think you will feel as a result of this change in your thoughts?

Handout 5

Irrational Beliefs

1. **The idea that it is necessary for adults to be loved by significant others for almost everything they do**. Instead, concentrate on your own self-respect, on winning approval for practical purposes, and on loving rather than on being loved.
2. **The idea that certain acts are awful or wicked and that people who perform such acts should be punished.** Instead, think a person's poor behavior does not make them a rotten individual.
3. **The idea that it is horrible when things are not the way you like them to be.** Instead, think that you would be better off trying to change bad conditions so that they become more satisfactory. If that is not possible, you need to temporarily accept and gracefully accept their existence.
4. **The idea that misery is forced on us by outside people, events, and circumstances.** Instead, think that your negative viewpoint is largely caused by the view you take of unfortunate conditions.
5. **The idea that if something is or may be dangerous or fearful, you should be terribly upset and obsess about it.** Instead, it is better to face it and declare it safe. When that is not possible, accept the inevitable.
6. **The idea that it is easier to avoid than to face difficulties and responsibilities.** Instead, remember that the easy way is often much harder in the long run.
7. **The idea that you need something stronger or greater than yourself on which to rely.** Instead, remember it is better to take slight risks of thinking and act less dependently.
8. **The idea that you should be competent, intelligent, and successful in all aspects of life.** Instead, it would be better to accept yourself as an imperfect person who has limitations and shortcomings like all other humans.
9. **The idea that because something once strongly affected our life, it should indefinitely affect it.** Instead, we can learn from our past experiences but not be overly-attached to or biased by them.
10. **The idea that we must have certain and perfect control over things.** Instead, think that the world is full of improbability and chance and that we can still enjoy life despite this.
11. **The idea that we have virtually no control over our emotions and that we cannot help feeling disturbed about things.** Instead, believe that you have real control over your destructive emotions if you choose to work at changing the thoughts that often create them.

How to Deal

- **Objectives:**
  - Clients will learn to facilitate management of emotions and feeling of stress.
  - Clients will be educated on strategies to manage symptoms.
  - Clients will be provided with an opportunity to identify coping skills that may be more beneficial to their health and functioning.
  - Clients will be given an opportunity to utilize and practice their new coping skills in a supportive environment.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity, Environment

- **Introduction:**
  - The purpose of this group is to assist clients in recognizing current habits that they utilize to cope with feelings and handle situations that may not be healthy.
  - Explain to the clients that coping skills are often used to deal with stressors in daily life. They can either be healthy or unhealthy. Discuss with the clients coping skills they currently use to deal with symptoms of their diagnoses and whether they are healthy/unhealthy and effective/ineffective.

- **Activity:**
  - Ask the client to brain storm situations which cause them to feel nervous, anxious, or angry. Have them identify situations which cause negative feelings.
  - Have the clients share how they manage events and stressors in their lives, their daily and personal responsibilities, or how they deal with the feelings brought up throughout the day.
  - On a white board make two columns. Label one column healthy and the other column unhealthy. Throughout the discussion on current coping skills, ask the clients to identify which category their current strategies fall under.
  - Following the discussion of unhealthy coping skills, have the clients brainstorm ideas that can be used instead of turning to unhealthy ways of coping.

        - These can include:
            - Reaching out to someone who is supportive of you.
            - Be open and honest about what you are feeling.
            - Taking a relaxing bath or utilize another method of stress relief.
            - Trying to be objective and working through a problem in your head before reacting or becoming worried.
            - Setting reachable daily goals.
            - Using a daily calendar or planner to help keep you organized and aware of commitments. Make sure to schedule in fun time too!
            - Find creative and artistic ways to express yourself.
            - Identify your emotions and the driving force behind them.
            - Take some time for yourself to collect your thoughts. Try journaling.

- **Reflection Questions:**
    - What are some techniques you have used to cope in the past?
    - Did any of the discussed methods for coping stand out to you? Which can you try in the future?
    - How comfortable do you feel trying one of the discussed coping skills that is new to you?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What do you notice about your prevalent patterns of coping?
        - What feelings did this group bring up for you?
        - What coping skill could you try next time you experience a negative situation? Why do you feel this would be beneficial to you?
        - What are two coping skills you could use? How would they be beneficial?

Reflect On This

- **Objectives:**
  - Clients will learn to recognize their thought patterns, beliefs, and understanding.
  - Clients will look more closely at how these thought processes came about, as well as the impact on their lives and functioning.
  - Clients will be introduced to methods for applying reflective thinking to their daily life.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Reflective thinking is something that works well in conjunction with journaling as well as during tasks which may be uncomfortable or new to the client.
  - Throughout this program, the client will be asked to reflect on group sessions, past experiences, current thoughts, beliefs, and actions, and his or her hopes for the future.

- **Activity:**
  - Define and discuss the benefits of utilizing reflective thinking with the clients.
    - Explain to the clients that reflective thinking is the process of looking critically at the way the individual is making judgments about their experiences.
    - To use reflective thinking in the client's life is on ongoing and constant process of evaluating your beliefs and knowledge.
    - When the client is reflectively thinking, they are in control of what they are learning and taking an active role in how they utilize or interpret new learning or experiences.
  - Discuss with the clients:
    - Why do you feel reflective thinking will be beneficial to your treatment? How can it help make new activities easier or more comfortable in the future?
    - How can reflective thinking be utilized in your everyday life?
  - Instruct the clients to think about their day yesterday. Ask the clients: What went well? What did not go so well? What could have you done

differently? What feelings did you have? Why do you think you had these feelings? Encourage clients to answer these kinds of questions in a journal on a daily basis.

- **Reflection Questions:**
  - Do you currently use reflective thinking in your life? What is an example of a time in which you used this type of thinking?
  - What gets in the way of reflective thinking?
  - What is a situation in which you can apply reflective thinking currently?

- **Journal Questions:**
  - Have the clients answer the following questions in their journal:
    - Have you had any realizations this week about why you feel the way you do? How do your feelings influence your habits?
    - How has it felt to apply the concepts of reflective thinking into your daily life?
    - Have you seen any changes in your thinking?

Life Skills

Life Skills

Activities in this section focus on the skills needed to be successful in the occupations of everyday life. These topics are beneficial for this population because often individuals with the dual diagnosis of an eating disorder and post-traumatic stress disorder struggle to maintain healthy habits and routines due to stressors in their environment. These activities will help the client identify strategies to deal with the stress they encounter on a daily basis and successfully function in daily life.

Activities are intended to be 60 minutes in length but may be adjusted as needed. These activities may be completed in any order but a suggested activity sequence is:

1. De-Stress: This is a group activity focused on identifying situations that create stress and learning techniques for the management of stress in daily life.
2. Keep Calm: This is a group activity focused on managing anger due to symptoms of illness or stress.
3. Be Assertive: This is a group activity focused on learning about assertiveness and practicing these skills through a role playing activity.
4. Seize the Moment: This is a group activity focused on areas of time management including planning ahead, delegation of tasks, dealing with perfectionism, and the importance of downtime.
5. Organize It: This is an individual activity focused on the home environment to address any home organization and management needs.
6. Budget Cents: This is an individual activity focused on taking responsibility for personal finances and creating a monthly budget.

Each group has a reflective component, as well as suggested journal questions for further self-reflection following each session. This reflection will assist the client in developing the skills learned and support the integration of the skills in daily life. Journal questions are provided for each session and assist the client in self-reflection of personal thoughts, feelings, behaviors, habits, and the environment in which daily activities are performed. Clients do not need to answer every question but are encouraged to write on a daily basis following each session in order achieve the benefits of self-reflection. Clients should be reminded that all journal entries are confidential unless permission is given for reading. Journal writing can be done in any format that is comfortable for the client, such as a letter written to them.

Several assessments are appropriate to guide the intervention sessions provided. The Occupational Self-Assessment (OSA) looks at the client's perception of occupational performance and the impact of the environment. Results of this assessment may indicate a need for individual or group sessions focused on the management of stress or anger, increasing assertiveness, learning about time management, addressing home management needs, or creating a personal budget.

The Role Checklist provides information about the various roles of the client and the impact of their diagnoses on these roles. Through this assessment, the therapist may identify areas of deficit for the client and choose to involve the client in groups relating to time management, home organization, or creating a personal budget.

The Eating Disorder Inventory-3 (EDI-3) and PTSD Checklist—Civilian Version (PCL-C) provide an in-depth look at the current symptomology of the client. Through this, the therapist can further question the client about the impact of these symptoms and

provide individual or group interventions relating to stress and anger management, assertiveness, time management, home organization, or budgeting.

De-Stress

- **Objectives:**
  - Clients will gain an understanding of how to identify, address, and manage symptoms of stress which occur in everyday life.
  - Clients will be able to identify situations which they find stressful and identify strategies to cope with this stress.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Performance Capacity

- **Introduction:**
  - This session will assist the client to identify situations which cause them stress
  - Begin the session with a discussion of:
    - What is stress?
    - How does stress commonly start?
    - What is the impact that stress can have on your function in daily life?
    - Have the clients make a list on a whiteboard of common causes of stress and the impact stress has on daily life.

- **Activity:**
  - Ask the clients to identify situations that bring about stress. Discuss:
    - What is an event that you experienced that caused you stress?
    - When do you often feel the most stressed?
    - How do you feel in these situations?
    - How have you dealt with these feelings in the past?
  - Then, ask the clients to share what they have tried in the past to deal with stress: What worked for you in the past? What could you have done that would have worked better? Clients can also give suggestions to the other group members about ways to deal with stress.
  - If needed, suggest techniques to try in the future to manage stress such as aromatherapy, taking a bath, exercising, organization of home and work space, and meeting a friend at the park.

- **Reflection Questions:**
    - Ask the clients:
        - What activities do you or did you do in the past which you found relaxing?
        - Who is someone in your support system that you can go to for assistance when you feel stressed?
        - What techniques would you try in the future to manage your feelings of stress?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - Identify which situations are known to cause stress for you.
            - What signs and symptoms do you experience when you are under stress?
            - What strategies can you use to manage stress?
            - How will you utilize these techniques in your daily life to assist you with coping with stress before and once it occurs?
        - Would it work for you to complete a weekly schedule with reminders in place to take time to relax and participate in enjoyable activities?
            - Why or why not?
            - If you did try this, how did it work?

Keep Calm

- **Objectives:**
  - Clients will develop skills to manage anger brought on by symptoms of their diagnosis and stress.
  - Clients will learn techniques to increase anger management.

- **Activity Type:** Group

- **MOHO Component Addressed**: Volition, Habituation, Performance Capacity

- **Introduction:**
  - Explain to the clients: Today we will learn to identify triggers that cause feelings of anger and to learn skills that assist the client to cope with these feelings.

- **Activity:**
  - Lead a group discussion on what causes feeling of anger:
    - How have you coped with anger in the past?
    - What was effective and what wasn't?
  - Provide clients with Anger Management handout *(Handout 6)* and review the techniques listed. Have the clients answer the questions at the bottom of the handout in relation to a situation that causes anger.

- **Reflection Questions/Activity:**
  - Ask the clients:
    - Have each client share a situation that makes them angry.
      - What thoughts and feelings do you have in this situation?
      - What they can do to take a break or avoid acting negatively in this situation. (Answers from *Handout 6*)
    - How will the techniques you learned today be beneficial to you?
    - How can you take steps to incorporate these techniques into your daily practice?

- **Journal Questions:**
  - Have the clients answer the following questions in their journal:
    - Discuss the healthy and unhealthy ways you have expressed anger in the past. What impact has this had on your life? How does this relate to your values?
    - What are some strategies you will practice using to express your anger in a more positive manner?

Handout 6

Anger Management

- **Identify Your Triggers:** When you feel yourself getting angry, take a break to reflect on your thoughts and feelings. Learning about your triggers and what causes you to feel angry will help you to be prepared when certain situations arise. This will help you to be less mad and upset.
- **Stop and Think:** Take time to think before you act. This will help you to use self-control. You may practice this by taking slow, deep breaths or leaving the situation. Think about the possible outcomes if you were to act out and the positive results of taking a break.
- **Act Responsibly:** Learning to remove yourself from the situation when you become angry can be helpful and avoid negative consequences. This will allow you to be safe and responsible.
- **Take A Time-Out:** Find an activity to do that will help you to clear your thoughts and decrease anger. This may be going for a walk, listening to music, or playing a game. This will help you to get out of a negative frame of mind and lift your spirits.
- **Express Yourself:** Keeping a journal can help you to get your thoughts down on paper and to let go of feelings of anger. If you would like, you may find it helpful to share your feelings with another person, such as a close relative or counselor. Being able to express your anger in a healthy manner will help build your self-esteem and improve quality of life.

Answer the following questions:

1. Identify a situation in which you become angry:

2. What thoughts and feelings do you have in this situation?

3. What is one thing you can do to take a time-out?

4. What might you journal about or who can you talk to?

Be Assertive

- **Objectives:**
  - Clients will learn how to be assertiveness in social situations and improve communication skills.
  - Clients will develop self-respect through the sharing of ideas.
  - Clients will learn to assert and identify personal needs or viewpoints.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Performance Capacity

- **Introduction:**
  - Today we will focus on the development of assertiveness skills, or expressing yourself in a respectful and appropriate manner, and self-respect through a variety of role playing activities.

- **Activity:**
  - Prior to beginning the role play activities, explain the difference between passive, aggressive, passive-aggressive, and assertive behaviors *(Handout 7)*. Discuss each style of communication with the clients and have them give examples of when they may have used this type of communication. Review how these behaviors may impact relationships and functioning and the benefits of assertive behaviors.
  - Divide the clients into pairs or small groups for participation in the role playing activities.
  - Provide situation cards *(Handout 8)* to each small group and have them role play the situation for the group.
  - Have the clients discuss:
    - How does it feel to practice these situations?
    - What was easy for you?
    - What behavior could you practice more?
    - Identify what you did well to support the use of assertive behavior.
  - Discuss the use of "I" statements and when the situation arises, provide examples by asking clients: How can you turn that statement into an "I" statement to make it more powerful?

- **Reflection Questions:**
    - Ask the clients:
        - What issues are important to you?
            - What do you want others to know you believe?
        - What situations can you start to use assertive behaviors in this week?
            - Practice using an "I" statement: When _____ (situation) happens, I feel _____ (identify emotion) because _____ (state underlying belief; refer to irrational beliefs handout). What I want from you is _____.

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - Give an example of a situation in which you were passive, aggressive, or passive-aggressive in the past? How did you feel in that situation? What were your beliefs? What did you do (your behavior) and does this reinforce a negative behavior or habit for you? How could you have approached the situation in a more assertive manner?
        - In what situations have you been assertive in the past? How has it been going in regards to using assertive behaviors? What is limiting this use? How can you utilize these techniques more?
        - In what environment is it easier to be assertive? Harder?
        - How can you approach those situations that are difficult for you?
        - How can being assertive be helpful to you in living a life consistent with your values and beliefs?
        - How can assertiveness help you to participate in your new interests?

Handout 7

Communication Styles

- **Passive**
  - Allow personal rights to be violated by others
  - Avoid eye contact
  - Use statements like maybe, probably, I guess, I can't, I don't care, etc.)
  - Over apologize
  - Avoid conflict at all times
  - *This leads to poor self-esteem, unresolved feelings, difficulty saying no, and strained relationships.*

- **Aggressive**
  - Disregard the rights of others
  - Demand that personal feelings are heard
  - Use "You" statements (You should…, you better…, If you don't, I'll…)
  - Use put-downs (Come on!, You must be kidding!, profanity, threatening remarks)
  - Avoid taking responsibility
  - Become defensive and blame others
  - *This leads to feelings of guilt and shame.*

- **Passive-Aggressive**
  - Blend of passive and aggressive
  - Violate the rights of others but appear to put them first
  - Inconsistent or confusing behavior
  - Pouting, eye rolling, whining, sarcasm, silent treatment, procrastination
  - *This leads to unresolved feelings along with guilt.*

- **Assertive**
  - Support both self and other's rights
  - Deal with feelings and conflict as they occur
  - Maintain good eye contact and use active listening techniques
  - Use "I" statements (I think…, I feel…, I want…)
  - Express interest and are willing to compromise
  - Use cooperative words (Let's, What can we do?)
  - Takes responsibility for own behaviors
  - Shows respect for others
  - *This leads to high self-esteem, self-respect, self-confidence, and the ability maintain mutually rewarding relationships.*

Handout 8

Situation Cards

Passive:		
When a friend asks if you want to go shopping or to a movie, you say "I don't care" and let the friend choose, even though you would prefer to go to a movie.	**When you are obviously upset and a friend ask what is wrong, you say "nothing".**	**A friend no longer asks your opinion because she knows you will only say "I don't know".**
Aggressive:		
You say whatever is on your mind.	**You get upset and angry if you do not win in an argument.**	**You often make very negative comments.**
Passive-Aggressive		
You don't get your way in a decision so you make comments under your breath and pout.	**You manipulate others to choose the option you want.**	**In conflict, you make the opponent look bad or manipulate the situation so that you win.**
Assertive		
You respect others decisions.	**When someone gives you a choice, you are direct and make decisions in a polite manner.**	**In conflict, you are willing to compromise and negotiate.**

Seize the Moment

- **Objectives:**
  - Clients will assess their current use of time.
  - Clients will learn to differentiate between essential, important, and less important tasks.
  - Clients will increase their ability to function with improved life balance.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Time management is an important part of everyday life. Often times, we find that we spend too little or too much time on a task.
  - Why is it important to talk about time management?
  - Does anyone have problems with time management?
  - Time management is important in order to achieve a more relaxed and healthy lifestyle.

- **Activity:**
  - Have clients fill out the activity log *(Handout 10)* for how they currently use their time. Then, discuss the following topics and provide the clients with the Time Management handout *(Handout 9).*
  - Time management
    - The way in which you organize/structure you daily activities over time.
    - Ineffective time management can lead to stress, anxiety, burnout, and illness.
    - Effective time management will allow more of the 3 types of downtime (rest, recreation, relationship).
  - Downtime
    - A time-out from responsibilities to give yourself an opportunity to rest and replenish your energy. This can be divided into 3 areas:
      - Rest time: set aside all activities and allow yourself to just be, allow yourself to stop doing, rest time = passive.
      - Recreation time: “re-create” you, replenish your energy, brightens and uplifts your spirits, anything you experience as fun or play.

- Relationship time: enjoy being with other people, allocating the time between different relationships; meeting the basic needs of affection, validation, and support is vital to your well-being.

- Ask the clients:
  - How can you allow for more downtime in your life?
    - Learn to enjoy non-work aspects of your life.
    - Be willing to do less; reduce the number of tasks and responsibilities your handle in a given day
  - Do you think there are negative effects from too much downtime?

- Delegation:
  - Being willing to let someone else take care of a task that has lower priority or that you don't have to do personally.
  - Frees up more time for tasks that are essential and require your personal attention.
  - Have each client give an example of a task they could delegate to others.
- Allowing extra time:
  - A common problem in time management is understanding the amount of time required to complete a task causing you to rush to get something done.
  - By allowing more time than you would expect, you'll feel less pressured and overwhelmed.
  - Be willing to do fewer things—allows you to proceed your day at a more relaxed and easy pace saving you a lot of stress.
  - Have clients give an example of a time when they could have allowed themselves extra time.
- Letting Go of Perfectionism
  - Perfectionism: setting standards and expectations too high; having no allowance for the inevitable mistakes, frustration, delays, and limitations in daily life.
  - Letting go of perfectionism requires an attitude shift. Remember to:
    - Simply do your best
    - Expect to make some mistakes along the way
    - Do your best and accept the results you get
    - Learn to laugh rather than despair at limitations
  - Ask the clients: Do you find yourself being limited by perfectionism? Can you give an example?

- Overcoming Procrastination
    - Procrastination is always self-defeating when you leave yourself too little time—this leaves you stressed.
    - Occurs when you don't want to do what needs to be done in the first place.
    - Delegate or prioritize, jump in even when you're not ready.
    - Promise yourself to do something fun/enjoyable afterwards.
    - Perfectionism—causes you to postpone starting because you fear you can't do it just right.
    - Motivation often follows behavior—getting started with a task often generates motivation to complete it. Then, you may have enough time left over to go back and refine your work.
    - Ask the client to give an example of when they procrastinated and how that may have impacted negative feelings.
- Saying No
    - What are some reasons people have difficulty saying no?
    - Difficulty saying no is usually tied in with your self-image.
    - If your work is who you are, then it will be hard for you to say no to work demands in order to make time for personal needs.
    - Learning to say no requires a willingness to relinquish cherished beliefs about you which can be hard for anyone to do.
    - This means accepting the reality that taking care of you isn't selfish.
    - Reevaluate the way you live your life. Try to slow down, pay attention, and learn how to live in a simpler, more balanced fashion.
    - Ask clients to give an example of when they had difficulty saying no? What feelings did it cause?
- Prioritizing
    - Prioritizing is a way to organize yourself while focusing on essential tasks first and building towards accomplishing more demanding tasks.
    - Remember to ask yourself "Is this important right now?", "Is this something I can control?" and "How much of this am I in control of?"
    - Discuss the three areas individually including tasks that may be included in each part (may be different for each group member)
        - Essential: require immediate attention, always necessary, time bound
        - Important: significant value but can be delayed for a time.

        - Less important: can postpone for a long time; depends on stage in life.

- **Reflection Questions:**
    - Ask the clients:
        - How does your use of time now impact your values? Interests?
            - Is it reflective of what you really want to do?
        - How have you managed your time in the past? What works for you and what doesn't work as well? What are some strategies you can use to overcome these weaker areas?
        - Refer to your activity log, where can you try some of these techniques mentioned?
        - Does time management have an impact on how you feel about yourself?
        - What do you notice about how you use your time? Are there any patterns?
        - What irrational beliefs do you have that impact how you use your time? (For example, an inability to say no)

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - How has time management affected your thinking, feelings, and behavior?
        - What is a step you can take to improve your time management?

Handout 9

Time Management

Downtime

- Time out from responsibilities so you can rest and replenish your energy
- 3 types:
  1.
  2.
  3.

Time Management

1. **Delegation**
   - Letting someone else take care of a task that has lower priority or that you don‘t have to personally do.
2. **Allowing Extra Time**
   - Allow extra time to complete a task so you feel less overwhelmed and pressured to complete it. Be willing to schedule fewer things into your day.
3. **Letting Go of Perfectionism**
   - Perfectionism: setting standards and expectations too high.
   - Letting go of perfectionism requires an attitude shift.
4. **Overcoming Procrastination**
   - Procrastination is always self-defeating. When you leave yourself too little time, you may feel stressed
   - Motivation follows behavior. Getting started with a task often generates motivation to complete it.
5. **Saying No**
   - Learning to say no requires a willingness to accept the reality that taking care of you isn’t selfish.
6. **Prioritizing**
   - A way to organize yourself and focus on the most important tasks first.
   - Tasks can be prioritized into 3 categories:

Essential	Important	Less Important

Handout 10

Activity Log

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Organize It

- **Objectives:**
  - Clients will be provided with an opportunity to address organization of their home environment.
  - Clients will identify areas of their environment that are creating stress and ways to manage the home environment to relieve stress.

- **Activity Type:** Individual

- **MOHO Component Addressed:** Volition, Habituation, Environment, Performance Capacity

- **Introduction:**
  - Today we will learn strategies to create a calming environment in which you can relax and utilize.
  - Creation of a calming environment can give you a place to go that is calming and be an expression of yourself.
  - These techniques will help provide the opportunity to follow a task through completion and provide an opportunity for success.

- **Activity:**
  - For this activity, you will meet with the client and discuss their needs within their home or other environments. These needs can include organization, creating a welcoming and calming space, or removing clutter. You may visit the home with the client or simply provide guidance about what the client can do on their own.
  - The client will identify which area they want to focus on during the session. Once it is determined what the client needs, assist the client to develop a plan of action, and what is needed to produce the goal for their home. This plan can include developing a daily schedule for chores or tasks that need to be completed around the home, helping the client decide what papers or bills need to be kept, and how to organize them.
  - This activity is also a good opportunity to discuss time management in relation to balancing work responsibilities, social activities, and relaxation.
  - The needs of each client will vary as personal situations are different so it is important to consider all variables.
  - **Note:** This activity will vary with each client. Be prepared to discuss issues on an individual basis and address needs as they arise.

- **Reflection Questions:**
    - Ask the client:
        - How does the organization of your environment impact your ability to help your life be consistent with your values? Pursue your interests?
        - What difficulties have you had in the past in your home environment?
        - How does it feel to focus on this task?
        - What emotions does organization bring up? Why?
        - What feelings are associated with the tasks?
        - What beliefs are present when completing the task?
        - Do you have any irrational beliefs during completion of the task?
        - Do you find it difficult to motivate yourself to begin a task?
        - How long does it usually take you to start a similar task? Are you finding yourself wandering and doing other things?
        - What new organization habits do you want to start?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - How does it feel when you put things off?
        - What do you notice about your beliefs about this task? How does it relate to your beliefs about other tasks?
        - What are specific behavior steps you can take? How can you keep yourself accountable for them?

Budget Cents

- **Objectives:**
  - Clients will develop skills necessary for financial management and independent living and increase self-efficacy.
  - Clients will develop a healthy habit for financial management.

- **Activity Type:** Individual

- **MOHO Component Addressed:** Habituation

- **Introduction:**
  - The purpose of this topic is to assist the client in monitoring spending and developing a budget for monthly spending.
  - This topic is sensitive to some people so it may be best done on an individual basis.

- **Activity:**
  - You will meet with the client and determine if they would benefit from a session discussing current spending and development of a budget.
  - Give the client fake money (possibly similar to the client's monthly income) and ask them to divide into categories such as living expenses, leisure, and savings.
  - The client will fill out the Monthly Expense worksheet *(Handout 11)* to determine what their spending has been in the past month.
  - The client can then identify the areas they spend the most; what areas they can limit spending; and areas which are priorities for spending (i.e. food, housing).
  - You and the client can then create a budget for the next month spending. This can be done through the use of the Monthly Expense worksheet *(Handout 11)* and putting in consistent monthly expenses and determining remaining money which can be allotted for areas such as personal costs, miscellaneous, and savings.
  - If needed, assist the client to set-up folders for bills and receipts in order to stay organized.
  - Meet with the client at a later date to discuss how things are going and what could be improved.

- **Reflection Questions:**
    - Ask the client:
        - Do you have any interests you would like to pursue that take money to participate?
            - How will managing your money help you pursue your interests?
        - How can you help keep your financial materials organized?
        - What are your future goals? How much money do you have to set aside to accomplish these goals?
        - What steps can you take to help yourself reach these goals?
        - What are your current beliefs and feelings about managing money?
        - How do you feel about your current financial situation? Does it impact you current symptoms?
        - How do money issues relate to your stress?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - Have you used budgeting or money management in the past?
        - What are your feelings about money management?
        - What beliefs do you have about money and how does it impact your financial situation?
        - Were there any areas that you found you were overspending? How can you limit this?
        - How do you see a monthly budget helping you in the future?

Handout 11

My Monthly Expense Worksheet

INCOME	
Wages:	
Supplemental loans (if any):	
Other:	
TOTAL:	

EXPENSES	
HOME EXPENSES:	
Rent or house payment:	
Renter or home owner insurance:	
Utilities:	
Phone line:	
Cellular phone:	
Repairs or improvement costs:	
Cable:	
Internet:	
Groceries:	
Dining out:	
Entertainment (movies, concerts, events, etc.):	
TOTAL:	
TRANSPORTATION COSTS:	
Car payment:	
Car insurance:	
Gas:	
Car repairs:	
Alternative transportation (bus, taxi, etc.):	
Parking costs:	
TOTAL:	
HEALTH AND WELLNESS COSTS:	
Medications (prescription and over the counter):	
Medical appointment/procedure dues:	
Medical insurance:	
Pet costs:	
Gym or sport team fees:	
TOTAL:	

PERSONAL COSTS:	
Clothing:	
Hair cut or personal care:	
Books, music, electronics:	
Credit cards payment:	
Money into savings:	
TOTAL:	
MISCELLANEOUS COSTS:	
Other:	
Other:	
Other:	
Other:	
Other:	
Other:	

TOTAL OF ALL EXPENSES	
Home Expenses TOTAL:	
Transportation Costs TOTAL:	
Health and wellness costs TOTAL:	
Personal costs TOTAL:	
Miscellaneous costs TOTAL:	
TOTAL OF EXPENSES:	
MONEY REMAINING: (Income – Expenses)	

Adapted from http://office.microsoft.com/en-us/templates/personal-budget-worksheet-TC006206279.aspx

Meals

Meals

Activities in this section focus on healthy habits and food. These topics are beneficial for this population because often times clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder struggle to maintain healthy daily habits related to planning, preparing, and eating meals.

Activities are intended to be 60 minutes in length but may be adjusted as needed. These activities may be completed in any order but a suggested sequence is:

1. Let's Eat Healthy: This is a group activity focused on teaching the clients about the healthy components of a meal and allowing them to create a weekly menu for healthy meals. This group may also be used to plan for the meal preparation group.
2. Shopping for a Healthier Life: This group activity allows the clients to go shopping for groceries for either the meal preparation group or for personal groceries.
3. Cooking Up Some Fun: This group activity focuses on preparing a healthy meal as a group. The clients decide on a meal to make as a group, delegate tasks, and make a meal that can be eaten if time allows.
4. Let's Go Out to Eat: This group activity allows the clients to choose a restaurant and eat a meal as a group in a social setting.

Each group has a reflective component, as well as suggested journal questions for further self-reflection following each section. This will assist the client in developing the skills learned and support integration of the skills in daily life. Journal questions are provided for each session and assist the client in self-reflection of personal thoughts,

feelings, behaviors, habits, and the environment in which daily activities are performed. Clients do not need to answer every question but are encouraged to write on a daily basis following each session in order achieve the benefits of self-reflection. Clients should be reminded that all journal entries are confidential unless permission is given for reading. Journal writing can be done in any format that is comfortable for the client, such as a letter written to them.

Several assessments are appropriate to guide interventions provided in this section of the program. The Eating Disorder Inventory-3 provides information about the client's current symptomology and can be used to further question the client about the impact of symptoms on daily function. The client can then be involved in groups relating to meal planning, grocery shopping, meal preparation, or eating in a social setting.

The Role Checklist provides information about the roles the client is currently participating in and has completed in the past. This assessment will assist you to understand the client's skill level and need for activities related to food. All groups in this section may be used based on the results of the Role Checklist.

Let's Eat Healthy

- **Objectives:**
  - Clients will learn skills needed to plan a healthy meal.
  - Clients will identify components of a healthy meal.
  - Clients will plan a weekly menu for meals.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Eating healthy is important for not only your body but also for your mind. Eating a healthy, balanced diet can have numerous positive effects
  - Imagine you just ate a great meal. What was it? How do you feel afterwards? What are you thinking about yourself?
  - Positive benefits of a healthy diet: increases positive feelings about self, prevents other health problems, etc.
  - Discuss with the clients the components of a meal *(Handout 12).*
  - In order to have a balanced diet, you must not only consume the appropriate portion size but also ensure that you are receiving the nutrition needed to maintain a healthy lifestyle.
  - How has your eating this past week compare to this list? *(Handout 12)*
  - **Note:** Review the weekly menu with the client and discuss feelings related to food and planning a menu in advance in an individual session if time allows.

- **Activity:**
  - Have the clients prepare a weekly meal plan either individually or as a group with the information they have just learned. Meals should have the appropriate foods and calorie intake. A template is provided *(Handout 13).*
  - Newer group members may find it beneficial to discuss a sample meal or weekly plan at first. Individuals who have participated in this group prior or have experience with meal planning may be able to help other clients.
  - Once the meal plan is completed, each client will review the plan with the therapist. It may be helpful to have a dietician available to ensure proper nutrition.

- **Reflection Questions:**
    - Ask the client:
        - How did it feel to talk about your eating process?
        - What feelings did you have while planning your weekly menu?
            - How can you break the pattern in meal planning?
        - How are your eating patterns related to your emotions? Thinking?
        - Why is it beneficial to eat healthy meals?
        - What are your irrational beliefs about food? What can you do to change these beliefs?
        - Do you have any feelings of anxiety about food? Refer to list of Descriptive Words for Journaling *(Handout 2).*

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What are some of your past behaviors regarding food?
        - What are your feelings associated with food?
        - What are your irrational beliefs about food? What can you do to change these beliefs?
        - What changes can you make in your eating habits and routines?

Note: The website, http://www.mypyramid.gov, has been developed by the U. S. Department of Agriculture and many great resources for appropriate nutrition and planning and tracking meals are available.

Handout 12

Healthy Eating

- Food Groups:
  - Fruits
    - Serving size: ½ cup (1 cup of fruit or 100% fruit juice or ½ cup of dried fruit)
    - Daily amount: 2 cups
  - Vegetables
    - Serving size: ½ cup (1 cup of raw or cooked vegetables or vegetable juice or 2 cups of raw leafy greens)
    - Daily amount: 2 ½ cups
  - Grains:
    - Bread, pasta, oatmeal, cereal, tortillas
    - At least half of all grains should be whole grains
    - Serving size: 1 ounce (1 slice of bread, 1 cup of cereal, ½ cup of cooked rice, pasta, or cooked cereal)
    - Daily amount: 6 ounces
  - Meat and Beans
    - Serving size: 2 ½ ounces (2 ½ ounces of lean meat, poultry, or fish, 1 egg, 1 tablespoon of peanut butter, ¼ cup cooked dry beans or ½ ounce of nuts or seeds)
    - Daily amount: 5 ½ ounces
  - Milk
    - Foods that retain their calcium content: milk, yogurt, cheese
    - Foods not included in this food group: cream cheese, cream, and butter
    - Serving size: 1 cup (1 cup of milk or yogurt, 1 ½ ounces of natural cheese or 2 ounces of processed cheese)
    - Daily amount: 3 cups
  - Oils
    - Includes canola, corn, olive, soybean, and sunflower oil
    - Some foods are naturally high in oils such as nuts, olives, some fish, and avocados; some foods are made up of mostly oil such as mayonnaise, some salad dressings, and soft margarine.
    - Oils are necessary for health and are a source of vitamin E
    - Daily amount: 3 teaspoons (serving: 1 teaspoon)
  - Empty Calories
    - It is important to have foods in your diet that provide energy for your body to function. This group includes fats and sugars.

Handout 13

Weekly Menu Plan

Daily Amounts:

Fruit: 2 cups (serving: ½ cup)
Vegetables: 2 ½ cups (serving: ½ cup)
Grains: 6 ounces (serving: 1 ounce)
Meat and Protein: 5 ½ ounces (serving: 2.5 ounces)
Milk: 3 cups (serving: 1 cup)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast: Fruit: ½ cup Protein: 1 ounce Grains: 1 ounce Milk: 1 cup							
Snack: Fruit: ½ cup							
Lunch: Protein: 2 ounces Grains: 2 ounces Fruit: ½ cup Veggie: 1 cup Milk: 1 cup							
Snack Grain: 1 ounce							
Dinner Protein: 2 ounces Grains: 2 ounces Veggie: 1 ½ cups Milk: 1 cup							
Snack Fruit: ½ cup							

Shopping for a Healthier Life

- **Objectives:**
  - Clients will explore beliefs and feelings about grocery shopping.
  - Clients will practice coping strategies in the busy environment of a grocery store.
  - Clients will buy groceries needed for a meal plan.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity, Environment

- **Introduction:**
  - Ask and discuss with clients:
    - Why is grocery shopping an essential part of life?
    - What difficulties have you had with shopping for groceries?
    - The clients should discuss grocery shopping and make a list of items needed.
    - Prior to going to the grocery store, discuss areas that may be stressful for the clients (certain areas of the stores, sounds, smells, etc.) and how the clients can cope with this.
  - Note: This group may be done in conjunction with the meal preparation group.

- **Activity:**
  - The clients should discuss a plan for shopping at the store. A worksheet is provided for a grocery list to be made *(Handout 14)*
  - The clients will then go to a grocery store to buy the groceries needed. If possible, each client should be asked to go through the checkout and pay for an item in order to get the full experience.

- **Reflection Questions:**
  - Ask the client:
    - How did it feel to plan the grocery shopping outing?
    - How did it feel to be in the grocery store?
    - What did it feel like picking out the appropriate groceries?
    - What did it feel like buying the groceries?
    - What are your habits related to buying groceries or shopping in general?

        - Did you have any irrational beliefs while grocery shopping? What can you do to change these beliefs?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What are your past experiences with grocery shopping?
        - Discuss your experience at the grocery store. Was it easy or difficult? What was difficult?
        - What thoughts go through you head when shopping? What are you telling yourself?
        - What feelings did you have during the outing?
            - How did you cope with those feelings?
        - Do you have any irrational beliefs about grocery shopping or while grocery shopping? What can you do to change these beliefs?
        - Were there any triggers in the grocery shopping environment that influenced your thinking or behavior?
        - What techniques might be helpful to you in addressing these feelings, thoughts, or behaviors?

Handout 14

Grocery List

Meal Being Prepared:

_____

Groceries Needed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Cooking Up Some Fun

- **Objectives:**
  - Clients will prepare a meal with peers.
  - Clients will learn to cope with negative feelings during meal preparation.
  - Clients will identify feelings associated with food and meal preparation.
  - Clients will explore beliefs related to food preparation.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation

- **Introduction:**
  - Clients will choose a meal to prepare as a group. Clients may need to plan their meal a day or two prior to preparing the meal to allow time to shop for groceries. Clients may be able to shop for the groceries when they go on the community outing to the grocery store.
  - Clients will discuss the process of preparing the meal so all group members understand what needs to be completed. Steps may be written on a white board or large piece of paper if available.
  - Discuss with clients any difficulties they may have when preparing the meal, especially if they are sensitive to food or are having difficulty with eating disorder behaviors.
  - Discuss coping mechanisms that can be used during meal preparation such as deep breathing or taking a short break. Have each client identify a situation that may be stressful or difficult for them during the meal preparation.

- **Activity:**
  - Have a list of possible meals *(Handout 16)* for the clients to make. The clients may then vote on the meal they would like to make. This means that some clients may not be making the meal they wanted to. Provide more or less structure depending on the clients in the group. Some clients may not know how to do the task they are assigned or working on so will need guidance to complete the task. This can be provided by you or another client. A worksheet *(Handout 15)* can be provided so that tasks can be divided somewhat equally among the group members. The therapist may assign a leader for the group or choose the tasks each group member will complete.
  - If time and facility policy allows, the group will also eat the meal.

- **Reflection Questions:**
    - Ask the clients:
        - What are your beliefs about how a meal should be prepared?
        - How do your beliefs impact your feelings?
        - How did it feel to plan and prepare a meal? What was difficult about the planning or preparing the meal?
        - What did or did not happen as you thought it should? What were your feelings when something unexpected happened?
        - How can you cope with your feelings? (If a situation arises, have the clients stop preparing the meal and practice coping skills)
        - Did you have any irrational beliefs about preparing a meal or those who you were working with? What can you do to change these?
        - How did communication with the other group members go?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What feelings did you have while planning or preparing the meal? Why do you think you experience these feelings? What can you do to cope with these feelings?
        - What irrational beliefs did you experience? What did you do to counteract them?
        - Did you feel any anxiety throughout the group? What caused the anxiety? What did you use to cope with these feelings?
        - Were there any triggers that caused these feelings?
        - What habits do you have related to meal planning and preparation? How does it impact your daily routine?
        - How did it feel to have tasks delegated? What feelings arose when you or someone else in the group did not stick to a delegated task or did someone else's task?
        - In what ways can you modify the way you approach meal preparation to reduce negative feelings or anxiety experienced?

Handout 15

Meal Preparation Group

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Group Member: _____ Meal Task: _____

Handout 16

Sample List of Meals

- **All meals should include milk, a vegetable, and a fruit.**

- **Possible main dishes include:**
  - Spaghetti with meat sauce and garlic bread
  - Sloppy Joes
  - Soup and sandwich
  - Chicken and rice casserole
  - Lasagna
  - Macaroni and Cheese
  - Tacos
  - Tator Tot Hotdish

Let's Go Out to Eat

- **Objectives:**
  - Clients will eat a meal with peers.
  - Clients will gain experience and exposure to dining in the community.

- **Activity Type:** Group

- **MOHO Component Addressed:** Habituation, Volition, Environment

- **Introduction:**
  - Discuss eating a meal at a restaurant (looking at the menu, choosing what to order, ordering, waiting for food, eating food, paying, etc.).
  - The clients then choose a restaurant to eat at a nearby the facility (Possibly have a list of 5 – 10 restaurants to choose from). Clients should offer suggestions of where to go and then vote to choose one restaurant to go to.
  - Have clients identify aspects of the activity they expect to experience as stressful or difficult.
  - Discuss coping skills that can be used while at the restaurant. Which coping skills would you expect to use? Examples include deep breathing, tightening toes or fingers and relaxing, and positive imagery.

- **Activity:**
  - Clients go as a group to the restaurant. Clients may sit as a whole group or several small groups.
  - Clients will look at the menu, choose what they will order, and order their own food.
  - While waiting for their food, clients should engage in conversation with other group members at their table. Clients may need redirection with conversation if inappropriate topics arise or prompting if there is a lack of conversation. This may not be an issue with all clients.
  - Clients will then eat their food and pay for their meal. The facility will generally pay for the meal but to get the experience of paying and communicating with the wait staff or cashier, clients should practice paying for their meal.

- **Reflection Questions:**
  - Ask the clients:
    - Would you go to this restaurant or a similar restaurant again?

        - How did the environment in the restaurant make you feel? What types of coping skills did you use?
        - Could you have changed anything in your environment? In what way would you adapt it?
        - How did you feel while planning and choosing a restaurant? Why do you think you felt that way?
        - How did you feel while at the restaurant? Why do you think you felt this way?
        - What types of habits do you have in relation to restaurants or to eating with other people? Do you go there often? Is it difficult or easy for you? Why do you think you have the feelings you do in relation to restaurants or eating with other people?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - How did you feel while planning and choosing a restaurant? Why do you think you had these feelings? How did you cope with them?
        - How did you feel while at the restaurant? Why do you think you had these feelings? How did you cope with them?
        - What experiences have you had with eating at a restaurant in the past? What feelings did you have? What coping strategies did you use
        - Was it helpful to have the support of peers while at the restaurant? How was it helpful?
        - Was eating at a restaurant difficult for you? Why?
        - In what ways can you modify the way you approach eating at a restaurant reduce negative feelings or anxiety experienced?

Self-Care

Self-Care

Activities in this section focus on self-care activities and the importance of performing personal cares during stressful times. Activities concentrate on body image and coping skills for clients diagnosed with the dual diagnosis of an eating disorder and post-traumatic stress disorder. These topics are beneficial for this population because of decreased function in daily occupations, especially related to self-care.

Activities are intended to be 60 minutes in length but may be adjusted as needed. These activities may be completed in any order but a suggested activity sequence is:

1. Think Positively: This is a group activity focused on the use of positive affirmations to replace negative thoughts and beliefs through the use of a self-awareness activity.
2. Mirror, Mirror: This is a group activity focused on improving body image allowing the client to see the true shape of their body through a tracing activity.
3. Dress for Success: This is an individual activity focused on improving body image and appropriate clothing selection. The client practices dressing and is shown how their current body image may be interfering with choosing the correct size of clothing.
4. Get a Good Night's Sleep: This is a group activity focused on strategies to improve sleep, including the use of a sleep journal to record habits and routines.
5. Let's Get Moving: This is a group activity focused on light exercise techniques, as well as energy conservation to promote a healthy lifestyle.

Each group has a reflective component, as well as suggested journal questions for further self-reflection following each section. This will assist the client in developing the skills learned and support integration of the skills in daily life. Journal questions are provided for each session and assist the client in self-reflection of personal thoughts, feelings, behaviors, habits, and the environment in which daily activities are performed. Clients do not need to answer every question but are encouraged to write on a daily basis following each session in order achieve the benefits of self-reflection. Clients should be reminded that all journal entries are confidential unless permission is given for reading. Journal writing can be done in any format that is comfortable for the client, such as a letter written to them.

Several assessments are appropriate to guide the activities chosen in this section of the program. The Occupational Self-Assessment (OSA) looks at the client's perception of occupational performance and the impact of the environment on daily activities. Information gathered through this assessment can assist the therapist in choosing activities related to positive affirmations, body image, sleep hygiene, or exercise based on the client's specific needs.

The Sleep Assessment, developed by the authors for this product, gathers information about the client's current sleep habits and patterns. This assessment assists the therapist in preparing for the group session focusing on sleep and should be administered prior to the session.

The Eating Disorder Inventory-3 (EDI-3) and PTSD Checklist—Civilian Version (PCL-C) obtain information about the current symptomology of the client. Further information about the impact on daily function can be gathered through an informal

interview. Based on the information gathered, the therapist may choose to involve the client on sessions involving positive affirmations, body image, sleep hygiene, or exercise.

Think Positively

- **Objectives:**
  - Clients will learn to replace negative thoughts with positive thoughts.
  - Clients will increase self-esteem through positive thoughts.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition

- **Introduction:**
  - Introduce the topic to the clients: Today we will be talking about affirmations. Affirmations are a way of replacing our negative thoughts with positive thoughts. They are statements about a desired outcome as if it is already coming into reality.
  - What are some negative thoughts that we often tell ourselves?
    - Create a list on a white board or sheet of paper
  - What are the results of these negative thoughts and messages?
    - Create a list in a second column on the same sheet of paper.
  - Affirmations are positive statements about who we really are. When we begin to recognize the negative messages we tell ourselves, we can begin to reprogram negative thoughts into positive messages by using positive affirmations like: "I am lovable", "I can do anything I set my mind to", or "I matter". Provide clients with a list of positive affirmations *(Handout 17).*
  - How do positive thoughts and messages influence behavior?
  - How do your negative thoughts and messages influence behavior?
  - How do positive or negative thoughts influence your feelings?
  - Here are a few hints to making affirmations work:
    - Keep them short and simple.
    - Choose only positive words.
    - Make sure the affirmation fits you and expresses your desires.
    - Try using positive affirmations. They help boost self-esteem, help diminish fears and self-doubts, improve self-confidence, and help you see the real you.

- **Activity:**
    - Positive Attribute Collage
        - Supplies Needed: paper, enough markers or writing utensils for each group member, magazines, scissors, glue sticks or tape and tables and chairs appropriate for size of group.
        - Divide clients into pairs or groups of three.
        - Hand out a piece of paper to every client and place several glue sticks or tape rolls along with markers or writing utensils on table to be shared between them.
    - Provide clients with the directions to create a collage by using magazines and/or drawings of three positive attributes of their partner. Clients will need to rip or cut out images from the magazines provided. These images will be glued on or taped to paper. Clients are allowed to draw positive attributes if desired. Clients may use affirmations from the list provided *(Handout 17).*
    - Each member will take a turn sharing the positive attributes chosen for his or her partner.
    - Positive reinforcement will come from the group as a whole through asking:
        - Does anyone have any other positive attributes pertaining to this person?
        - What other attributes can you name that fit?

- **Reflection Questions:**
    - Increasing self-esteem is an active process. You have to work at turning negative thoughts into positive thoughts.
    - Ask the clients:
        - Did hearing the positive attributes about you help build your confidence level among peers?
        - How did this exercise change the way you thought about yourself or how you interact with your peers?
        - How are you feeling when someone shares a positive affirmation?
        - How do you behave in regards to using a positive affirmation?
            - Did you find it difficult to use affirmations?
            - Do you resist it?
            - Can you accept it and say thank you?
        - What are your beliefs about hearing positive things about yourself?
            - Are any of these feelings irrational?
            - How does that influence your feelings or behaviors about yourself?

        - Do you feel it is important to spend time with people who have positive self-esteem?
        - How do you maintain a healthy self-esteem?
        - What can a healthy self-esteem enable you to do?
        - How are self-esteem and success related?
        - What is one goal you have for using affirmations?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - How did it feel to identifying positive traits in yourself or others?
        - What factors made it hard to identify positive attributes?
        - What did you think of attributes others said about you?
        - Explore how past experiences have impacted your self-perceptions?
            - What negative self-talk and beliefs are associated, if any, with these perceptions?
            - How can you restructure or reword these into more positive phrases?
            - How are your past experiences holding you from restructuring your self-talk?
        - What changes can you make to your self-talk to positively influence your perceptions of yourself?

Handout 17

Positive Affirmations

- I am healthy and happy.
- My life is overflowing with good things.
- I am free to live in peace and security.
- I will start each day positively.
- I accept me, each and every cell of who I am.
- I will do all that I can today.
- I nourish my body with healthy foods and enjoy exercising daily.
- I am no longer holding onto anxiety about my life.
- I have a lot of energy.
- Fear is just a thought. It is not based in reality, and it does not control my actions.
- I am a brilliant and smart person.
- My body is calm and rested.
- I am safe. I am calm. I am beautiful.
- I will address each issue with a sense of serenity.
- I control my thoughts; they do not control me.
- I am deserving of love and kindness.
- Each and every day, things are getting better.
- I am a unique individual and my body reflects who I am.
- I release all fear from my life.
- I am not alone.
- I find success in anything I try to do.
- Everything is getting better every day.
- I replace all of the fear I feel with love.
- I am free from fearful thoughts.
- My spirit is grounded in peace and it expands to embrace my thoughts.

Mirror, Mirror

- **Objectives:**
  - Clients will increase awareness of body shape and size.
  - Clients will decrease negative thoughts about body weight and shape.
  - Clients will adapt their beliefs and feelings regarding self-perception.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition

- **Introduction:**
  - Explain to clients:
    - With a positive or healthy body image you are comfortable with your body and have an accurate perception of your size and shape.
    - What is your perception of your body? Write down words that come to mind when you think of your body.
  - Have you found anything helpful in viewing your body positively?
  - Body image greatly impacts self-esteem and self-confidence, and is influenced by your thoughts, beliefs, and assumptions about yourself.

- **Activity:**
  - First, each client must draw a life-size image of how they feel their body looks.
  - Then, you will assist each client to trace their body onto a large sheet of paper to see the actual shape of their body, preferably on the same sheet of paper.
  - The client then compares the two images to see how their perception of their body image is different than the actual shape of their body.
  - Depending on the group of clients, this session may need to be done individually.

- **Reflection Questions:**
  - Ask the clients:
    - Were your two drawings different?
    - Were you surprised they were the same or different?
    - What are your beliefs about what your body should be? How does this impact your feelings?
    - How did it feel to do this activity?
    - What did you learn from this activity?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What are your feelings about your body?
            - How did you feel doing this activity?
            - How are your feelings influenced by your personal beliefs?
        - Do you feel you have a positive or negative body image? What are your beliefs about your body? Where do these beliefs come from and are any of them based on irrational beliefs? Explain.
        - How did it feel to see your true body shape?
        - How do you feel your environment or the people around you influence your feelings about your body?
        - What did you learn from this activity?
        - How can you build on what you have already learned?

Dress for Success

- **Objectives:**
  - Clients will learn and identify the proper size of clothing needed for their body.
  - Clients will be able to tolerate dressing in the appropriate clothing.
  - Clients will explore beliefs, feelings and habits related to shopping for clothes.

- **Activity Type:** Individual

- **MOHO Component Addressed:** Habituation

- **Introduction:**
  - Today, we will discuss the proper size of clothing and practice dressing.
  - Dressing in the appropriate clothing can have a dramatic effect on self-esteem, self-confidence, body image, and assertiveness.
  - Note: This group may be more appropriate for an individual setting.

- **Activity:**
  - Begin by having the client look at clothing in catalogs.
    - Ask them, what are your feelings about shopping for and trying on clothes?
    - What are your expectations for this shopping experience?
    - Give the client suggestions for types of clothing to try on for fit.
  - Then, have the client practices dressing in the appropriate size clothing. Therapist should watch for balance issues, fatigue, and weakness due to poor diet. The clients own clothes can be used or you can take the client to a store to try on clothing.
  - Have client choose which clothing they feel is the appropriate size and then show the client if the clothing is too large by grasping the extra fabric. Discuss this with the client and then choose clothing of the appropriate size to try on.

- **Reflection Questions:**
  - Ask the client:
    - What did it feel like trying on clothing?
    - Was it difficult to try on the appropriate size of clothing?
    - How did it feel buying clothing?
    - What are your habits in relation to buying clothing?

            - Where or how did you begin to have these habits?
            - How can you break them?
            - What new patterns would you like to develop?
        - What are your beliefs around clothes shopping?
            - How do these beliefs impact what you choose or don't choose to try on?
            - How do others around you impact your beliefs?

- **Journal Questions:**
    - Have the client answer the following questions in their journal:
        - What have you noticed about your thinking as you choose clothing?
        - Have you noticed any changes in patterns of thinking or behavior related to clothing choice?
        - How is your clothing choice influenced by others around you?
            - Who influences you most?
            - What do you need to say to this person?
        - How does the shopping environment influence you?
        - What insights have you gained about shopping?
        - How will these insights influence your behavior in the future?

Get a Good Night's Sleep

- **Objectives:**
  - Client will have increased awareness of sleep habits and routines.
  - Client will develop an evening schedule to develop beneficial habits to promote restful sleep.

- **Activity Type:** Group

- **MOHO Component Addressed:** Habituation, Routines, Environment

- **Introduction:**
  - Today we will focus on developing techniques to improve sleep patterns and promote regular sleep habits. We will learn ways to modify your environment in order to increase sleep performance and decrease stress.

- **Activity:**
  - Assist clients in determining what problems they feel are present related to sleep and what clients would like to see in relation to their sleep patterns.
  - Discuss the routines that each client has in place in order to prepare for sleep, such as listening to music or doing yoga, as well as what they feel is working and what can be improved. This discussion will give the clients a chance to provide others with feedback and suggestions.
  - Then, discuss information and tips for improvement of sleep such as a relaxing environment, unwinding, limiting food intake, and making sure you have a proper bed will increase sleep performance.
  - Provide clients with materials related to this topic such as the handout for a sleep journal and appropriate foods *(Handout 18)* to use in their everyday life.
  - **Note:** Address issues for the Sleep Assessment as they arise during group discussion.

- **Reflection Questions:**
  - Ask the clients:
    - Out of everything we discussed what can you take home and apply to your own life?
    - Were you able to relate to what the other group members brought up?
    - What influences your habits related to sleep?

        - What have you learned about how your sleep environment influences your sleep habits?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What were your feelings about sleep and rest regarding the sleep strategies discussed in this group?
        - What are your habits in relationship to mental and physical activity?
            - How do these habits impact your sleep?
        - When do you allow yourself to relax? What does relaxation have to do with your sleep patterns?
        - Are there any strategies mentioned in the group session that you believe will be helpful to you in your sleeping habits?
          What are some steps you can take this week to positively impact your sleep?

Handout 18

Sleep Journal

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Wake Time							
Estimated Time to Fall Asleep							
Estimated Time of Awakenings and Time Spent Awake							
Amount of Sleep							
Bedtime							
Time and Duration of Naps							
Amount of physical activity throughout the day							

Amount of mental activity or stress throughout the day							
Alcohol or Caffeine, how much? When?							
What was eaten before bed? (Up to 3 hrs. prior)							
How you felt today?							

Adapted from: Wellness Councils of America, 2007

<u>Foods That Promote Sleep</u>
Bananas
Grapefruit
Baked Potatoes
Chamomile Tea
Turkey
Cinnamon
Calcium containing food such as milk

<u>Foods That Do Not Promote Sleep</u>
Sugars
Chocolate
Tomato
Spinach
Sausage/Bacon or High Fat Foods
Spicy Foods

<u>Caffeine (avoid 3-6 hrs. before bed)</u>
Chocolate
Pop
Energy Drinks
Coffee
Some Teas
Some Medications

Let's Get Moving

- **Objectives:**
  - Clients will practice light healthy exercise.
  - Clients will learn about energy conservation techniques.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Exercise is an important part of a healthy lifestyle.
  - The key is to find the appropriate amount of exercise for you. Exercising too often or too intense can have negative effects on the body and cause fatigue and muscle pain.
  - Today, we will talk about healthy ways to exercise as well as how to conserve your energy throughout the day.

- **Activity:**
  - Discuss several areas of light exercise. A short (10 – 20 minute) exercise tape or practice of these techniques may be done if time and space allows.
    - Stretching:
      - Stretching has several benefits including:
        - Improved flexibility
        - Decreased risk of injury
        - Increased blood flow to the muscle
        - Increased range of motion
      - Tips for safe stretching:
        - Focus on major muscle groups: calves, thighs, hips, lower back, neck, shoulders.
        - Don't bounce as you are stretching as this causes small tears in the muscle which tighten when healing making you less flexible.
        - Hold each stretch for approximately 30 seconds and repeat each stretch 3 – 4 times.
        - Stretch regularly (2 – 3 times per week) to achieve the best benefits.
        - Gentle movement, such as yoga or tai chi may be a good way to stretch.

        - Assist the clients in performing a series of stretches to support and affirm the benefits of stretching. Demonstrate several stretches for the arms and legs.
            - It is important for the clients to feel the proper way to stretch and to get moving so that it is more likely to be remembered and become a part of their daily routine.
- Yoga:
    - Yoga focuses on the mind and body and helps you to achieve peacefulness, relax, and manage stress and anxiety.
    - There are many styles, forms and intensities of yoga so it is best to find a style that you enjoy or prefer.
    - Yoga is made up of:
        - Poses: Yoga includes a series of movements designed to increase strength and flexibility.
        - Breathing: Yoga teaches you to control your breathing in order to control your body and quiet your mind.
    - Benefits of Yoga:
        - Reducing stress
        - Increasing balance, flexibility, range of motion, and strength
        - Decreasing depression, pain, anxiety, fatigue or sleep problems
        - Improving mood
    - Again, perform some basic yoga moves with the clients to support the utilization of this technique following this class. Yoga poses can be found on a variety of websites or through watching a video on yoga.
- Energy Conservation:
    - Energy conservation involves strategies that allow you to reduce fatigue and help to maintain or stop weight loss.
    - Some tips for energy conservation include:
        - Plan ahead to avoid rushing through a task or to get everything done.
        - Schedule household tasks throughout the week.
        - Delegate housework or tasks to others when possible.
        - Drag or slide objects rather than lifting.
        - Stop working if you become overly tired.

        - Prior to shopping, have an organized list.
        - Shop at less busy times and use a grocery cart for support.
        - Arrange your home for easy access to frequently used items.
        - Balance leisure activities and rest.
    - If space allows, have the clients practice these techniques in their environment. Ensure each client understand the recommendations and how to perform them at home in addition to the clinic.

- **Reflection Questions:**
    - Ask the client:
        - What do you do that could be considered exercise?
            - When do you do these activities? Where? How often?
        - How do you determine if you are over-exercising?
            - How much is too much exercise?
            - How do you feel about cutting back? Why?
        - How do you feel when you are exercising? Is there any activity you can do to get the same feeling?
        - What are your beliefs related to exercising?
            - Are any irrational?
            - How does that impact your exercise behavior?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - How did it feel to do a small amount of exercise?
        - Do you have a regular exercise routine?
        - Is it an appropriate amount or do you over-exercise?
        - Do you have any goals for exercise?
        - What are some of the beliefs you have in relation to exercise? If you change these beliefs how might they change the behaviors that you hold?
        - What would be the next step for you to change or alter your beliefs or behaviors related to exercise?

Note: If facility funds allow, a small exercise area with a treadmill and other basic exercise equipment may be valuable but must be monitored closely to prevent over-exercise or negative.

Leisure and Social Exploration

Leisure and Social Exploration

Activities in this section focus on leisure interests, as well as social participation and can be tailored to each client or group of clients. These topics are beneficial for this population because leisure and social participation are often affected in clients with the dual diagnosis of an eating disorder and post-traumatic stress disorder. It is important for the clients to participate in leisure activities in order to increase social participation and have time away from responsibilities and roles. This section aims to increase knowledge of leisure activities and allows the client to practice doing leisure in order to find new interests.

Activities are intended to be 60 minutes in length but may be adjusted as needed. These activities may be completed in any order but a suggested activity sequence is:

1. Step Back and Relax: This is a group activity where clients learn relaxation techniques they can utilize in a group or individually.
2. Fun Together: This is a group activity where clients participate in a craft or game activity to increase leisure interests and social participation.
3. Share Your Talents: This is a group activity where one client chooses an activity (craft, game, hobby, etc.) they enjoy and teach the rest of the clients about it.
4. Let's Go Out: This is a group community outing activity where the clients choose a leisure activity in the community to participate in as a group.

Each group has a reflective component, as well as suggested journal questions for further self-reflection following each section. This will assist the client in developing the skills learned and support integration of the skills in daily life. Journal questions are

provided for each session and assist the client in self-reflection of personal thoughts, feelings, behaviors, habits, and the environment in which daily activities are performed. Clients do not need to answer every question but are encouraged to write on a daily basis following each session in order achieve the benefits of self-reflection. Clients should be reminded that all journal entries are confidential unless permission is given for reading. Journal writing can be done in any format that is comfortable for the client, such as a letter written to them.

Several assessments may guide intervention in this section of the program. The Occupational Self-Assessment (OSA) gathers information about the client's perception of their occupational performance and the impact of the environment on participation in daily activities. Clients with deficits in certain areas may benefit from interventions focusing on relaxation, craft or leisure interests, or community outings with the support of peers.

The Modified Interest Checklist gathers information about the client's leisure interests in the past, present, and future. This can guide the therapist in choosing leisure, craft, or community outing activities for the group sessions in this section of the program.

The Assessment of Communication and Interactions Skills (ACIS) obtains information about the client's function and use of communication skills in a social setting. This can be useful in identifying areas of deficit and may guide intervention involving the client in social situations through leisure and craft activities or a community outing with peers.

The Eating Disorder Inventory-3 (EDI-3) and PTSD Checklist—Civilian Version (PCL-C) obtain information about the symptomology of the client and can be further

used to question the client about the impact of symptoms on occupational performance through the use of an informal interview. This may identify deficit areas involving leisure and social participation indicating the need for the client to participate in relaxation, craft or leisure activities, or a community outing with the support of peers.

Step Back and Relax

- **Objectives:**
  - Clients will learn strategies that can be used to combat feelings of stress or anxiety.
  - Clients will identify strategies that can be used in a variety of settings or situations.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - The purpose of this activity is to introduce the concept of relaxation to help counter feelings of stress and anxiety in an effective manner.
  - An outline is provided that can be followed to introduce a variety of relaxation techniques to the clients.

- **Activity:**
  - Begin the session by asking the clients:
    - What are some ways that you try to relax?
    - Have these ways been effective?
    - Are these techniques healthy?
    - How do you feel after relaxing?
  - Introduce the relaxation strategy.
    - Share the benefits of this technique. Relaxation can benefit a client's overall health as it works to decrease heart rate, breathing rate and lower blood pressure. It also can release muscle tension, improve concentration and help control emotional responses such as anger or anxiety.
  - Some suggested strategies include relaxed breathing, progressive muscle relaxation *(Handout 19)*, visualization of a calming scene *(Handout 20)*, and meditation.
    - Many strategies can be used in a variety of settings. Relaxed or pursed breathing is a technique that can be used in public areas such as the grocery store when one becomes frustrated or anxious, visualization can be used on a crowded area where it can be used, and progressive muscle relaxation can be used at work or school.

- When teaching the skill, it can be beneficial to practice a skill together as a group. Utilizing calming music in the background can support the visualization of a calming scene or to further promote relaxed breathing.
- Consider the environment that is being used: dim the lights, use a room with ample space to stretch out in, and provide the clients with comfortable chairs to sit in during the session.
- Provide the clients with a handout that outlines the technique discussed during the group session which they can utilize on their own. Ensure that the clients understand that these techniques can take time to master and practice is beneficial to target their specific needs.

- **Reflection Questions:**
  - Each member will take a turn sharing his or her feelings before and after using this technique.
  - Did you find it difficult to use this relaxation technique?
  - Did you feel any physical or mental changes after utilizing this technique?
  - What are some situations where use of this technique would be helpful to you?

- **Journal Questions:**
  - Have the clients answer the following questions in their journal:
    - Think about a time you felt anxious or worried. How may have using a relaxation strategy benefitted you?
    - What are some signs that you are getting stressed? Next time you identify these signs, try a relaxation technique before these feelings become difficult to manage.
    - What is one goal you have for using a relaxation technique?

Handout 19

Progressive Muscle Relaxation

This is a relaxation technique that is focused on the goal of reducing tension and stiffness in various muscle groups throughout your body. The benefit of this technique is that you become aware of the amount of tension throughout your body. It is beneficial to start at either the head or the toes and work your way through the body. Progressive muscle relaxation can be done while seated. Find a comfortable position to be in for this technique and focus on tensing and relaxing one muscle group at a time. Hold the tension then allow the muscles to relax completely. Hold for 5 seconds and relax for 20 – 30 seconds. Repeat each muscle group 3 – 5 times.

Groups to target include:

- Shoulders: Shrug and relax your shoulders. Raise your shoulders up and release down slowly.

- Arms: Reach your arms up straight overhead or out to your sides. Drop them slowly.

- Hands: Clench fingers into a fist then stretch fingers out wide.

- Abdominals: Pull abdominal muscles in and release out slowly.

- Legs: Bring legs up towards your chest and lower to the floor slowly.

- Feet: Bring toes so they point up and then down. Also, roll ankles in slow circles in one direction and then the other.

Handout 20

Imagining a Peaceful Scene

Imagine a place that you enjoy or that is peaceful and calming to you. Think about the details in this location. Try to engage all the senses.

- Where are you?
- What do you see by you?
- What sounds are around you?
- What can you feel?
- What can you smell?

Try and stay in this scene for several minutes. While you are imagining this peaceful scene, disregard any negative thoughts in your mind. Focus on the scene rather than your physical surroundings. Allow your body and mind to relax and release any tension or anxiety you may be feeling.

Fun Together

- **Objectives:**
  - Clients will identify new leisure activities and interests.
  - Clients will have the opportunity to socialize with peers.
  - Clients will provide the opportunity to engage in healthy and enjoyable activities.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity, Environment

- **Introduction:**
  - Choose a craft or game for the group. Client input should be considered when choosing the activity. Try to pick a new activity for the group which provides all clients with an equal opportunity for performance.
  - Engagement in a craft or game will give clients the chance to utilize the skills they have learned.

- **Activity:**
  - An outline for an activity chosen can be as follows:
    - Introduce the activity or game.
    - Outline any rules or expectations for the group, what should or shouldn't be done and the focus of this activity.
    - Hand out materials or equipment needed for the session.
    - If the activity allows, the therapist should talk with clients during the activity to see what sorts of feelings participation evokes.
    - Wrap up the group with a discussion summarizing the purpose, asking how the members enjoyed the activity, and what could be modified in the future.
  - Suggested activities include board games like Catch Phrase, Scattergories, Bananagrams, and Mad Gab; sport activities like Chair Volleyball (where the participants play seated in a chair at all times with a balloon as the ball), badminton, ladder ball and bocce ball; and craft activities such as scrapbooking, woodworking, and knitting. Many more games or activities can be adapted to work with this population as a means of leisure exploration and the provided list are suggestions to get started.

- **Reflection Questions:**
    - Following the activity, ask the clients:
        - Did you enjoy this activity?
        - Will you use this activity again?
        - What was difficult for you when doing this activity?
        - What went well?
        - What are your beliefs about having fun?
            - How does that effect how you feel about this activity?
        - Did you find yourself using any coping strategies while engaged in this activity? How did this impact you?
        - Would you engage in this or a similar activity again? Why or why not?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What emotions did you feel during this activity? Anger, frustration, fear? What caused these feelings?
        - How did you feel after the completion of this activity?
        - Did you find it difficult or was it easier than expected?
        - How do your beliefs about having fun influence your participation in activities or how you socialize with others?
        - Who can you share this experience with?
        - Can you see yourself using this activity in the future?
        - What changes might you make for your habits of participating in social or leisure activities?

Share Your Talents

- **Objectives:**
  - Clients will utilize life skills learned in previous group discussions.
  - Clients will educate peers about a possible new leisure opportunity.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition

- **Introduction:**
  - Prior to the group, preferably 3 – 5 days prior, choose a client to lead the group for all current group members. The client must pick a leisure activity of interest to them to teach to the group. This activity can be a game, sport, craft, or any other activity you see fitting well in the client group. An outline is provided for the client to follow when planning their activity *(Handout 21).*
  - This activity gives the client a chance to utilize the skills they have learned and to educate their peers about an enjoyable activity. The client should involve the entire group as much as possible.

- **Activity:**
  - Prior to the activity, the client who is leading should fill out the attached worksheet.
  - Client will then conduct the group, sharing their chosen activity.

- **Reflection Questions:**
  - Following the activity, the client will then ask the group the following questions:
    - Did you enjoy this activity?
    - Will you use this activity again?
    - How does this activity compare to the types of activities you usually participate in?
      - Could you see yourself changing your patterns of participation?
  - For the leader:
    - How did you feel leading the group?
    - Did you find it difficult or was it easier than expected?
    - What would you differently next time?
    - What was it like to share your interests?

        - How were you feeling when someone liked you activity? Disliked your activity?
        - How did the social responses of other impact you?
    - For other group members:
        - Did you enjoy the activity presented?
        - Would you do the activity again?
        - Have you done a similar activity in the past? Will you do a similar activity in the future?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - What did you learn about your own talents?
        - What talents or interests will you share with others in the future?
            - What has been stopping you in the past?
        - How have you feelings about leisure activities changed since this experience?

Handout 21

Share Your Talents

Leader:

Name of activity:

Description of the activity:

Why did you choose this activity?

What feelings or beliefs do you associate with this activity?

How often do you do this activity?

Why is this activity enjoyable to you?

Let's Go Out

- **Objectives:**
  - Clients will engage in leisure activities with peers.
  - Clients will have the opportunity to participate in a safe, social activity.
  - Clients will be able to educate peers about a possible new leisure opportunity.

- **Activity Type:** Group

- **MOHO Component Addressed:** Volition, Habituation, Performance Capacity

- **Introduction:**
  - Prior to the group, the clients will choose a leisure activity they would like to do or an event they would like to attend as a community outing. This may need to be done 1 – 2 days prior to arrange for travel or appointment times. The leisure activity can be chosen by the group as a whole through a democratic vote or the members can take turns choosing an activity.
  - The community outing can include going to the park to have a picnic and play kickball, attending an art showing, going to a community concert etc.
  - The outing must be appropriate for all members' age, religion, and cultural observance.
  - During these outing, clients will have the opportunity to utilize the skills they have learned and manage any feelings or issues that come with trying new things.
  - The activity should involve the entire group as much as possible and provide opportunities for interaction.

- **Activity:**
  - The clients will attend a community outing. Throughout the outing periodically check in with each client to see what feelings they have regarding being in public, trying a new activity, or being out with other people.
    - How are you feeling? Were you expecting to have difficult feelings?
    - What are you doing to cope with these feelings?
    - Are you enjoying this outing? What would make it better?
  - Upon returning to the facility, the therapist will lead a wrap-up discussion on:
    - How the group functioned as a whole.

        - Summarize the overall feelings brought up during this outing.
        - Beliefs evident during this experience.
        - Irrational beliefs that were brought up and that could be refuted.
        - Provide assistance for the members to process their experience.
    - Provide clients with a handout of places or activities in the community which they can participate in outside of the hospital.
        - A recommended outline includes having:
            - Local Tours. These can include local landmarks, buildings, or local companies
            - Museums or Theaters in the area
            - Local parks, lakes or picnic areas
            - Sports arenas or game areas (local sports teams –high school or professional, mini golf facilities, dance centers, etc.)
            - Outdoor or walking clubs
            - Arts and Craft opportunities (local art shows, painting lessons, coffee shops that have open microphone nights, etc.)
            - Areas for sight seeing
            - Seasonal events (parades, fairs, local festivals, etc.)
            - Music events
            - Volunteer opportunities
        - It is beneficial to include contact information including addresses, websites and phone numbers, cost information, and hours of operation if known.
        - Let clients know where to look for opportunities such as in newspapers, local fliers and resources guides outlining special events coming up in the area.

- **Reflection Questions:**
    - Following the activity, ask the clients:
        - Did you enjoy this outing?
        - Will you repeat an outing like this again?
        - Who could you see yourself going on an outing with in the future?
        - How comfortable were you on this outing?
        - What skills did you utilize while on this outing?
        - How did the environment influence your feelings? Your thoughts?
        - How is this activity consistent with events you would usually participate in?

        - Did you notice any habitual patterns of thinking which showed up throughout this activity?

- **Journal Questions:**
    - Have the clients answer the following questions in their journal:
        - How did you feel being out with the group?
        - Did you find it difficult or was it easier than expected?
        - What would you differently next time?
        - Did this outing bring up any feelings of anxiousness or concern?
        - Have you done a similar activity in the past? How did the outcome of this outing compare to the experience you had previously?
        - What were your feelings about yourself during this activity?
        - Were there any specific fears or thoughts which you encountered in this activity?

Chapter V

Summary

The purpose of this project was to develop a program for the treatment of the dual diagnosis of an eating disorder and post-traumatic stress disorder based on information gathered through a literature review. A program made up of five sections was developed based on the Model of Human Occupation and cognitive behavioral therapy techniques. A referral form, possible assessments, and an occupational therapy evaluation summary form are provided to guide an occupational therapist through the evaluation process. The developed activities focus on the use of self-reflection through group discussion and journaling throughout the program. Utilization of self-reflection, in addition to the activities, supports the client's awareness of their thought patterns so they can change unhealthy beliefs and habits into positive habits and routines.

The program could be implemented in an outpatient psychosocial setting specifically treating individuals with the dual diagnosis of an eating disorder and post-traumatic stress disorder. It could also be utilized in other mental health settings if there are enough clients identified as having the dual diagnosis of an eating disorder and post-traumatic stress disorder to compose a group. In order to fully implement this program, it may take an occupational therapy department or facility that has a desire to specialize in the area of practice focused on the treatment of these diagnoses.

Clinical strengths of this program include the fact that it includes both individual and group components which can be implemented in a variety of settings. Several of the

sessions are outlined so that the therapist can add more activities to this program while maintaining a consistent format throughout. Similarly, the provided journal questions guide the clients in self-reflection even beyond the therapy session and the therapist can add questions personalized to individual clients in order to facilitate adaptations in thinking patterns and habits.

Limitations of this project include this being a new product which has not been used in practice with clients previously. There is limited presence of specific treatment settings where this program can be implemented. Therapists must also be familiar with the use of a model to guide practice as well as the Model of Human Occupation in order to be able to apply the basic concepts during the group and individual sessions. It is recommended that prior to implementation of this program therapists gain an understanding of the Model of Human Occupation and how it relates to the treatment of this population.

This product was developed to be easily implemented into existing mental health facilities which have a large number of clients who fall into this dual diagnosis population. The role of the occupational therapist as one member of the healthcare team for the treatment of clients with this dual diagnosis is to provide opportunities for the development of appropriate coping skills, supported social engagement, improvement of impacted areas of self-care and sleep patterns, and leisure and social exploration.

In the future, this program could be published for use by occupational therapists treating clients with an eating disorder and post-traumatic stress disorder. This would allow distribution to occupational therapists around the United States. After implementation of the program into several facilities, a pilot study could be conducted to

determine the effectiveness of the assessment tools and interventions for the treatment of the desired population. This would allow for identification of improvements to be made in the program in order to improve usefulness and success of this program for the treatment of individuals with the dual diagnosis of an eating disorder and post-traumatic stress disorder. Additionally, this program has the potential to be adapted to fit other areas of treatment such as community settings or prevention programs as well as for use with other populations with diagnoses that lead to similar deficits in occupational performance.

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