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Eating Disorders: A Guide for the Occupational Therapist

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Abstract

Eating disorders are serious illnesses that can impact physical and mental health. Increasingly, occupational therapists encounter this population in general psychiatric hospitals and treatment facilities, as well as specialized eating disorders treatment facilities. Yet, questions concerning the role of occupational therapy in the treatment of eating disorders remain. The purpose of this project is to increase the awareness of the role of occupational therapy in the treatment of eating disorders by providing a guide for effective treatment of these illnesses. A literature review includes information regarding eating disorders, the demographics and diagnostic criteria of eating disorders, multidisciplinary treatment settings and strategies, and the role of occupational therapy in treatment. The occupational therapy treatment guide utilizes the Model of Human Occupation (MOHO) to address volition, habitation, performance capacity, and the environment as influencing factors among individuals diagnosed with eating disorders. The guide provides useful information regarding initial intake evaluation, suggested assessments, treatment planning, sample activities, and outcome measures.
CHAPTER I
INTRODUCTION

According to the National Eating Disorders Association (2002), approximately 10 million females and one million males suffer from eating disorders in the United States. Most often, these include anorexia nervosa and bulimia nervosa. As the incidence of eating disorders rises, so does the likelihood that occupational therapists will encounter this population within general psychiatric hospitals and treatment facilities, as well as eating disorders treatment facilities. Yet, healthcare professionals, including some occupational therapists, may not understand the role of occupational therapy in the treatment of eating disorders (Giles & Allen, 1986; Lim & Agnew, 1994; Kane, Robinson, & Leicht, 2005).

The American Psychiatric Association (2000) defines eating disorders as psychological disorders that are “characterized by severe disturbances in eating behavior,” (p. 583). Persons diagnosed with eating disorders may perceive a distorted view of self and abilities, as well as an impairment of role identification and performance. Further, personal values may be replaced by those of society, with emphasis on diet and weight. These individuals exhibit inappropriate and rigid habits through eating disorder symptoms that include binge-eating, purging behaviors, caloric restriction, and excessive exercise. Additionally, interests may be limited to participation in eating disorder symptoms (Barris, 1986).
The purpose of this project is to increase the awareness of the role of occupational therapy in the treatment of eating disorders by providing a guide for effective treatment of these illnesses. The goal of occupational therapy in the treatment of eating disorders is to “maximize the clients’ function in social, psychological, and physical domains, and to assist them in engaging in meaningful, satisfactory occupations,” (Henderson, 1999, p. 44). Occupational therapy treatment may address body image, self-esteem, relaxation techniques, coping skills, communication skills, meal planning and preparation, and expressive activities (Martin, 1998; Breden, 1992).

In developing the treatment guide, the Model of Human Occupation (MOHO) will be utilized as the guiding model of treatment. MOHO effectively guides the occupational therapy treatment of eating disorders as it holistically addresses volition, habitation, performance capacity, and the environment as influencing factors among individuals diagnosed with eating disorders. In utilizing MOHO, the occupational therapist may specifically address values, motivating factors, interests, roles, and rigid habits.

While using MOHO as the guiding model for this scholarly project, components of the psychoanalytic and cognitive-behavioral frames of reference will be incorporated in developing the treatment manual for eating disorders. Using the psychoanalytic frame of reference, the occupational therapist may address feelings and self-concept issues (Lim & Agnew, 1994). The application of this frame of reference will be evident in expressive activities and communication groups. When applying the cognitive-behavioral frame of reference, the occupational therapist may address distorted beliefs and encourage clients to challenge these through problem-solving and coping skills (Henderson, 1999). The utilization of the cognitive-behavioral frame of reference will be evident in such
treatment interventions as body image groups, relaxation groups, coping skills, and communication skills groups.

As eating disorders become more prevalent in the United States, it is necessary for occupational therapists to understand their role in the treatment of this population. This scholarly project will present a guide for the occupational therapist that includes a compilation of resources to guide the treatment of individuals diagnosed with eating disorders. In chapter two, a literature review will be conducted regarding eating disorders. This literature review will address demographics and diagnostic criteria related to eating disorders, multidisciplinary treatment settings and strategies, and the role of occupational therapy in treatment.
CHAPTER II
REVIEW OF LITERATURE

In the review of literature, aspects of eating disorders including definitions, incidence, causes, and diagnostic criteria will be addressed. The treatment of anorexia nervosa and bulimia nervosa including treatment settings, duration of treatment, the multidisciplinary treatment team, and approaches to treatment will also be presented. Finally, the role of occupational therapy in the treatment of eating disorders, including occupational therapy evaluation, frames of reference, and treatment modalities, will be addressed.

Eating Disorders: Anorexia Nervosa and Bulimia Nervosa

Definitions of Anorexia Nervosa and Bulimia Nervosa

Anorexia nervosa is defined as a disorder in which individuals refuse to maintain a minimally normal weight, intensely fear gaining weight, and misinterpret perceptions of their body and its shape (American Psychiatric Association, 2000). In published literature, anorexia nervosa may be referred to as “anorexia.” By definition, the term “anorexia” means loss of appetite. Therefore, it is necessary to note the difference between the terms “anorexia” and “anorexia nervosa.”

Bulimia nervosa is a disorder that occurs when individuals repeatedly engage in binge-eating and use inappropriate compensatory behaviors. These compensatory behaviors can include self-induced vomiting; misuse of such medications as laxatives, diuretics, or diet pills; fasting; or excessive exercise (American Psychiatric Association,
Binge-eating is defined as “eating in a discrete period of time an amount of food that is definitely larger than most individuals would eat under similar circumstances,” (American Psychiatric Association, 2000, p. 589). Clinicians may refer to binges as being subjective or objective. Fairburn, Cooper, and Cooper (1986) report that subjective binges are episodes in which individuals perceive eating more food than they should have and identify a feeling of lack of control while doing so. Objective binge-eating is similar to the definition of binge-eating as described by the American Psychiatric Association.

Incidence of Anorexia Nervosa and Bulimia Nervosa

According to the National Eating Disorders Association (2002), approximately 10 million females and one million males in the United States suffer from eating disorders. Despite the vast number of persons affected by eating disorders, many of these individuals will not seek treatment for the illness. Therefore, the American Psychiatric Association (2000) indicates that the incidence of anorexia nervosa within the United States population is approximately 0.5%. The incidence of bulimia nervosa is slightly higher, between 1.0% and 3.0% (American Psychiatric Association, 2000). Further, Sadock and Sadock (2004) suggest that bulimia nervosa may occur in up to 40% of college females. Although eating disorders are primarily related to females, anorexia nervosa and bulimia nervosa occur in a 10 to one ratio of females to males (Thompson, 2004). Andersen (2002) reports between 10% and 20% of persons diagnosed with anorexia nervosa are male, and states “male cases of bulimia nervosa are uncommon,” (p. 189).

Although eating disorders may affect men and women of various ages, the typical onset of anorexia nervosa occurs during adolescence. Sadock and Sadock (2004) indicate
that anorexia nervosa develops between the ages of 10 and 30 years, however, the American Psychiatric Association (2000) reports an onset between 14 and 18 years. The age of onset of bulimia nervosa may vary, and develops during late adolescence or early adulthood (American Psychiatric Association, 2000).

Causes of Anorexia Nervosa and Bulimia Nervosa

The causes of anorexia nervosa and bulimia nervosa may vary and are not limited to one single factor. The development of eating disorders may be related to genetic factors. A family history of either anorexia nervosa or bulimia nervosa may increase the risk of their development. According to the American Psychiatric Association (2000), individuals have a higher risk of developing anorexia nervosa if there is a history of first-degree relatives who have been diagnosed with the disorder. Likewise, individuals have an increased risk of developing bulimia nervosa if family history of the disorder is evident. However, Pritts and Susman (2003) report that it remains unclear whether genetics influence the development of eating disorders as research findings have not consistently provided definitive links.

Sadock and Sadock (2004) suggest that the onset of anorexia nervosa and bulimia nervosa may be influenced by psychological issues. Anorexia nervosa may be developed among those individuals seeking autonomy and uniqueness, as well as control of their bodies and their lives, which can lead to self-starvation. Individuals diagnosed with anorexia nervosa may become isolative and rigid, and can develop anxiety and depression. In contrast, persons diagnosed with bulimia nervosa are “more outgoing, angry, and impulsive” than those diagnosed with anorexia nervosa (p.306). Further,
Sadock and Sadock (2004) state that substance dependence, shoplifting, and emotional lability are common among individuals diagnosed with bulimia nervosa.

Tozzi, Sullivan, Fear, McKenzie, and Bulik (2003) conducted a study to identify the causes, according to patient reports, of anorexia nervosa and factors that influenced recovery. In their literature review, Tozzi et al. cite sociocultural, family, and individual factors related to the onset of eating disorders. These may include cultural pressures for thinness, dieting history, personality disorders, stress, and family history of eating disorders, depression, and anxiety. For the purposes of their study, Tozzi et al. interviewed 69 females diagnosed with anorexia nervosa and who had undergone treatment for the disorders. At the conclusion of the study, findings indicated that one-third of the participants reported family dysfunction as a factor related to the onset of anorexia nervosa. Descriptions of family dysfunction included difficult relationships with parents, family conflicts, emotional abuse, parental over-control, and childhood neglect. Furthermore, the participants reported factors related to anorexia nervosa which included low self-esteem, perfectionism, high expectations by self and others, dieting and weight loss, control, inappropriate comments, puberty-related changes, and stressful life events. Finally, the participants stated that supportive relationships, medications, therapy, improved self-esteem, and maturation out of anorexia nervosa influenced recovery.

**Diagnostic Criteria of Anorexia Nervosa and Bulimia Nervosa**

According to the American Psychiatric Association (2000), the diagnostic criteria for anorexia nervosa include refusal to maintain body weight, identify fears of gaining weight, describe distorted body image, and report amenorrhea (See Appendix A).
Individuals diagnosed with anorexia nervosa may report depressed mood, isolation, irritability, changes in sleep, and disinterest in sex. These persons may also report discomfort with eating in public, difficulty in expressing feelings, and exhibit rigidity, a strong sense of control, and perfectionism (American Psychiatric Association, 2000). Physical symptoms can include sensitivity to cold temperatures, a covering of fine hair over the body, constipation, dry skin, bradychardia, and slowed cognition. Additionally, Sadock and Sadock (2004) report that some individuals diagnosed with anorexia nervosa may collect recipes and prepare elaborate meals for others.

As clinicians diagnose individuals with anorexia nervosa, it is necessary to identify one of two subtypes of the illness. According to the American Psychiatric Association (2000), individuals diagnosed with anorexia nervosa may present either the restricting subtype or binge-eating/purging subtype (See Appendix A). Although the binge-eating/purging subtype of anorexia nervosa may appear similar to bulimia nervosa, there is a specific difference between the two disorders. To be diagnosed with the binge-eating/purging subtype of anorexia nervosa, the individual must regularly engage in binge-eating and/or purging behaviors during the current episode of anorexia nervosa. The individual diagnosed with the restricting subtype has not regularly engaged in binge-eating or purging behaviors during the current episode of anorexia nervosa.

The diagnostic criteria of bulimia nervosa, according to the American Psychiatric Association (2000) includes recurrent episodes of binge-eating, regular use of inappropriate compensatory behaviors, at least twice weekly episodes of binge-eating and compensatory behaviors over three months, distorted body image, and binge-eating and compensatory behaviors do not occur during episode of anorexia nervosa (See Appendix
B). Individuals diagnosed with bulimia nervosa may report anxiety and depressive symptoms. Chemical dependence may be associated with bulimia nervosa as it occurs in at least 30% of persons with the disorder (American Psychiatric Association, 2000). Physical symptoms related to bulimia nervosa may include dental problems, swollen salivary glands, small cuts or calluses on top of the hand, and fluid and electrolyte imbalance (American Psychiatric Association, 2000).

Similar to anorexia nervosa, bulimia nervosa is diagnosed with one of two subtypes: purging type or non-purging type (See Appendix B). In the purging subtype, the individual demonstrates recurrent use of self-induced vomiting or ingestion of laxatives, diuretics, or enemas during the current episode of bulimia nervosa. The individual diagnosed with the non-purging subtype engages in fasting or excessive exercise, but does not demonstrate self-induced vomiting or the misuse of laxatives, diuretics, or enemas during the current episode of bulimia nervosa (American Psychiatric Association, 2000).

Some individuals may demonstrate the symptoms of an eating disorder, but do not meet criteria to be diagnosed with anorexia nervosa or bulimia nervosa. In these cases, individuals may be diagnosed with eating disorder, not otherwise specified (EDNOS). According to the American Psychiatric Association (2000), EDNOS is diagnosed if the criteria for anorexia nervosa are met, except that amenorrhea has not occurred and the individual is in the normal weight range (See Appendix C). Further, binge-eating and compensatory behaviors must occur less than twice weekly and over a time period of less than three months. Finally, the individual must use compensatory behaviors after eating small amounts of food and does not swallow large amounts of food.
The Treatment of Anorexia Nervosa and Bulimia Nervosa

Treatment Settings

Individuals seeking treatment for anorexia nervosa or bulimia nervosa may be admitted to one of three types of treatment settings, including outpatient treatment, partial hospitalization programming, or inpatient hospitalization. These types of care address the different stages of treatment and recovery from eating disorders. According to Fairburn (2005), there is no current evidence to support a single treatment setting over others. In this section, evidence regarding the utilization of outpatient treatment, partial hospitalization programming, or inpatient hospitalization will be reviewed.

Outpatient Treatment

Outpatient treatment may be necessary for individuals who are able to live and function independently, yet require ongoing support of the treatment professional. Stewart and Williamson (2004) describe the structure of treatment settings, including outpatient therapy, at an eating disorders treatment facility located in Louisiana. In fact, Stewart and Williamson report two forms of outpatient treatment care at this facility-intensive outpatient treatment and continuing outpatient care. Continuing outpatient care, as described by Stewart and Williamson, is comparable to traditional outpatient treatment. Traditional outpatient treatment may offer medical treatment, pharmacological management, nutritional counseling, and individual, group, or family therapy. Intensive outpatient treatment may include up to four hours of individual, group, and family therapy daily. Intensive outpatient therapy may be used in transition from inpatient or partial hospitalization programming or for individuals who found traditional outpatient therapy unsuccessful. According to Stewart and Williamson (2004), intensive
outpatient therapy may be recommended for persons who are medically stable and do not report suicidal or homicidal ideation. Individuals must also demonstrate motivation for recovery and report a decrease in restriction or binge-purge behaviors, yet require ongoing support and structure in therapy and dietary counseling.

Hay, Bacaltchuk, Claudino, Ben-Tovim, and Yong (2005) conducted a study to examine the efficacy of outpatient psychotherapy in the treatment of individuals, males and females, diagnosed with anorexia nervosa. A meta-analysis was completed to identify randomized controlled trials regarding the effectiveness of traditional outpatient therapy versus such therapies as time-limited individual psychotherapies, interpersonal psychotherapy (IPT), cognitive-analytic therapy (CAT), and cognitive-behavioral therapy (CBT). Also, Hay et al. communicated with the developers of these trials to gain more information. The outcome measures of this study were based upon weight restoration, participant satisfaction ratings, level of depression, symptomology, recovery rating scales, and level of interpersonal function. At the conclusion of their review of empirical data, Hay et al. reported that the utilization of CAT was favored to traditional outpatient psychotherapy in two studies; however, CAT was not favored to traditional outpatient psychotherapy in another study. In a comparison of time-limited individual psychotherapies, IPT, CAT, and CBT, differences in efficacy were not noted. Hay et al. state that specific psychotherapies appear to be more effective than traditional outpatient psychotherapy, though ongoing research is necessary to determine the reasons for this.
Partial Hospitalization Programming

Partial hospitalization programming (PHP) is indicated when individuals require more intensive support and care than outpatient treatment can provide. According to the Association for Ambulatory Behavioral Healthcare (n.d.), PHP incorporates the intensive support of inpatient hospitalization and schedule flexibility and costs of outpatient treatment. Stewart and Williamson (2004) report that day treatment programming lasts between six and eight hours, which allows individuals to return home in the evening. Individuals may be referred to PHP with recurrent binge-purge behaviors and restrictive eating, but are medically stable (Stewart & Williamson, 2004).

Kong (2005) conducted a study comparing the efficacy of partial hospitalization programming (PHP) to outpatient treatment in changing eating behaviors, weight, psychological symptoms, and self-esteem in persons diagnosed with eating disorders. A group of 43 participants diagnosed with anorexia nervosa or bulimia nervosa were selected to participate in either PHP or traditional outpatient services. Outcome data was measured using the Eating Disorder Examination, Eating Disorder Inventory-2, Beck Depression Inventory, and Rosenberg Self-Esteem Scale. Participants in PHP attended group therapies such as assertiveness training, body image therapy, pharmacological education, nutrition group, relationship group, family group, and community meetings. Traditional outpatient treatment participants received interpersonal psychotherapy, cognitive-behavioral therapy (CBT), and pharmacotherapy in individual sessions. At the conclusion of the study, Kong (2005) noted that PHP participants reported improved psychological symptoms and decreased eating disordered behaviors compared to the traditional outpatient therapy participants.
Inpatient Hospitalization

When an individual’s medical condition becomes unstable due to the effects of an eating disorder, inpatient hospitalization may be necessary. These indications can include 25-30% loss of body weight, psychological or psychiatric symptomology unsuccessfully treated in outpatient care and/or PHP, daily binge-purge cycles, unstable vital signs, and extensive abuse of laxatives, diuretics, and/or enemas (Matusevich, Garcia, Gutt, de la Parra, & Finkelsztein, 2002; Weiner, 1999). As individuals are admitted to inpatient hospitalization, they are closely monitored by staff for health and safety reasons, as well as redirection related to eating disordered behaviors.

Vandereycken (2003) conducted a literature review to identify when an individual should be hospitalized for the treatment of an eating disorder and what type of inpatient setting is most appropriate. An individual may be admitted to inpatient hospitalization upon assessment of a variety of factors such as medical stability, suicidal or homicidal ideation, weight, motivation for recovery, existence of other psychological disorders, structure needed, impairment, severity of eating disordered behaviors, and the availability of treatment of facilities. Despite the number of eating disorders treatment facilities, there continues to be a lack of research regarding comparison studies of approaches used among the various facilities. Further, Vandereycken (2003) reports insufficient empirical evidence supporting the use of inpatient treatment services, and suggests further research is needed to address its benefits in relation to PHP and outpatient therapies.
Duration of Treatment

The length of treatment in outpatient therapy, partial hospitalization, and inpatient hospitalization is variable. The variation in length of treatment is related to the individuals' medical status, severity of eating disordered behaviors, body weight, and response to treatment (Weiner, 1999). According to Vandereycken (2003), the average hospitalization is 10 weeks, but ranges between four and 24 weeks. Eating disorder treatment facilities may employ level systems, in which individuals in inpatient and partial hospitalization treatment can gain increased privileges and autonomy. Requirements to reach higher levels in these systems may include medical stability, weight gain or weight stability, response to treatment, and a decrease in eating disordered behaviors (Vandereycken, 2003; Stewart & Williamson, 2004). After clients are discharged from inpatient or partial hospitalization, referrals may be placed for outpatient services.

Treatment Team

A multidisciplinary team approach is commonly used to treat persons with eating disorders. A number of professional disciplines may provide services including psychiatry, internal medicine, psychology, therapists and counselors, social work, dietetics, recreational therapy, occupational therapy, movement therapy, nursing staff, and mental health technicians (Stewart & Williamson, 2004; Weiner, 1999; Mitchell, 2001). Each of these disciplines provides an important role in the treatment of eating disorders.

Weiner (1999) describes some of the professional services. An internist oversees the management of medications and treats complications related to medical instability,
while the psychiatrist diagnoses and treats psychiatric symptoms. The psychologist may conduct research and, along with therapists and counselors, provides group and individual treatment. The social worker maintains communication with the families of clients and arranges resources. A dietitian provides dietary education, meal planning, and establishes weight goals with the client and primary therapist. Nursing staff monitor the clients and may provide group therapy. Recreation and movement therapists can develop an exercise program and address body image issues. Additionally, Mitchell (2001) states that occupational therapy services may address meal preparation, shopping, and interpersonal skills during treatment. Although each of the disciplines may offer services unique from others, treatment facilities vary and may or may not include all of the described disciplines.

_Approaches to Treatment_

The treatment of eating disorders not only includes the utilization of a variety of professionals, but also a number of treatment strategies. Although research has led to emerging areas of treatment such as internet-based treatment strategies, professionals continue to employ traditional approaches. In the following sections, key aspects of the traditional approaches of pharmacological therapy, cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT) and individual psychotherapy will be discussed.

_Pharmacological Therapy_

As individuals diagnosed with anorexia nervosa and bulimia nervosa may demonstrate symptoms of depression, anxiety, obsessive-compulsive disorder, and personality disorders, pharmacological intervention may be necessary. Walsh (2002) reports that persons with anorexia nervosa may present psychological symptoms that can
be addressed with pharmacotherapy. The variety of psychiatric symptoms demonstrated in persons diagnosed with eating disorders has led to research regarding the efficacy of antidepressant and antipsychotic medications in pharmacological treatment.

Walsh (2002) describes results of studies which indicate that antidepressants improve mood and preoccupied thoughts regarding body shape and weight among individuals diagnosed with bulimia nervosa. According to de Zwaan, Roerig, and Mitchell (2004), study findings have indicated the effectiveness of antidepressants in weight gain among persons diagnosed with anorexia nervosa. The use of antidepressant medications has been found to reduce anxiety, depression, and binge-purge behaviors, yet “the percentage of subjects free of symptoms at the end of treatment is usually low,” (p. 195). Although antidepressant medications appear to improve the symptoms of eating disorders, research regarding their specific effects is ongoing.

Research focusing on the efficacy of antipsychotic medications in the treatment of eating disorders has not been as widespread as studies of antidepressants. However, some research findings have indicated that antipsychotics have resulted in a reduction of eating disordered behaviors and improved preoccupied thoughts of food and body image (de Zwaan, Roerig, & Mitchell, 2004). Despite these improvements, de Zwaan, Roerig, and Mitchell also report possible side effects and lack of weight gain in response to antipsychotics. Research remains ongoing regarding the use of antipsychotic medications in the treatment of eating disorders.
Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT), developed by Aaron Beck, “assumes that a person’s cognitive function and beliefs mediate or influence his or her affect and behavior,” (Bruce & Borg, 2002, p. 163). Professionals employ this approach as a core concept in the treatment of eating disorders. Pike, Devlin, and Loeb (2004) state “individuals with eating disorders overvalue weight and shape to compensate for feelings of low self-esteem,” and “attempt to self-regulate their emotional world and manage stressful interpersonal situation, at least in part, with food,” (p. 133). Further, the individual responds to emotions and negative self-concept with developing a pattern of eating disordered behaviors. These behaviors may be addressed during therapy as the client and psychologist or therapist discusses goals regarding eating behaviors and target weight range. Throughout treatment, clients identify personal thoughts about food and self-concept and, with the guidance of the psychologist or therapist, begin to develop ways to modify these beliefs (Vitousek, 2002).

As CBT is widely used among professionals in the treatment of eating disorders, a number of studies have been completed regarding its efficacy. Gilbert (2000) reports CBT to be the most effective treatment approach in decreasing binge-purge cycles and increasing attitude about weight and shape among individuals diagnosed with bulimia nervosa. Furthermore, research findings indicate that CBT may be successful in decreasing the risk of relapse of individuals diagnosed with bulimia nervosa (Gilbert, 2000). Pike, Devlin, and Loeb (2004) cite results of a study which showed that CBT is “effective in improving clinical outcome and preventing relapse in adult patients with anorexia nervosa,” (p. 141).
Lundgren, Danoff-Burg, and Anderson (2004) conducted a meta-analysis of fifteen outcome studies to determine the efficacy of CBT in the treatment of bulimia nervosa. These studies included group and individual CBT programs. After analyzing the pretreatment and posttreatment studies, Lundgren, Danoff-Burg, and Anderson found that 36.4% of the studies indicated a decrease in binge frequency after CBT. Also, 92.8% of the studies indicated a decrease in purge episodes. Although no change was noted regarding self-esteem, a decrease in shape concern, weight concern, and dietary restraint were evident.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) was developed by Marsha Linehan for the treatment of individuals diagnosed with borderline personality disorder. Linehan (1993) suggests that maladaptive behavior is caused by personal factors and environmental influences reinforce these factors. While DBT was originally developed to treat borderline personality disorder, clinicians have since applied the theory to the treatment of eating disorders.

According to Blocher McCabe, LaVia, and Marcus (2004), DBT is used in the treatment of eating disorders for a number of reasons. First, comorbid borderline personality disorder and self-injurious behaviors are common among individuals diagnosed with eating disorders. Also, mood dysregulation related eating disorders may be addressed by DBT. DBT encourages skills acquisition and its principles are adaptable to the treatment of eating disorders. When utilizing DBT as a treatment method for eating disorders, the clients practice such skills as core mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. Specifically, therapists may address
clients' insight, assertiveness skills, conflict resolution, stress management, and educate the client about the effects eating disorders may have on mood.

Palmer, Birchall, Damani, Gatward, McGrain, and Parker (2003) conducted a study to evaluate the efficacy of a DBT program for persons diagnosed with an eating disorder and borderline personality disorder. The study included seven participants; all were females with a history of self-injurious behaviors. Outcomes of the study were based upon the length of hospital stays and self-injurious acts 18 months before and after participation. The 18-month program included a team of three nurses, two psychiatrists, and a psychologist, all trained in DBT. Participants were provided a weekly therapy session and skills training group, as well as telephone contact outside of programming. At the conclusion of the study, findings indicated a reduction of self-injurious behaviors and eating disorder symptoms during and after treatment. Further, the length of hospital stays decreased during and after DBT.

Safer, Telch, and Agras (2001) examined the efficacy of DBT in the treatment of one female diagnosed with bulimia nervosa. The participant described her history of binge-purge behaviors over the past 13 years, and reported an unsuccessful response to counseling. The program included twenty weekly 50-minute individual sessions. These sessions included training in core mindfulness, emotion regulation, distress tolerance, relapse prevention, and review of skills. Study outcomes were determined by weekly diaries, rates of binge-purge behaviors, completion of the Eating Disorders Examination before and after treatment, and follow-up interviews. According to the single case study findings, the participant decreased binge-purge behaviors to zero episodes during the last
15 weeks of treatment. In a six-month follow-up interview, the participant reported two binge-purge episodes after treatment.

**Individual and Group Psychotherapy**

During treatment, persons diagnosed with eating disorders often undergo individual and/or group psychotherapy. Stewart and Williamson (2004) describe individual therapy as the “binding factor across therapeutic modalities,” (p. 832). It addresses the psychological aspects of eating disorders and places accountability with the client. An individual therapist oversees the treatment plan of the client and reports progress to the multidisciplinary team. Individual therapy addresses such goals as mindfulness, insight, motivation for recovery, acceptance of self, and development of identity. Group therapy addresses the same goals as individual therapy, yet encourages interpersonal growth and feedback group discussion (Stewart & Williamson, 2004).

Chen, Touyz, Beumont, Fairburn, Griffiths, Butow, Russell, Schotte, Gertler, and Basten (2003) conducted a study to compare the efficacy of group and individual cognitive-behavioral therapy among persons diagnosed with bulimia nervosa. The study included 44 female participants diagnosed with bulimia nervosa. Study outcomes were assessed using the Eating Disorders Examination, Global Severity Index of the Symptom Checklist 90-R, Beck Depression Inventory, State Trait Anxiety Inventory, and the Rosenberg Self-Esteem Scale. Participants in the individual cognitive-behavioral therapy (ICBT) program were provided nineteen 50-minute sessions over four and one-half months. Group cognitive-behavioral therapy (GCBT) program participants were provided identical session content as those in ICBT in nineteen 90-minute sessions over four and one-half months. At the conclusion of the study, both ICBT and GCBT were
found to be effective in reducing symptoms related to bulimia nervosa. In contrast, participants in the ICBT group demonstrated greater rates of abstinence from binge-purge behaviors than those in the GCBT group.

**Occupational Therapy in the Treatment of Eating Disorders**

*The Role of Occupational Therapy*

As the incidence of eating disorders rises, occupational therapy has the potential to become a powerful resource in the treatment of these illnesses. Currently, the role of occupational therapy is variable among treatment facilities. Mitchell (2001) states that occupational therapy services in inpatient hospitalization and partial hospitalization programs are important to address such areas as meal preparation, shopping, and interpersonal skills. According to Kane, Robinson, and Leicht (2005), occupational therapists may also address meal planning skills, coping skills, relaxation techniques, and utilize expressive and movement therapies through educational and discussion groups. Despite the unique services provided in the treatment of eating disorders, occupational therapy programs are not always utilized in treatment facilities.

In a study by Kane, Robinson, and Leicht (2005), psychologists experienced in the treatment of eating disorders completed questionnaires regarding their awareness of the services occupational therapists may provide. Over 50% of the psychologists reported using similar treatment strategies as occupational therapists, including coping skills, relaxation techniques, assertiveness training, and cooking skills. Although they reported using similar treatment strategies, less than half of the psychologists were aware that occupational therapists may provide these same services. Kane, Robinson, and Leicht also stated that the findings of their study may indicate the need for occupational
therapists to educate other professionals regarding the services they are able to provide in
the treatment of eating disorders.

**Occupational Therapy Evaluation**

As individuals are admitted to inpatient hospitalization or partial hospitalization
programming to undergo treatment for eating disorders, they are subject to a number of
evaluations and interviews, including an occupational therapy evaluation. The
occupational therapist may use the initial assessment to gather relevant information about
the client to guide treatment planning. Information may be gathered through the use of
structured assessments and interviews.

Bridgett (1993) identifies and describes evaluation protocol for use by the
occupational therapist in the treatment of eating disorders. This protocol contains seven
areas of assessment: physical status; history in work, school, leisure, family, and social
participation; self-concept; body image; time management; interests and activities; and
balance of control. In addressing these areas of assessment, the occupational therapist
can use an interview format. Further, the occupational therapist can use other forms of
evaluation to gather information for the protocol. Manual muscle testing and motor
proficiency tests may used to assess physical status; individuals may complete self-
portraits to describe self-concept and body image. An interest inventory or internal-
external control scale can be administered to collect data.

Giles and Allen (1986) suggest assessing the individual’s function in completing
activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
When addressing ADLs, the occupational therapist evaluates the performance of self-
cares and quality of sleep. Assessment of IADLs can include household management,
meal planning and preparation, financial management, and shopping. During the interview, the occupational therapist and client may discuss social relationships, leisure participation, function at work or school. The client may describe cognitive deficits, such as memory and concentration, and the occupational therapist may observe for other deficits during the interview.

According to Barris (1986), the occupational therapist may utilize assessments to address areas related to the Model of Human Occupation (MOHO) and gather a holistic view of functioning among persons diagnosed with eating disorders. Barris (1986) suggests assessing leisure and work histories and using specific assessments including Reid-Ware Three-Factor Internal-External Scale, Life Attitude Profile, Role Checklist, Role Performance Scale, Occupational Questionnaire, and Projects Inventory. These assessments can provide data regarding locus of control, values, interests, roles, and occupational history.

Frames of Reference

When treating clients diagnosed with eating disorders, occupational therapists may employ a variety of frames of reference. The occupational therapist may select frames of reference based upon occupation-based theories and/or interdisciplinary theories guiding the practice of the treatment facility.

Lim and Agnew (1994) conducted a study to identify the frames of reference occupational therapists use in the treatment of eating disorders and determine which of these approaches is most commonly used. Based on the results of 21 questionnaires completed by occupational therapists experienced in the treatment of eating disorders, the cognitive-behavioral frame of reference and the Model of Human Occupation (MOHO)
were identified as the most utilized in occupational therapy treatment. Occupational therapists also reported using more than one frame of reference during treatment, as indicated by 95.2% of questionnaire responses.

Although the findings of the Lim and Agnew (1994) study indicate cognitive-behavioral and MOHO as the most utilized frames of reference in the occupational therapy treatment of eating disorders, other frames of reference may be utilized. The psychoanalytic, behavioral, and developmental frames of reference may also be applied in treatment. Application of these frames of reference, as well as the cognitive-behavioral frame of reference and MOHO, in occupational therapy treatment is reviewed here.

When applying the psychoanalytic frame of reference to treatment, the occupational therapist addresses “underlying psychological problems and self doubts,” (Lim & Agnew, 1994, p. 310) related to the development of eating disorders. During occupational therapy intervention, clients may identify and describe feelings and improve self-esteem through expressive activities. Despite the support of a number of clinicians, Henderson (1999) cites study findings which indicate that solely using the psychoanalytic frame of reference in treatment may not be effective as it does not address functional problems of individuals diagnosed with eating disorders.

According to the behavioral frame of reference, the onset of eating disorders is related to “learned maladaptive behaviors,” (Henderson, 1999, p. 47). The application of this frame of reference to occupational therapy includes reshaping these behaviors through the use of positive and negative reinforcements (Rockwell, 1990). The clients, in turn, may learn appropriate behaviors to support weight gain. Using the behavioral frame
of reference, the occupational therapist may address body image, time management, and coping skills. Yet, Henderson (1999) also reports insufficient empirical evidence supporting the efficacy of the behavioral frame of reference.

In the treatment of eating disorders, clinicians may refer to the developmental frame of reference and familial frame of reference to guide intervention. In the familial frame of reference, a dysfunctional family environment and underlying issues are believed to be a factor in the onset of eating disorders (Rockwell, 1990). Clinicians supporting the developmental frame of reference suggest that the cause of eating disorders is due, in part, to inconsistent response to childhood needs (Henderson, 1999). Although the developmental and familial frames of reference may be utilized in the treatment of eating disorders, Henderson (1999) reports no evidence of the application of these approaches in occupational therapy.

As stated earlier in this section, the cognitive-behavioral frame of reference is often utilized by occupational therapists in the treatment of eating disorders. According to Ward (2003), this approach is effective as it addresses appropriate eating habits and body image, reduces perfectionism, and improves self-concept. When applying the cognitive-behavioral frame of reference to treatment, the occupational therapist may assist clients in identifying distorted thoughts and challenging these through problem-solving (Henderson, 1999). Henderson (1999) also suggests that the efficacy of the cognitive-behavioral frame of reference is related to encouraging clients to take responsibility for their thoughts and behaviors.

Like the cognitive-behavioral frame of reference, the Model of Human Occupation (MOHO) is commonly used by occupational therapists in the treatment of
eating disorders. MOHO addresses the motivating factors, patterns, and performance
capacities that influence an individual’s participation in occupations (Kielhofner, 2002).
Based on these factors, MOHO is comprised of three subsystems: volition, habituation,
and performance capacity. Additionally, the individual’s physical and social
environments can impact each of the subsystems (Forsyth & Kielhofner, 2003). As
MOHO addresses volition, habituation, performance, and environment issues, Barris
(1986) states that it may be effectively applied to the treatment of persons diagnosed with
eating disorders. Additionally, Barris (1986) suggests that occupational therapists apply
MOHO to treatment and address insight, social participation, and control through play,
journaling, and time management activities.

Treatment Modalities

During occupational therapy treatment, persons diagnosed with eating disorders
participate in groups which address healthy coping skills, body image and self-esteem,
communication and social skills, perfectionism, time management, eating habits, and
meal planning and preparation. Occupational therapists may utilize a variety of mediums
in treatment. In this section, specific treatment modalities will be described.

Breden (1992) describes the use of occupational therapy services in addressing
stress management, task skills, and meal preparation. Stress management skills are
necessary to interrupt patterns of eating disorder symptoms. During stress management
groups, clients may discuss stressors and practice progressive muscle relaxation and deep
breathing. Breden (1992) also includes activities to related to time management,
problem-solving, and communication skills in stress management groups. In meal
preparation, clients are able to practice coping skills while addressing ritualistic behaviors
and obsessive thoughts. Task skills groups include the use of craft activities, which are used to improve concentration, problem-solving, self-esteem, interpersonal skills, and perfectionism. Finally, individual occupational therapy may be necessary for those who are unable to participate in group activities.

In the treatment of eating disorders, Martin (1998) reports goals of occupational therapy may include establishing and maintaining rapport with clients, encouraging weight restoration and maintenance through healthy eating habits, addressing social skills, promoting positive body image and self-expression, encouraging use of appropriate coping skills, interrupting eating disorder symptoms, and providing opportunities to shop for food, cook, and eat with others. Further, Martin (1998) describes three stages in the treatment of eating disorders. In treatment stage one, the occupational therapist establishes therapeutic rapport with the client. During this stage, the client is encouraged to monitor urges for eating disorder behaviors. Expressive activities, such as art, crafts, and writing, may used to provide a sense of meaning and self-confidence for the individual, and facilitate expression of thoughts and feelings (Martin, 1998).

At stage two, regulated exercise can begin. As excessive exercise may be an issue among persons diagnosed with eating disorders, Martin (1998) states that it is necessary to discuss and practice the appropriate use of exercise. Exercise programs may include stretching, aerobics, and walking. Also, the practice of relaxation techniques such as deep breathing and muscle relaxation may be a beneficial for coping with stress. Clothes shopping may be important for clients at this stage as their clothing may no longer fit due to weight restoration. Finally, persons diagnosed with eating disorders may report
isolation or concerns with social relationships. Therefore, the occupational therapist may address these issues through activities focusing on assertiveness training, practice of conversation skills, expression of feelings, and expression of emotions. Clients are encouraged to practice appropriate coping skills during meal planning and preparation, as well as group restaurant outings (Martin, 1998).

During stage three, the occupational therapist encourages clients to continue practicing and enhancing skills learned during earlier stages of treatment. Martin (1998) suggests that meal planning and preparation continue to be addressed in therapy, as well as healthy exercise. The exploration of leisure interests is also important, as appropriate leisure activities can provide a means of coping with eating disorder symptoms. As discharge nears, the occupational therapist can educate clients about relapse prevention. Clients can discuss potential stressors and high-risk situations which can lead eating disorder symptoms, and identify appropriate coping skills to address these (Martin, 1998).

Summary

Eating disorders affect a vast number of persons in the United States and impact their physical and mental health. These individuals may seek care in outpatient, inpatient, and partial hospitalization settings. Each of these settings can be beneficial, depending on the person’s medical stability and needs (Stewart & Williamson, 2004; Matusevich, Garcia, Gutt, de la Parra, & Finkelsztein, 2002; Weiner, 1999). Due to the complex nature of eating disorders, a multidisciplinary team, including occupational therapy, is necessary in treatment. Treatment typically includes medical care,
pharmacological management, nutritional counseling, psychotherapy, and life management skills (Stewart & Williamson, 2004; Weiner, 1999; Mitchell, 2001).

The role of occupational therapy is important in the treatment of eating disorders. In occupational therapy treatment, areas of dysfunction related to eating disorders may be addressed in groups which focus on healthy coping skills, body image and self-esteem, communication and social skills, perfectionism, time management, eating habits, and meal planning and preparation (Breden, 1992; Martin, 1998). Yet, healthcare professionals, including some occupational therapists, may not be aware of the benefits of occupational therapy in the treatment of eating disorders (Lim & Agnew, 1994; Kane, Robinson, & Leicht, 2005). To provide effective and appropriate care to persons diagnosed with eating disorders, occupational therapists must increase their awareness of these disorders and their role in treatment.

In chapter three, the process used to design the eating disorders treatment manual for occupational therapists will be described. The process guiding the gathering of information and developing the product will be discussed. Additionally, the relationship between the literature review and the treatment manual will be identified.
CHAPTER III

METHODOLOGY

The product of this scholarly project presents a guide for use by occupational therapists in the treatment of eating disorders. The product was developed following the completion of the literature review. The literature was located following searches from the databases of OT Search, PubMed, and CINAHL. Further, staff from the eating disorders treatment facility at Meritcare Health System recommended literature appropriate for the scholarly project. After reviewing the literature, evidence of questions regarding the role of occupational therapy in the treatment of eating disorders was noted.

The product is organized to address the role of occupational therapy in evaluation and assessment, treatment planning, intervention, and measurement of outcomes. The first section of the product presents information related to the initial intake evaluation and provides a sample format for this evaluation. The initial intake evaluation form presented in the product was adapted from an occupational therapy intake evaluation utilized at the eating disorders treatment facility at Meritcare Health System (2003). The evaluation form was adapted to include components of the Model of Human Occupation (MOHO) and areas of occupation, including Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), education, work, leisure, and social participation (American Occupational Therapy Association, 2002). The next section of the product addresses suggested assessments that can be administered to evaluate occupational performance among individuals diagnosed with
eating disorders. This section was developed upon review of MOHO-based assessment tools provided by the Occupational Therapy Department, as the Model of Human Occupation Clearinghouse website (Model of Human Occupation Clearinghouse, n.d.). These assessments can be utilized to evaluate the components of MOHO, including volition, habituation, performance capacity and skills, and environment. The administration guidelines and procedures were reviewed to collect specific information related to each assessment.

Treatment planning is presented in the third section of the product. This section includes tables of information regarding the components of MOHO and how they can be affected by an eating disorder. Each component of MOHO is addressed, as well as subsystems of the components. The information provided in these tables relates the components of MOHO, as described by Kielhofner (2002) to problems demonstrated among individuals diagnosed with eating disorders. Further, treatment objectives that will address these problems and challenges are provided. The information presented in the treatment planning section was formulated upon review of literature related to MOHO, as well as literature regarding the application of MOHO in the occupational therapy treatment of eating disorders. Barris (1986) describes how dysfunction with the components of volition, habituation, performance capacity and skills, and environment is demonstrated among individuals diagnosed with eating disorders.

The fourth section of the product includes sample activities that are appropriate to implement in occupational therapy intervention and address each component of MOHO. The activities are organized to present their relation to treatment objectives, description of activity format, identify appropriate age groups for the activity, and activity resources.
A number of the activities provided in this section are based on occupational therapy interventions utilized at the eating disorders treatment facility at Meritcare Health System. Additionally, *Life Management Skills* I through IV and *Life Management Skills* VI (Korb-Khalsa, Azok, & Leutenberg, 1989; Korb-Khalsa, Azok, & Leutenberg, 1991; Korb-Khalsa & Leutenberg, 1994; Korb-Khalsa & Leutenberg, 1996; Korb-Khalsa, Azok, & Leutenberg, 2000) were reviewed to gather activity resources to address the MOHO components of volition, habituation, performance capacity and skills, and environment. Some activities within *Life Management Skills* I through IV and *Life Management Skills* VI were adapted to meet treatment objectives related to eating disorders.

The final section of the product presents information regarding suggested outcome measures in occupational therapy treatment. Outcome measures are utilized by occupational therapists to measure client progress to treatment. The American Occupational Therapy Association (2002) describes types of occupational therapy outcome measures to evaluate occupational participation. In the outcome measures section of the product, the utilization of occupational performance, role competence, and quality of life outcome measures is described. A variety of MOHO-based assessment tools are described in relation to their functionality as an outcome measure. Information regarding the use of MOHO-based assessments as outcome measures was identified after a review of their administration guidelines. Additionally, suggestions for non-standardized outcome measures are based on literature related to MOHO concepts.

The product of this scholarly project was developed after the review of professional literature and incorporates information from variety of resources. It provides
information regarding occupational therapy in the treatment of eating disorders, including initial evaluation, assessment, treatment planning, therapeutic activities, and outcome measures. In chapter four, the product of this scholarly project is presented in its entirety.
CHAPTER IV
PRODUCT

Introduction

The eating disorders treatment guide will be developed for use by occupational therapy students and/or practicing occupational therapists. The purpose of this guide is to assist in providing effective occupational therapy treatment of eating disorders. Further, it will assist the occupational therapist in identifying appropriate, occupation-based treatment for this population.

In developing the treatment guide, MOHO is utilized as the guiding model of treatment. The application of MOHO is effective in occupational therapy treatment as it holistically addresses volition, habitation, performance capacity, and the environment as influencing factors among individuals diagnosed with eating disorders. Components of the psychoanalytic and cognitive-behavioral frames of reference are incorporated in the development of the guide. The psychoanalytic frame of reference is utilized to address feelings and self-concept issues. Distorted beliefs related to eating disorders are challenged through problem-solving and coping skills using the cognitive-behavioral frame of reference.

The treatment guide presents a sample format for the initial intake interview, which will include information regarding areas of occupation and aspects of the Model of Human Occupation (MOHO). A description of potential MOHO-based evaluations and their appropriateness in assessing persons diagnosed with eating disorders is provided.
Further, sample activities appropriate for use in occupational therapy groups are presented, as well as guidelines for their usage. The activities will address specific treatment objectives related to the clients' problem areas. Finally, the treatment guide includes potential outcome evaluations to determine the efficacy of occupational therapy services in the treatment of eating disorders.
Eating Disorders: A Guide for the Occupational Therapist

Developed by: Randi Horner, MOTS

Advisor: Sonia Zimmerman, MA, OTR/L, FAOTA
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Initial Intake Evaluation
Initial Intake Evaluation

Upon admission to an eating disorders treatment program, the client will undergo an initial intake evaluation with staff from a variety of disciplines. The purpose of this interview is to gather client information to guide treatment planning, develop rapport with the client, and establish treatment goals. Multidisciplinary staff can use the initial intake interview to assess the client’s medical condition and history, psychological history, nutritional status, social history, and history of eating disorder symptoms. In occupational therapy, the initial intake interview can be used to evaluate the client’s occupational performance. The occupational therapist will assess the client’s engagement in Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), education, work, leisure, and social participation (American Occupational Therapy Association, 2002). Further, components of the Model of Human Occupation, including volition, habituation, performance capacity, and environment, can be reflected in the evaluation.
Occupational Therapy Intake Evaluation

ADLs:______________________________________________________________

______________________________________________________________

Household Management:__________________________________________

______________________________________________________________

Health Management & Maintenance:________________________________

______________________________________________________________

Role Performance:________________________________________________

______________________________________________________________

Self-Concept:____________________________________________________

______________________________________________________________

Interests:________________________________________________________

______________________________________________________________

Social Participation:______________________________________________

______________________________________________________________

Daily Routines:___________________________________________________

______________________________________________________________

Goals:____________________________________________________________

______________________________________________________________

Therapist Summary/Observations:___________________________________

______________________________________________________________

______________________________________________________________

Therapist Signature_________________________ Date__________________

Adapted from Meritcare Health System (2003)
Potential Assessments
Assessment

Along with completion of an initial intake evaluation, the occupational therapist can administer assessments to obtain detailed information regarding the client’s occupational performance. Occupational performance will be identified through assessment of volition, habituation, performance capacity, and environment. In the following section, descriptive information regarding assessments appropriate to individuals diagnosed with eating disorders will be presented. These assessments are based on components of the Model of Human Occupation (MOHO). When applying these assessments to practice, it is necessary to note whether they are age-appropriate in review of administration guidelines.
Occupational Self Assessment (OSA)

**Background:**
- Developed by Baron, Kielhofner, Goldhammer, and Wolenski (1999)
- Based on components of the Model of Human Occupation (MOHO)

**Purpose:**
- Evaluate occupational competence, values, and environment, as well as the client's satisfaction with occupational competence and environment
- Can guide the development of occupational therapy goals and treatment

**Administration:**
- Self-report tool with summary form
- Can be used as an assessment prior to therapy and as a follow-up to evaluate progress
- Contains 29 statements that address occupational performance, habituation, values, and environment
- Allow as much time as the client needs to complete assessment
  - *Section 1:* Presents statements regarding the individual and his/her occupations.
    - *Step 1:* Refers to statements regarding occupations and the client's functioning in these areas. The client may circle statements that apply to him/her.
    - *Step 2:* The client may circle statements that reflect the value placed on each area referred to in Step 1.
    - *Step 3:* The client may identify potential areas of change
  - *Section 2:* Follow same directions for Section 1, Steps 1 through 3
- At its completion, the occupational therapist may review the assessment with the client.

The OSA may be purchased through the Model of Human Occupation Clearinghouse at http://www.moho.uic.edu/assess/osa.html
Occupational Performance History Interview II (OPHI-II)

**Background:**
- Developed by Kielhofner, Mallinson, Crawford, Nowak, Rigby, Henry, and Walens (1998)
- Based on components of the Model of Human Occupation (MOHO)

**Purpose:**
- Evaluate occupational roles, daily routine, occupational behavior settings, activity/occupational choices, and critical life events
- Can guide the development of occupational therapy goals and treatment

**Administration:**
- Semi-structured interview with rating scales, life history narrative, and summary form
- Administration time: 45 to 60 minutes
  - **Interview:** Includes discussion of roles, routine, environment, activity/occupational choices, and critical life events
  - **Interview Rating Scales:** Includes four-point rating scales of occupational identity, occupational competence, occupational behavior settings
    - 4: Exceptionally competent occupational functioning
    - 3: Good, appropriate, satisfactory occupational functioning
    - 2: Some occupational dysfunction
    - 1: Extremely occupationally dysfunctional
  - **Life History Narrative:** The occupational therapist may complete a life history narrative form based on client interview

The OPHI-II may be purchased through the Model of Human Occupation Clearinghouse at http://www.moho.uic.edu/assess/ophi.html
Assessment of Communication and Interaction Skills (ACIS)

Background:
- Based on components of the Model of Human Occupation (MOHO)

Purpose:
- Evaluate the client during communication and interaction with others
- Addresses volition as a component of communication and interaction
- Can guide the development of occupational therapy goals and treatment

Administration:
- Observational tool with summary form
- Administration time: 20 to 60 minutes
- Administered during unstructured situations, parallel groups, cooperative groups, or one or one interactions
- Occurs a natural setting, a simulated life role situation, and situations unrelated to life roles of the client
- The occupational therapist and client may discuss situations and settings would be appropriate and meaningful to administer the assessment.
- Assesses the domains of physicality, information exchange, and relations during communication and interaction
- Includes a four-point rating scale of 20 areas related to the domains
  - 4: Skill supports ongoing social action
  - 3: Questionable skill, however, does not disrupt ongoing social action
  - 2: Ineffective skill which impacts ongoing social action
  - 1: Deficit skill which causes unacceptable delay or breakdown in social action

The ACIS may be purchased through the Model of Human Occupation Clearinghouse at http://www.moho.uic.edu/assess/acis.html
Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS)

**Background:**
- Developed by Deshpande, Kielhofner, Henriksson, Haglund, Olson, Forsyth, and Kulkarn (2002)
- Based on components of the Model of Human Occupation (MOHO)

**Purpose:**
- Evaluate occupational participation and adaptation, volition, habituation, performance capacity, and environment
- Can guide the development of occupational therapy goals and treatment

**Administration:**
- Semi-structured interview with rating scale and summary form
- Administration time: 40-60 minutes
  - **Interview:** Includes discussion of occupational participation and adaptation, volition, habituation, performance capacity, and environment
  - **Interview Rating Scales:**
    - **S:** Strength; supports occupational participation
    - **D:** Difficulty; minor interference with or risk to occupational participation
    - **W:** Weakness; major interference with occupational participation
    - **P:** Problem; prevents occupational participation

The OCAIRS may be purchased through the Model of Human Occupation Clearinghouse at [http://www.moho.uic.edu/assess/ocairs.html](http://www.moho.uic.edu/assess/ocairs.html)
The Model of Human Occupation Screening Tool (MOHOST)

Background:
• Developed by Parkinson, Forsyth, and Kielhofner (2004)
• Based on components of the Model of Human Occupation (MOHO)

Purpose:
• Evaluate occupational functioning, volition, habituation, performance capacity, and environment
• Can guide the development of occupational therapy goals and treatment

Administration:
• Primarily an observation tool with summary form, yet information may be obtained interview with client and his/her family or staff
• 20-item rating scale of occupational functioning, volition, habituation, performance capacity, and environment
• Includes four-point ratings for each item
  • 4: Competent
  • 3: Questionable
  • 2: Ineffective
  • 1: Deficient

The MOHOST may be purchased through the Model of Human Occupation Clearinghouse at http://www.moho.uic.edu/assess/mohost.html
Role Checklist

**Background:**
- Developed by Oakley (1984)
- Based on components of the Model of Human Occupation (MOHO)

**Purpose:**
- Evaluate participation in life roles and the value placed on these roles
- Can guide the development of occupational therapy goals and treatment

**Administration:**
- Checklist format
- Checklist includes two parts with statements regarding 10 occupational roles
  - **Part 1:** Identify participation in occupational roles in present, past, and future
  - **Part 2:** Identify value of each role in present, past, and future

The Role Checklist may be obtained with permission of Frances Oakley at the National Institutes of Health. For contact information, refer to [http://www.moho.uic.edu/mohorelatedsrsrcs.html](http://www.moho.uic.edu/mohorelatedsrsrcs.html).
Modified Interest Checklist

Background:
- Developed by Kielhofner and Neville (1983)
- Based on components of the Model of Human Occupation (MOHO)

Purpose:
- Evaluate leisure interests
- Can guide the development of occupational therapy goals and treatment

Administration:
- Checklist format
- Presents 68 activities
  - Indicate interest in past 10 years and past year
  - Indicate current participation in activity
  - Indicate interest to pursue activity in future

The Modified Interest Checklist may be obtained through the Model of Human Occupation Clearinghouse at http://www.moho.uic.edu/mohorelatedrsrses.html.
Treatment Planning
## Treatment Planning

<table>
<thead>
<tr>
<th>MOHO Component</th>
<th>Problems/Challenges</th>
<th>Treatment Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volition</td>
<td>• Personal causation&lt;br&gt;• Distorted view of self and abilities&lt;br&gt;• Distorted body image&lt;br&gt;• Lack motivation for recovery&lt;br&gt;• Perfectionism/strong sense of control&lt;br&gt;• Difficulty in prioritizing occupations&lt;br&gt;• Lack balance between work, self-cares, and leisure</td>
<td>• Identify strategies to improve self-esteem&lt;br&gt;• Identify and interrupt negative self-talk&lt;br&gt;• Identify positive ways to nurture body image&lt;br&gt;• Identify strategies to motivate self for recovery&lt;br&gt;• Identify effects of eating disorder on self</td>
</tr>
<tr>
<td></td>
<td>• Values&lt;br&gt;• Values emphasize diet and weight</td>
<td>• Develop insight into what is important and meaningful</td>
</tr>
<tr>
<td></td>
<td>• Interests&lt;br&gt;• Limited interests</td>
<td>• Identify potential leisure interests</td>
</tr>
</tbody>
</table>
## Treatment Planning

<table>
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<tr>
<th>MOHO Component</th>
<th>Problems/Challenges</th>
<th>Treatment Objectives</th>
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<tr>
<td><strong>Habituation</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Roles</td>
<td></td>
<td>• Identify effects of eating disorder on self and others</td>
</tr>
<tr>
<td></td>
<td>• Difficulty identifying appropriate roles</td>
<td>• Identify expectations of self and others</td>
</tr>
<tr>
<td></td>
<td>• Impaired role performance</td>
<td></td>
</tr>
<tr>
<td><strong>Habits</strong></td>
<td>• Compensatory strategies related to eating disorder</td>
<td>• Identify and practice positive coping skills</td>
</tr>
<tr>
<td></td>
<td>• Inappropriate/unhealthy coping skills</td>
<td>• Identify and interrupt eating disorder urges</td>
</tr>
<tr>
<td></td>
<td>• Impulsive behaviors (bulimia nervosa)</td>
<td>• Plan and prepare a meal to meet nutritional needs</td>
</tr>
<tr>
<td></td>
<td>• Rigid routines</td>
<td>• Order and eat meal on a community restaurant outing</td>
</tr>
<tr>
<td></td>
<td>• Excessive time spent completing personal grooming tasks</td>
<td>• Increase awareness of how routines are affected by eating disorder symptoms</td>
</tr>
<tr>
<td></td>
<td>• Lack balance between work, self-cares, and leisure</td>
<td>• Identify an appropriate balance between work, self-cares, and leisure</td>
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</table>
## Treatment Planning

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<th>Treatment Objectives</th>
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</thead>
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<tr>
<td>• Difficulty asserting wants and needs of others</td>
<td>• Identify and practice assertive communication skills</td>
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<tr>
<td>• Difficulty identifying and expressing emotions</td>
<td>• Increase awareness of emotions and their use in communication</td>
<td></td>
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<tr>
<td>• Decreased ability to complete activities of daily living (ADLs)</td>
<td>• Identify and practice positive coping skills</td>
<td></td>
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<tr>
<td>• Decreased memory and concentration</td>
<td></td>
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<tr>
<td><strong>Environment</strong></td>
<td></td>
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<tr>
<td>• Substance abuse</td>
<td>• Identify and practice positive coping skills</td>
<td></td>
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<tr>
<td>• History of physical, sexual, or psychological abuse</td>
<td>• Identify community resources for support</td>
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<tr>
<td>• Societal pressures related to beauty and weight</td>
<td>• Increase awareness of how eating disorders impacts relationships</td>
<td></td>
</tr>
<tr>
<td>• Dysfunctional family/home situation</td>
<td>• Practice assertive communication</td>
<td></td>
</tr>
<tr>
<td>• Limited support/social network</td>
<td>• Identify skills to develop meaningful relationships with others</td>
<td></td>
</tr>
</tbody>
</table>
Sample Activities
Sample Activities

The following activities are appropriate in addressing occupational therapy treatment objectives among individuals diagnosed with eating disorders. These activities are based upon the Model of Human Occupation (MOHO) and include components of the cognitive-behavioral frame of reference and psychoanalytic frame of reference. The activities can be adapted to the needs of clients as appropriate.

The sample activities will be organized according to the following MOHO components:

- Volition
- Habituation
- Performance Capacity
- Environment
Volition
“Compliment Circle”

Objective(s):
- MOHO component addressed: Volition
- Increase self-esteem and self-awareness through verbal communication
- Practice providing and receiving verbal feedback

Age(s):
- Adolescents

Material(s):
- Small ball of yarn

Activity:
- Introduce group by discussing impact of verbal feedback on self-esteem
- With the group sitting in a circle, one participant may begin by holding the ball of yarn. This participant will provide an appropriate compliment to a peer and “throw” the ball of yarn to that person, while still holding the end of the yarn.
- Each group member will continue to give and receive compliments until the entire ball of yarn is distributed.
- The group may discuss thoughts and feelings related to giving and receiving compliments

Resource:
“Dear Body of Mine” Letter

Objective(s):
• MOHO component addressed: Volition
• Increase awareness of the effects of negative self-talk on body image
• Identify positive ways to nurture and improve body image

Age(s):
• Adults
• Adolescents

Material(s):
• “Dear Body of Mine” worksheet (p. 174), journal, or white/colored paper

Activity:
• Introduce group by discussing negative and positive self-talk and their effects on body image
• Distribute worksheet or plain paper to clients (they may also choose to write in their journal) to write a letter to their body. The letter may include things they want to change about their body, identifying negative self-talk, positive qualities about their body, ideas to improve body image, etc.
• Allow 20-25 minutes for writing.
• Clients may share the letters with the group; the group may discuss coping strategies for negative body image

Resource:
Body Image Bookmarks

Objective(s):
- MOHO component addressed: Volition
- Increase perception of body image by interrupting negative thoughts with positive self-talk

Age(s):
- Adults
- Adolescents

Material(s):
- Large index cards (these may be cut in half)
- Scissors
- Glue sticks
- Markers, pens, or color pencils
- Magazines
- Clear bind/seal tape

Activity:
- Introduce group by discussing negative and positive self-talk
- Clients may create bookmarks with an appropriate body image affirmation message
  - For ideas regarding affirmations, refer to: http://www.something-fishy.org/reach/affirmations.php
- The affirmation may be placed on the front of the bookmark using markers, pens, color pencils, or letters from magazines
- The bookmark may be decorated as desired, and a collage (on back of bookmark) may be created using appropriate, non-triggering magazine pictures
- The clients may share bookmarks and discuss how the affirmations may be beneficial
- If desired, the bookmarks may be “laminated” using clear bind/seal tape

Resource:
Body Image Bingo

Objective(s):
• MOHO component addressed: Volition
• Identify positive ways to nurture and improve body image

Age(s):
• Adolescents
• Adults

Material(s):
• Body image bingo card (see next page)
• Colored beads (for scoring)

Activity:
• Introduce group by discussing importance of identifying and practicing strategies to improve body image
• Prior to group, the occupational therapist will add numbers to attached worksheet to create a different bingo card for each client
• As the facilitator calls a letter and number, the client(s) with that square will answer the question appropriately
• Clients may use beads for scoring on bingo cards
• Take turns answering questions; participants win by getting a horizontal, vertical, or diagonal row

Resource(s):
Adapted from:


### Body Image Bingo

<table>
<thead>
<tr>
<th>B</th>
<th>I</th>
<th>N</th>
<th>G</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
<td>11-20</td>
<td>21-30</td>
<td>31-40</td>
<td>41-50</td>
</tr>
<tr>
<td>Healthy body image is</td>
<td>Something I CAN change now is</td>
<td>Two ways I get confidence are</td>
<td>Something I cannot change is</td>
<td>A healthy risk I should take is</td>
</tr>
<tr>
<td>I feel best about myself when</td>
<td>I am inspired by</td>
<td>I can pamper myself by</td>
<td>I have improved my body image by</td>
<td>My goals for this week are</td>
</tr>
<tr>
<td>Three adjectives to describe my body are</td>
<td>People often compliment me about</td>
<td>FREE</td>
<td>One person that always makes me feel good about myself is</td>
<td>Give a compliment to the person on your left.</td>
</tr>
<tr>
<td>Three things about my body I am grateful for are</td>
<td>One thing I like about this group is</td>
<td>An example of negative self-talk that affects my body image is</td>
<td>Give a compliment to yourself.</td>
<td>Name a body image affirmation that is helpful for you.</td>
</tr>
<tr>
<td>I can interrupt negative self-talk by</td>
<td>Body image affects my recovery by</td>
<td>Three healthy activities I can enjoy are</td>
<td>I am proud of my ability to</td>
<td>I had been putting off until I had the &quot;perfect&quot; body.</td>
</tr>
</tbody>
</table>

“Helpsheet for Change: How I Need to Help Myself Now”

Objective(s):
- MOHO component addressed: Volition
- Reflect upon personal improvements regarding body image
- Identify positive ways to nurture and improve body image

Age(s):
- Adults

Material(s):
- “Helpsheet for Change” worksheet (pp. 199-200)

Activity:
- Introduce group by discussing activities from previous body image groups
- Distribute worksheet to clients and allow 15-20 minutes for completion
- Clients may discuss worksheet, including areas they have improved upon and areas they must continue to address
- Together, the group may discuss ideas to address areas for improvement regarding body image

Resource:
“Dear Eating Disorder”

Objective(s):
- MOHO component addressed: Volition
- Increase awareness of how eating disorder impacts self and others
- Identify strategies to motivate self for recovery

Age(s):
- Adults
- Adolescents

Material(s):
- Journal or white/colored paper

Activity:
- Distribute plain paper to clients (they may also choose to write in their journal) to write a letter to their eating disorder. The letter may include things they dislike about their eating disorder, its impact on their lives and the lives of their loved ones, and how it has inhibited them.
- Allow 20-25 minutes for writing.
- Clients may share the letters with the group; the group may discuss how this letter can be used to challenge and motivate them to recovery

Resource:
“What Do I Value?”

**Objective(s):**
- MOHO component addressed: Volition
- Increase awareness and insight into what one finds important and meaningful

**Age(s):**
- Adults
- Adolescents

**Material(s):**
- “What do I value?” worksheet

**Activity:**
- Introduce group by discussing values and their relation to self-satisfaction
- Distribute worksheet amongst clients and allow 15-20 minutes to complete
- Clients may share the values most important to them and discuss how they are expressed and/or opposed

**Resource:**
Leisure Planning

Objective(s):
- MOHO component addressed: Volition
- Identify potential leisure interests and availability of specific leisure interests
- Increase awareness of leisure as a coping skill

Age(s):
- Adults
- Adolescents

Material(s):
- “Leisure Link” inventory
- “Leisure Scavenger Hunt” worksheet
- Local phone books

Activity:
- Introduce group by discussing importance of incorporating leisure into healthy lifestyle
- Distribute “Leisure Link” inventory to clients for completion and discuss potential leisure interests
- Distribute “Leisure Scavenger Hunt” worksheet to clients for completion, as well as phone books for resources
- Discuss availability information and community resources for leisure as gathered by the clients

NOTE** As some clients may not receive treatment within their home community, provide extra “Leisure Scavenger Hunt” worksheets to locate leisure resources specific to their home community

Resource:

Habituation
“52 Cards”

Objective(s):
- MOHO component addressed: Habituation
- Identify positive coping strategies to be used during treatment and recovery.

Age(s):
- Adolescents

Material(s):
- 52 Cards
  Written by: Lynn Gordon
  Illustrated by: Karen Johnson
  Publisher: Chronicle Books LLC

The following card sets are available at Barnes and Noble and Amazon books:
- 52 Rainy Day Activities
- 52 Things to Try Once in Your Life
- 52 Ways to Celebrate Life
- 52 Ways to Find Serenity
- 52 Ways to Make a Difference
- 52 Ways to Nurture Your Creativity
- 52 Ways to Pamper Yourself
- 52 Silly Things to Do When You Are Blue
- 52 Ways to Simplify Your Life
- 52 Ways to Balance Your Life
- 52 Easy Ways to Energize
- 52 Art Activity Kit

Activity:
- Introduce group by describing purpose of activity
- Distribute card sets to group and encourage participants to write activities of interest in journal or on separate sheet of paper
- The group may discuss new coping strategies they identified from the cards

NOTE** Prior to distributing card sets to clients, remove cards regarding areas inappropriate to adolescents and potentially triggering issues

Resource:
Unpublished document.
“Coping Skills Alphabet”

**Objective(s):**
- MOHO component addressed: Habituation
- Increase awareness of healthy and appropriate coping skills to be used during treatment and recovery.

**Age(s):**
- Adolescents

**Material(s):**
- “Coping Skills Alphabet” worksheet

**Activity:**
- Introduce group by discussing passive and active coping skills
  - Passive coping skills may be described as strategies that distract self from stressors (i.e. watching movies, sleeping, playing a card game, etc.).
  - Active coping skills are strategies that directly address issues and concerns (i.e. utilizing support system, journaling, practicing assertive communication, etc.)
- Distribute worksheet to clients and identify positive coping skills for each letter of the alphabet.
- Encourage participants to identify passive and active coping skills when completing the worksheet.
- As participants discuss coping skills alphabet, the group facilitator may complete worksheet of the group’s ideas and give copies to each participant.

**Resource:**
“Coping Bank”

Objective(s):
- MOHO component addressed: Habituation
- Increase awareness of healthy and appropriate coping strategies to be used during treatment and recovery

Age(s):
- Adults
- Adolescents

Material(s):
- Shoebox, plastic container, wooden craft box (or a container that may be easily opened)
- Markers, crayons, or colored pencils
- Construction paper or cardstock
- Decorative materials: ribbon, fabric, stickers, stamps, etc.
- Scissors
- Glue

Activity:
- Introduce group by discussing coping banks and their purpose
- The clients may decorate boxes/containers as appropriate; slits may be cut into boxes if necessary
- The clients will write a variety of positive coping strategies on slips of paper and add to the “coping bank”
  - For ideas regarding coping strategies, refer to:
    http://www.something-fishy.org/reach/copingbank.php and
    http://www.something-fishy.org/reach/waystocope.php
- Discuss with clients that they may “withdraw” coping strategies from the bank in times stress and “deposit” these coping strategies (as well as new ones) back into the bank
- The group may share ideas regarding coping strategies

Resource:
"Destroying Distress"
Relaxation Technique

Objective(s):
- MOHO component addressed: Habituation
- Increase awareness of relaxation as positive coping strategy
- Discuss and practice progressive muscle relaxation, deep breathing, and guided imagery relaxation techniques

Age(s):
- Adults
- Adolescents

Material(s):
- “Destroying Distress” relaxation techniques (pp. 67-70)
- Relaxation chairs with foot rests, yoga/exercise mats, or blankets
- Pillows or neck rests

Activity:
- Introduce group by discussing relaxation as a positive coping strategy and specific techniques including progressive muscle relaxation, deep breathing, and guided imagery
- If available, the clients may sit in relaxation chairs with feet elevated on foot rests or lay on their backs on exercise mats or blankets. Pillows or neck rests may be available to rest head comfortably.
- Read “Destroying Distress” relaxation techniques, by T.F. Cash.
- The clients may discuss the relaxation techniques; whether they were beneficial and specific techniques that improved/did not improve stress

NOTE** Revise “Destroying Distress” relaxation techniques as appropriate for clients in the eating disorders treatment facility. For example, some relaxation techniques refer to the body as “heavy.” As this may be triggering for some individuals, it is important refrain from use of this word.

Resource:
Community Restaurant Outing

Objective(s):
- MOHO component addressed: Habituation
- Order and eat meal on a community restaurant outing
- Plan meal to meet nutritional needs
- Practice positive coping skills
- Identify and interrupt eating disorder urges

Age(s):
- Adults
- Adolescents

Material(s):
- Method of transportation for clients and staff

Activity:
- This group may be co-lead with a dietician to address nutritional aspects of meal
- Allow at least 90 minutes to complete outing (driving time, order and eat meal, etc.)
- Prepare to provide one staff member (occupational therapist, dietician, or nursing) per three clients for support
- Pre-determine restaurant location several days before outing to allow time for meal planning with clients
- Prior to outing, discuss thoughts and concerns related to outing
- Staff may provide support as necessary for clients throughout meal
- Upon return to vehicle or treatment facility, discuss thoughts, concerns, and eating disorder urges related to outing

Resource:
Meal Preparation Group

Objective(s):
- MOHO component addressed: Habituation
- Plan and prepare a meal to meet nutritional needs

Age(s):
- Adults
- Adolescents

Material(s):
- Kitchen and appliances
- Kitchen tools/accessories
- Dining place settings
- Grocery items

Activity:
- This group may be co-lead with a dietician to address nutritional aspects of meal
- Allow at least two hours to prepare and eat meal
- Pre-determine menu several days before outing to allow time for meal planning with clients
- Staff may provide support as necessary for clients throughout meal preparation
- Clients will prepare and serve meal and staff will join clients for dining

Resource:
Stress Management Game

Objective(s):
- MOHO component addressed: Habituation
- Identify healthy coping skills to manage stress

Age(s):
- Adults
- Adolescents

Material(s):
- "Stress Management Game" worksheet, cut into game pieces

Activity:
- Introduce group by discussing stress and the “fight or flight” response
- Clients may select a game piece from bowl, read it aloud to group, and share the answer
- As a group, discuss healthy and unhealthy ways to manage stress

Resource:
“Balance Your Life”

Objective(s):
- MOHO component addressed: Habituation
- Increase awareness of daily routines and how they are impacted by eating disorder symptoms
- Identify an appropriate plan to balance ADLs, work/school activities, leisure, and free time

Age(s):
- Adults
- Adolescents

Material(s):
- Two copies of “Balance Your Life” worksheet
- Colored pencils, markers, or crayons

Activity:
- Introduce group by discussing balance as part of a healthy lifestyle
- The clients may select four different colors of pencils, markers, or crayons and color each section of the balance wheel worksheet that signifies time spent participating in ADLs, work/school activities, leisure, and IADLs (i.e. household management, care of others, community mobility, health management, meal preparation, and shopping) prior to treatment
- The clients may select another color to create dots in each section of the balance wheel in which they participated in eating disorder symptoms prior to treatment
- The clients may discuss worksheet and the impact of eating disorders on time management
- Using a second balance wheel worksheet, clients may use four different colors for each section to signify anticipated time spent participating in ADLs, work/school activities, leisure, and IADLs following treatment
- The clients may discuss worksheet and how they plan to incorporate healthy balance to their lifestyle

Resource:
Weekend Planning

Objective(s):
- MOHO component addressed: Habituation
- Plan and prepare an appropriate weekend schedule
- Identify positive coping skills

Age(s):
- Adults
- Adolescents

Material(s):
- “Weekend Planning” worksheet
- Three dice

Activity:
- Introduce group by discussing importance of developing an appropriate weekend schedule
- Distribute worksheet to clients and discuss healthy and unhealthy uses of free time
- The group may discuss upcoming weekend challenges and practice planning for the weekend by discussing the second section of the worksheet

OR

- The clients may take turns shaking one, two, and/or three dice to answer statements provided in the second section of the worksheet

Resource:
Performance Capacity & Skills
Assertive Communication

Objective(s):
- MOHO component addressed: Performance capacity & skills
- Identify and practice assertive communication skills
- Increase awareness of communication styles, including: passive, aggressive, passive-aggressive, and assertive communication styles

Age(s):
- Adults
- Adolescents

Material(s):
- Communication style scenario cards (created by occupational therapist prior to group)

Activity:
- Introduce group by defining and discussing passive, aggressive, passive-aggressive, and assertive styles of communication
- Discuss and practice “I feel….” statements in assertive communication
- Clients may select scenario cards from bowl, read aloud, and identify a passive, aggressive, passive-aggressive, and assertive response for the scenario
- Clients may identify and share experiences with each of these styles, as well as assertive communication that may have been used in these experiences

Resource:
Emotion Charades

Objective(s):
- MOHO component addressed: Performance capacity & skills
- Increase awareness of emotions and their use in communication
- Practice appropriate expression of feelings and emotions

Age(s):
- Adults
- Adolescents

Material(s):
- Emotion charades cards (created prior to group by occupational therapist)

Activity:
- Introduce group by discussing purpose of emotions in communication
- Clients may select charade card from bowl and perform skit independently or cooperatively, as appropriate
  - The occupational therapist may create cards with various scenarios prior to group (as appropriate to age group)
- Clients may express emotions/feelings associated with skit non-verbally
- After charades game, discuss thoughts and feelings related to expression of emotions

Resource:
“Emotions”

Objective(s):
- MOHO component addressed: Performance capacity & skills
- Increase awareness of emotions and their use in communication
- Practice identifying and describing emotions in relation to life experiences appropriately

Age(s):
- Adults
- Adolescents

Material(s):
- “Emotions” worksheet; cut emotions squares out of handout

Activity:
- Prior to group, the facilitator may cut the emotions squares out of handout and place in an envelope
- Introduce group by discussing the purpose of emotions in communication
- Clients may select an emotion square from the envelope, identify the emotion, and discuss a situation in which he/she experienced the emotion
- Clients may take turns identifying and describing emotions, and can be allowed one “pass” in which they are unable to identify an experience with a specific emotion

Resource:
“What’s Going On with Them?”

Objective(s):
- MOHO component addressed: Performance capacity & skills
- Identify and describe emotions
- Develop empathy for others
- Increase awareness of positive and negative perceptions of others related to interpretation of verbal and non-verbal expression

Age(s):
- Adolescents

Material(s):
- "What's Going On with Them?" scenario cards
  - Discard any cards which may be inappropriate for group discussion

Activity:
- Introduce group by discussing importance of verbal and nonverbal expression in communication
- Remind clients that the activity is NOT about mind reading or making assumptions, but to develop an understanding of potential underlying issues
- Clients may select scenario cards from bowl and discuss underlying issues related to the behaviors
- Clients may discuss personal experiences and situations in which they may have misinterpreted a behavior

Resource:
### Anger Management

**Objective(s):**
- MOHO component addressed: Performance capacity & skills
- Increase awareness of anger and its impact on communication
- Identify strategies to appropriately express and cope with anger

**Age(s):**
- Adults
- Adolescents

**Material(s):**
- Anger quiz worksheet
- Anger management techniques worksheets

**Activity:**
- Introduce group by discussing communication styles (i.e. assertive communication, passive-aggressive communication, aggressive communication, and passive communication) and how they may be influenced by anger
- Distribute anger quiz for completion and discuss findings
- Distribute anger management worksheets and discuss coping techniques
- Clients may identify and discuss situations personal experiences related to anger and how they may express and/or cope with anger more appropriately in the future

**Resource(s):**


Environment
“Breaking the Ice”

Objective(s):
- MOHO component addressed: Environment
- Develop rapport and relationships through self-disclosure
- Increase awareness of self and others by giving and receiving feedback

Age(s):
- Adolescents

Material(s):
- “Ice breakers” sheet (see next page)

Activity:
- Introduce purpose of activity by discussing importance of meaningful and appropriate relationships
- The “Ice Breakers” sheet may be cut into game pieces for clients to select from bowl and read aloud
  
  OR

- “Ice Breakers” questions may be read aloud by the occupational therapist for clients to answer
- Participants may discuss “Ice Breakers” and share personal experiences, as well as identify similarities and differences

Resource(s):
Adapted from:
Ice Breakers

1. My favorite movie is....
2. If I were an animal, I would be....because....
3. In 5 years, I would like to be doing....
4. My favorite entertainer/performer is....
5. My favorite season is....because....
6. My favorite color is....
7. My favorite holiday is....because....
8. One thing I admire most in other people is....because....
9. I would like to vacation to....
10. My favorite school subject is....because....
11. Two positive coping skills I use are....
12. One unique thing about me is....
13. Five adjectives to describe myself are....
14. People say I’m....
15. For fun, I like to....
16. I work (or have worked) at....
17. Something or someone that makes me laugh is....
18. The job I (would) like to do is....
19. My favorite sport is....
20. What I like best about myself is....

Adapted from Carrell, S. (2000)
Life Events

Objective(s):
- MOHO component addressed: Environment
- Develop relationship and understanding of self and others
- Identify coping skills for a variety of life events

Age(s):
- Adolescents

Material(s):
- "Life Events" worksheet (see next page)

Activity:
- Introduce group by discussing importance relating self to others
- Provide clients attached worksheet and encourage them to find someone among the group who has experienced these life events in the past year
- The clients may ask one another to discuss the situation, depending on appropriateness and clients' comfort
- The clients may describe coping techniques that they used in the situation
- Encourage participants to try and find a different person for each event

Resource:
Adapted from:

## Life Events

<table>
<thead>
<tr>
<th>Parents divorce</th>
<th>Death of a loved one</th>
<th>Starting or stopping school</th>
<th>Moved to new town or city</th>
<th>Addition to family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduated from high school</td>
<td>Began a new relationship</td>
<td>Pressured to use drugs or alcohol</td>
<td>Argument with close friend</td>
<td>Won a contest</td>
</tr>
<tr>
<td>Sickness in family</td>
<td>Change in personal habits</td>
<td>Argument with family member</td>
<td>Ended a relationship</td>
<td>School difficulties</td>
</tr>
<tr>
<td>Learned a new skill</td>
<td>New job</td>
<td>Money issues</td>
<td>Law trouble</td>
<td>Went on a vacation</td>
</tr>
<tr>
<td>Joined a club</td>
<td>Got a driver’s license</td>
<td>Best friend moved away</td>
<td>Was selected for a team at school</td>
<td>Change in responsibilities at home</td>
</tr>
</tbody>
</table>

Relapse Management

Objective(s):
- MOHO component addressed: Environment
- Identify community/social resources for support
- Increase awareness of eating disorder urges
- Identify and practice positive coping skills

Age(s):
- Adults
- Adolescents

Material(s):
- Colored/construction paper
- Scissors
- Markers, colored pencil, pens, or crayons

Activity:
- Introduce group by discussing importance of community and/or social support for eating disorder urges
- The clients may create a risk management pamphlet to reference in times of stress or urge to participate in eating disorder symptoms. This may include:
  - Names and contact information of family and friends who may be supportive during stress/urges
  - Community resources (support group, crisis hotline, etc.)
  - Identify symptoms of preceding urges
  - Identify positive coping strategies
  - Other areas may be added as appropriate
- The clients may share and discuss pamphlet to gather information regarding resources

Resource:
Developed by Randi Horner, MOTS (2005)

Adapted from:
Potential Outcome Measures
Outcome Measures

The occupational therapist can utilize outcome measures to evaluate client progress in treatment in relation to treatment objectives. Standardized and non-standardized assessments can be included or developed by the occupational therapist as appropriate. Outcome measures can assist the occupational therapist in determining problems that need to be further addressed in treatment and areas that have improved with intervention.

According to the American Occupational Therapy Association (2002), outcomes can be used to measure participation in occupations. In assessing outcomes of occupational therapy in the treatment of eating disorders, various types of outcomes may be appropriate. Potential areas of outcome assessment include occupational performance, client satisfaction, role competence, adaptation, health and wellness, prevention, and quality of life (American Occupational Therapy Association [AOTA], 2002). Although it is important to evaluate efficacy of treatment using each of these outcomes, client progress can be appropriately evaluated through assessment of occupational performance, role competence, and quality of life.

Occupational performance outcome assessments measure the ability to perform areas of occupation (AOTA, 2002). A variety of measures can be utilized to assess occupational performance. The Occupational Self Assessment (OSA) can be administered to assess occupational competence and evaluate progress. The Assessment of Communication and Interaction Skills (ACIS) can be implemented to measure progress related to interpersonal communication. Further, the Model of Human Occupation Screening Tool (MOHOST) is appropriate to assess occupational functioning
and performance capacity. Although standardized assessments are useful in measuring outcomes, the occupational therapist can develop an observation scale to measure daily progress. Also, it is appropriate for the occupational therapist to document the client's ability to participate in occupations.

Role competence outcome assessments measure the ability to engage in roles as appropriate (AOTA, 2002). The Occupational Performance History Interview II (OPHI-II) is appropriate to assess roles and their impact on occupational performance. The Role Checklist can be used to specifically address roles and their value to the client. The occupational therapist can utilize a non-standardized interview with the client to gather information regarding changes in role functioning throughout treatment.

Quality of life outcome assessments are used to evaluate the client's perception of self-satisfaction, self-concept, health and functioning, and socioeconomic factors (AOTA, 2002). The OSA is an appropriate client-report tool to assess satisfaction with occupational competence and environment. The occupational therapist can develop a client self-evaluation form to address perception of body image, self-esteem, and assessment of health status. It is appropriate to document the client's reports of self-concept, health status, and satisfaction with treatment as they occur in occupational therapy groups. Additionally, standardized quality of life assessments can be utilized as appropriate.

Outcome measures are an essential tool in the occupational therapy treatment of eating disorders. The outcome measures described in this section can assist the occupational therapist in assessing client progress in treatment. Further measures can be developed by the occupational therapist to meet the specific needs of the facility.
References


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CHAPTER V

SUMMARY

Eating disorders are complex illnesses that can impact both physical and mental health and often require multidisciplinary treatment settings and strategies. Individuals diagnosed with eating disorders seek treatment in outpatient, inpatient, and partial hospitalization settings (Stewart & Williamson, 2004; Matusevich, Garcia, Gutt, de la Parra, & Finkelsztein, 2002; Weiner, 1999). Treatment typically includes medical care, pharmacological management, nutritional counseling, psychotherapy, and life management skills (Stewart & Williamson, 2004; Weiner, 1999; Mitchell, 2001).

Individuals diagnosed with eating disorders demonstrate rigid habits, role impairment, inappropriate coping skills, distortion of self-concept, impaired communication skills, and a limited social network. Occupational therapy has a unique role within the multidisciplinary team as it addresses these occupational performance issues. The occupational therapist can address areas of dysfunction related to eating disorders in group settings which focus on healthy coping skills, body image and self-esteem, communication and social skills, perfectionism, time management, eating habits, and meal planning and preparation (Breden, 1992; Martin, 1998). Yet, healthcare professionals, including occupational therapists, have questions regarding the role of occupational therapy in the treatment of eating disorder. This project seeks to increase the awareness of the role of occupational therapy in the treatment of eating disorders by providing a guide for effective occupational therapy treatment of these illnesses.
Limitations and Recommendations for Future Action

The majority of occupational therapy literature specific to eating disorders is dated between the years of 1986 and 1994. Although the benefits of occupational therapy are discussed in this literature, outcomes-based research is recommended to increase awareness among healthcare professionals, including occupational therapists, regarding the role of occupational therapy in the treatment of eating disorders. This scholarly project provides information regarding appropriate outcome measures that can be utilized by occupational therapists in the treatment of eating disorders. Non-standardized outcome measure samples have not been provided in this scholarly project and it is recommended that the occupational therapist develop non-standardized outcome measures to evaluate specific needs of the client and facility. Further types of outcomes can be selected for measurement as deemed appropriate.

The scholarly project does not address the adaptation of occupational therapy treatment for male clients. Male clients demonstrate challenges unique to those of females, thus indicating need to develop occupational therapy intervention specific to the male population. Further, this scholarly project does not address the treatment of individuals diagnosed with binge eating disorder. Research regarding the treatment of males diagnosed with eating disorders, as well as individuals diagnosed with binge eating disorder, can be useful to address the problems unique to those populations.

Other occupational therapy models and frames of reference that may be appropriate to this population have not been discussed. Although the Model of Human Occupation (MOHO) holistically addresses the spectrum of problems and challenges of individuals diagnosed with eating disorders, the complex problems and challenges related
to eating disorders can best be addressed through the application of multiple models and frames of reference. Therefore, it is recommended that occupational therapy intervention be developed to incorporate pertinent components of a variety of models and frames of reference.

Implementation of Project

The purpose of this project is to increase the awareness of the role of occupational therapy in the treatment of eating disorders. Therefore, this scholarly project is suitable for presentation at occupational therapy and non-occupational therapy inservices or conferences to make the information available to practitioners and students. It is hoped that this scholarly project will serve as an educational tool to address questions regarding occupational therapy treatment of eating disorders.

Conclusions

The physical and mental effects of eating disorders limit occupational performance in a variety of areas that are related to rigid habits, role impairment, unhealthy coping skills, distorted self-concept, and impaired communication skills. Physical and mental health of the individual may be influenced by the individual’s perception of his/her occupational performance, as well as actual performance. A unique opportunity for occupational therapy exists to address occupational performance within the context of a multidisciplinary team to develop mastery and restore competence in the occupations of everyday life.
Appendix A

Diagnostic Criteria of Anorexia Nervosa

A. Body weight that is below a minimally normal level for age and weight. In meeting this criterion, individuals weigh less than 85% of that weight that is considered normal for their age and height.

B. Intense fear of gaining weight or becoming fat, although the individual is underweight.

C. Significant distortion of body weight and shape.

D. In postmenarcheal females, amenorrhea (i.e. absence of three consecutive menstrual cycles).

Subtypes of Anorexia Nervosa

A. Restricting Type: Weight loss is accomplished primarily through dieting, fasting, or excessive exercise. In the current episode, individuals have not regularly engaged in binge eating or purging.

B. Binge-Eating/Purging Type: Individuals regularly engage in binge eating, purging, or both during the current episode. Purging may occur through self-induced vomiting or misuse of laxatives, diuretics, or enemas. Also, some individuals in this subtype do not binge eat, but do engage in purging behaviors after consumption of small amounts of food.

Appendix B

Diagnostic Criteria of Bulimia Nervosa

A. Recurrent episodes of binge eating. Episodes are characterized by the following:
   1. Eating an amount of food that is definitely larger than most people would eat during similar time periods and circumstances.
   2. A sense of lack of control over eating during the episode.

B. Recurrent use of inappropriate compensatory behaviors to prevent weight gain, including self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. Binge eating and inappropriate compensatory behaviors occur at least twice weekly for three months.

D. Significant distortion of body weight and shape.

E. Disturbance does occur exclusively during episodes of anorexia nervosa.

Subtypes of Bulimia Nervosa

A. Purging Type: During current episode, individuals regularly engage in self-induced vomiting or misuse of laxatives, diuretics, and enemas.

B. Non-Purging Type: During current episode, individuals use other inappropriate compensatory behaviors, including fasting or excessive exercise, and do not regularly engage in self-induced vomiting or misuse of laxatives, diuretics, and enemas.

Appendix C

Diagnostic Criteria of Eating Disorder Not Otherwise Specified

A. For females, all criteria of anorexia nervosa are met, except that they have regular menstrual cycles.

B. All criteria of anorexia nervosa are met, except that current weight remains within normal range.

C. All criteria of bulimia nervosa are met, except that binge eating and inappropriate compensatory behaviors occur less than twice weekly or for duration of less than three months.

D. Regular use of inappropriate compensatory behavior by individuals of normal body weight after eating small amounts of food.

E. Repeated chewing and spitting out, but not swallowing, large amounts of food.

References


Kong, S. (2005). Day treatment programme for patients with eating disorders:


