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continued

# The Cognitive Behavioral Therapy Approach to Eating Disorders

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continued

## Learning Outcomes

- Identify characteristics of common eating disorders and the occupational therapists role in the cognitive behavioral therapy approach to treating eating disorders.
- List the stages of CBT treatment and assess a client's readiness for progressing through the various stages of treatment.
- Design appropriate treatment interventions for the client with an eating disorder in an outpatient setting.

continued

continued

## Occupational Therapy

- Occupational Therapists (OT's) focus on enabling people to participate in meaningful and purposeful activities of daily life.
- Occupational balance
- For a person struggling with an eating disorder (ED), prior healthy roles and occupations fade and their primary occupation becomes the ED and the rituals and behavior required to maintain it.

continued

## Occupational Therapists

- Provide a safe setting where a person with ED can engage in multi sensory activities via doing
- Practice habits which create or reinforce healthy roles and occupations
- Provide patient with setting where verbal insights can be converted into new behavior
- Develop functional life skills through meaningful occupations
- Identify the source of a client's relationship with food and weight

continued<sup>®</sup>

## Occupational Therapy

- Implement a variety of activities to help individuals engage in daily routines such as meal planning and grocery shopping.
- Experiential components sit at the heart of authentic OT theory and practice.

continued<sup>®</sup>

## Evidence Based Research

- “The occupational therapist is vital to providing a complete assessment and thorough treatment of the population with eating disorders” (Breden, 1992)

continued

## Evidence Based Research

- Occupational Therapists working in ED face challenges related to lack of evidence base for occupational therapy in this area. Future research should focus on developing further evidence for occupational therapy in eating disorders and designing outcome measures that capture improvements in daily functioning. These efforts would strengthen the role of OT and reduce risk of burnout” (Devery, 2018).

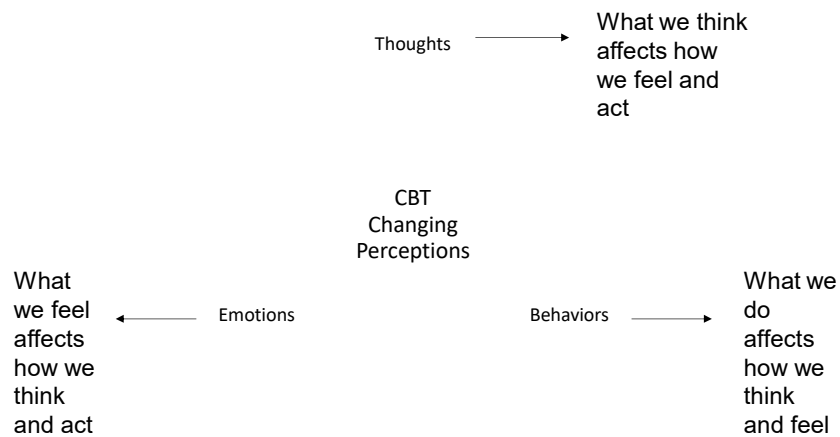
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## Cognitive Behavioral Therapy

- Cognitive Behavioral Therapy (CBT) is a short term, goal oriented psychotherapy treatment that takes a hands on, practical approach to problem-solving.
- CBT works to change peoples attitudes and behavior by focusing on thoughts, images, beliefs, & attitudes that are held (a person’s cognitive processes) and how these processes relate to the way a person behaves as a way of dealing with emotional problems.

continued

## Cognitive Behavioral Therapy

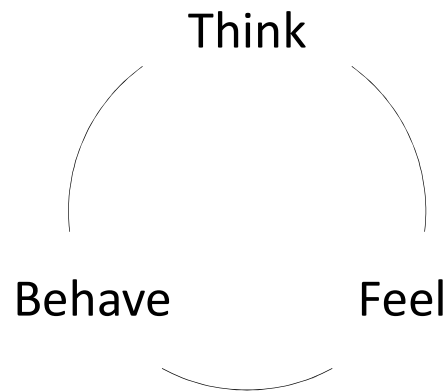


## Cognitive Behavioral Therapy

- Problem-focused
- Action-oriented
- Used for the treatment of:
  - Anxiety disorders
  - Panic disorders
  - Behavioral difficulties in children
  - Chronic fatigue
  - Anger management

continued

## Cognitive Behavioral Therapy



continued

## Cognitive Behavioral Therapy

- Number of CBT sessions can range from 5 to 20
- Sessions: 30-60 minutes

continued



continued

## Evidence

- CBT effective in treating addictions (Powers et al., 2008), smoking (Song et al., 2010), and gambling (Oakley-Brown, et al., 2000), reducing symptoms of schizophrenia (Gould et al., 2001), depression (Van Straten et al., 2010) bipolar (Gregory, 2010), and eating disorders (Murphy et al., 2010).
- CBT is also highly effective for various anxiety related disorders (Hofmann & Smits, 2008) & obsessive compulsive disorder (Kaczurkin, 2013).

continued

## Evidence

- CBT can successfully treat insomnia, stress, criminal behaviors, anger and aggression (Hoffman, et al., 2012)

## Psychopathology

- Genetics
  - 1<sup>st</sup> and 2<sup>nd</sup> degree relatives more prone to developing ED
  - Twin siblings 50% chance of developing ED
  - 50-80% risk
- Behavioral
- Psychodynamic

## Eating Disorders

- Eating disorders (ED) such as anorexia, bulimia, and binge eating disorder include extreme emotions, attitudes, and behaviors surrounding weight & food issues.
- ED are serious emotional and physical problems that can have life-threatening consequences for females and males (National Eating Disorders, 2017).
- Almost half of sufferers never seek or receive professional treatment.

continued

## Eating Disorder Statistics

- 4/10 individuals have either personally experienced ED or know someone who has.
- 1.0-4.0% of women have suffered from anorexia in their lifetime, and it has the highest fatality rate of any mental illness.
- 4% of anorexic individuals die from complications of the disease.
- 4% of females in the U.S will have bulimia during their lifetime (3.9% of these individuals will die)

continued

## Eating Disorder Types

- The main types of ED include:
  - Anorexia Nervosa
  - Binge Eating Disorder
  - Bulimia Nervosa

continued

## Anorexia Nervosa

- Low weight d/t inadequate food intake, intense fear of weight gain, obsession with weight and body image, persistent behavior related to preventing weight gain, a distorted image of own body and inability to understand severity of problem.
- Binge and purge
- Compulsive lengthy exercise

continued

## Binge Eating Disorder

- Binge eaters can often eat alone because of feelings of embarrassment about own behavior, eating when not hungry and until they are uncomfortably full.
- Severe, life threatening disorder, treatable.

continued

## Bulimia Nervosa

- Cycles of bingeing and purging
- Bingeing: frequently consuming large amounts of food
- Purging: getting rid of excess calories through self-vomiting, laxatives, stimulants, water fasting, or excessive exercise.
- Most people are at their normal weight.
- Related to self-image

continued

## Diagnosis

- Physical checkup
- Full blood count
- Psychological evaluation
- X-rays (on occasion for potential stress fracture, broken bone)
- Electrocardiogram (heartbeat regularities)
- Several specific symptoms would need to be present during a certain period of time (3/3+ months)

continued

## Comorbidities

- 33-50% of anorexia patients have a comorbid mood disorder, such as depression. Mood disorders are more common in the binge/purge subtype than in the restrictive subtype.
- About ½ of anorexia patients have comorbid anxiety disorders, including obsessive compulsive disorder and social phobia.
- More than half of bulimia and binge eating patients have comorbid anxiety disorders.

continued

## Comorbidities

- 1 in 10 bulimia and binge eating patients have a comorbid substance abuse disorder, usually alcohol use.
- Individuals can also suffer from medical disorders, psychosis, neurosis, personality disorders and different types of depression.
- Individuals with ED have high chances to develop other psych disorders.

continued

## Comorbidities

- 80% of those with anorexia have suffered major depression at some point, and as many as 80% of bulimics have suffered from anxiety disorder.
- Difficult to pinpoint whether ED makes the person develop depression or anxiety as a result or whether depression and anxiety prompts the person to obsess over eating and body image.
- Most individuals with ED have LOW self-esteem and issues with self control, loneliness, history of trauma.

continued

## Comorbidities

- Anorexic patients and those suffering from depression have similar brain related changes.
  - Levels of cortisol and vasopressin hormones tend to be elevated most times, causing high levels of stress.
  - Continuous high levels of these hormones lead to health related problems such as lowering immune system and disease of internal organs (including brain)

continued

## Comorbidities

- Certain comorbid disorders such as substance abuse are more prevalent in binge eating/purging types, whereas anxiety related disorders including OCD are more prevalent in patients with anorexia than bulimia.

continued

## Cognitive Factors

- Need for “being in control”
- Low perception of control
- Dysfunctional thought patterns
- Maintenance of disorder reinforced by:
  - A) dietary restrictions enhances sense of being in control
  - B) starvation encourages dietary restriction
  - C) concerns about shape and weight encourage restriction



continued

## Emotional Factors

- Normal coping: talking to a friend, going for a walk, seeing a counselor, engaging in recreational activity
- Abnormal coping: disordered eating behavior, purging, bingeing
- “Bingeing and purging was described as a continuing cycle of emotions where people would overeat if feeling upset, then make themselves sick to stop feelings of guilt that came from overeating” (Health Talk, 2015).

continued

## Emotional Factors

- Many individuals with ED suffer from depression and other mood disorders and use eating behavior as medication (self soothing, balancing emotions).
- Similarity between ED and addiction disorders: using a substance to feel better, calm emotions, to feel relaxed or in control.
- Many individuals with ED may also suffer from other addictive disorders at the same time (gambling, alcohol use, smoking)

continued

## Risk Factors

- Low self-esteem
- Difficulty expressing emotions and feelings such as sadness or anger
- Ineffective coping strategies
- Need to please others
- Black and white thinking (extreme thinking)
- Research shows many individuals with ED suffered from abuse in the past (e.g. ED as a coping factor)

continued

## Assessment

- How serious the eating problem is and whether the patient (or client) needs to have an emergency treatment in the hospital instead.
- Collaborate with client on whether CBT treatment is needed and appropriate at the current stage of illness.
- Allow client to voice their concerns or perceived obstacles to the CBT treatment.
- Let client know what is to be expected and that full participation is necessary.

continued

## Initial Assessment

- Individuals with CBT are referred to a CBT therapist by their own doctor or family.
- If patient is young, their family may be present.
- An opportunity for the therapist to observe the nature of the relationship within the family.

continued

## Initial Assessment

- Assess clients motivation
  - Low desire: they believe they are “ok” and don’t need treatment, they believe they will become excessively overweight, see their current bodyweight as an achievement
  - Reasons: improve certain health-related conditions, feel more energy, have a more fulfilling relationship with family, feel successful.

## Initial Assessment

- Motivate the Client:
  - Show genuine interest in the client's story, start session on an engaging level
  - Letting them know you understand their situation (i.e. complex, painful, etc.)
  - Seeing the client as an "individual" with their strengths and weaknesses, needs and ambitions
  - Becoming aware of the need to be in control
  - "The control of weight and shape is not a means to an end- but an end in itself" (Grave, 2012).

## Initial Assessment

- Motivate the Client:
  - Be open and honest with them about the nature of their disorder, how long it can take and what to expect.
  - Empower through information and encouragement

continued

## Initial Assessment

- Gather the following information:
  - How long the problem has been going on for
  - What problems it creates for the sufferer
  - When and in which circumstance it started
  - What other co-existing medical problems and treatments the person may have
  - What eating habits and other eating-related behaviors the person has
  - Any perceived obstacles
  - How the person sees their own future
  - Any other info to obtain an overview picture

continued

## Initial Assessment

- Information can be detailed and extensive, sometimes it takes 2 sessions to make an appropriate assessment.
- Important to determine if the patient has depression or ongoing suicidal thinking

continued

## Nutrition

- ED is a complex psychological condition related to both interpersonal factors and eating behavior.
- Eating can become an extremely difficult process where every calorie can be counted and every bite is split into tiny chunks, many rules are created.
- Individuals with anxiety do not derive pleasure from eating food but instead feel a sense of anxiety.

continued

## Nutrition

- The continuous restrictive eating and malnutrition result in pervasive disturbances of most organ systems including cardiovascular and gastrointestinal complications, endocrine disorders and other metabolic alterations.
- Nutrition restoration is a core element in treatment because of the need to restore weight to avoid severe physical complications and to improve cognitive function to make therapy interventions useful and effective.

continued

## Nutrition

- Individuals with a LT ongoing anorexia, can be highly deficient in many nutrients.
- Weight restoration may be achieved by force feeding in the hospital.
- A person with bulimia can consume 3,000-10,000 calories in an hour.
- Episodes of binge eating can occur at least twice a week for many months.
- Lead to guilt and shame

continued

## Nutrition

- Many people with bulimia choose high-fat, high-sugar foods that are easy to regurgitate. They become adept at inducing vomiting, triggering gag reflex, and vomiting.
- Many people with anorexia develop bulimia after awhile.

continued

## Care Plan

- Discuss goals (create an action plan) and any perceived obstacles on the way to reaching their goals.
- What are the goals?
- Client needs to come back to a 'normal regular eating' instead of the 'strict dieting'
  - Client needs to learn to eat 3 meals and 2-3 snacks each day at regular intervals at approximately same time every day.

continued

## Care Plan

- Client needs to overcome resistance to normal eating
  - Education about the relationship between eating habits (bingeing, purging and calorie restriction) and negative body image.



continued

## Care Plan

- Controlling urge to binge and purge through learning and understanding the consequences of such behavior (e.g. learning to accept negative moods, finding pleasurable activities that don't involve food).
- Learning to change perception of body image
  - Using mirrors and weight scales less than before and in a more appropriate way (checking makeup, brushing hair).

continued

## Care Plan

- Finding new sources that can boost self esteem
  - Encouraging client to explore possibilities for developing new skills, finding a hobby
- Becoming aware of own ED mindset
  - Paying attention to their thinking, behaviors, feelings and emotions

continued

## SMART

- Specific
- Measurable
- Achievable
- Realistic
- Time-Based

continued

## Motivational Factors

- Highly important factor in CBT
- Fluid- needs to be reassessed frequently
- Most patients with ED display low motivation
- Transtheoretical Model of Health Behavior Change

continued

## Motivational Factors

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

continued

## Motivational Factors

- Assess the clients motivation for change by using the Transtheoretical Model of Health Behavior Change
- When the client relapses, he or she is not hitting the next stage, but downshifts to the previous stage instead

continued

## Anxiety and ED

- Strong correlation between anxiety and ED
- Anxiety is one of the symptoms of ED
- “Anxiety is a broad term depicting the several disorders that can influence nervousness, apprehension, fear and worrying. Anxiety is a natural human emotion that individuals experience at various times and a normal response to stressors...however, when it becomes extreme or disproportionate to the situation, it may fall under category of Anxiety disorder” (Eating Disorder Hope, 2017)

continued

## Anxiety and ED

- Co-existing ED and anxiety disorder can result in complex and longer-term recovery. Both disorders would need to be treated at the same time.
- What occurs first?
- 2/3 of people with ED develop anxiety disorder at some point in life, 42% of people with ED experienced their first episode of anxiety well before the onset of ED. Other studies agree that an anxiety disorder is usually the onset of an ED, but panic disorder often follows (ADAA, 2017).

continued

## Anxiety and ED

- Anxiety can either be a symptom or co-existing illness caused by a traumatic event, hormonal imbalance, side effect from medication, genetic inheritance, etc.
- Eating disorder can manifest as a way to cope with anxiety: constant feelings of worry get replaced by focusing on eating-related behavior.
- Obsessive Compulsive Disorder
  - Cutting food into tiny pieces and weighing small bits of food before consuming

continued

## Anxiety and ED

- “Struggling with severe anxiety for instance, being able to control the aspect of one’s life, such as food, weight, exercise, indirectly gives the suffer a false sense of control, which can temporarily relieve symptoms experienced due to anxiety” (Eating Disorder Hope, 2017).
- Setting up rules that give a sense of control
- ED doesn't develop overnight
- ED and anxiety are treated together

## Socratic Questioning

- Fosters critical thinking
- Searches for general, commonly held truths that shape beliefs, and scrutinizes them to determine their consistency with other beliefs (Abou Said Doau, 2015)
- Helps client open up and understand their issues in a rational way
- Questions are not seeking correct answers but involving the client to participate in the dialogue in a more active way.

## Socratic Questioning

- Systematic, disciplined, deep and focuses on fundamental concepts, principles, issues, theories or problems.
- Effective working with ED even low motivation
- Presumes emotions influence thinking and behavior
- CBT helps client become aware of dysfunctional thinking patterns and replace them with more helpful beliefs and values

continued

## Socratic Questioning

- Clarify thinking: e.g. “Why do you say that? Could you explain in more detail?”
- Challenging assumptions: e.g. “Is it what always happens? How do you know that its true?”
- Asking for evidence as a basis for argument: e.g. “Where is the evidence for what you are saying?”
- Asking for alternative viewpoints: e.g. “Could it be seen in a different way by someone else? How else could you describe it?”

continued

## Socratic Method

- Thinking about implications and consequences: e.g., “If this and this happened, how would it affect your family? If you continued with this behavior, what would eventually happen?”

continued

## Psychoeducation

- Educating the client about ED, manifestations, cognitive processes and behaviors, managing symptoms, and emotions
- Handouts, worksheets, teaching problem solving techniques

continued

## Exposure Therapy

- Safe and effective method for ED
- Facing fear and gaining control over the feelings of anxiety related to some specific object or situation
- Gradual, combined with relaxation and visualization techniques
- Benefits seen in 12 weeks or so
- Anxiety is core psychological feature



continued

## Exposure Therapy

- Working with anxiety- provoking factors (e.g. related to weight, shape, and foods on forbidden list).
- Working with other attributes (e.g. clothing)
- Graduated Exposure Therapy: ‘Systematic Desensitization’; involves a structured approach (e.g. firstly – relaxation technique, then first step of exposure)

continued

## Exposure Therapy

- “Repeated exposure makes us desensitized. We get bored, we know nothing bad happened so we stop being alert. The brain creates new connections, and fear reactions don’t get activated anymore” (Eva Musby, 2017)
- Used over several sessions
- Mindfulness: teaching client to relax, observe and be present (e.g., observing and describing food that is forbidden or feared).

continued

continued

## Exposure Therapy

- Describing emotions, feelings, touching, smelling, sampling
- Working with own weight and body image (e.g. standing in front of mirror, observing own body weight and commenting on it)
- Learning to accept own body shape and become less judgmental
- Changing clothing at each session to the point of wearing a bathing suit and seeing own image for 5-10 minutes

continued

## Exposure Therapy

- Comments are verbalized out loud while the therapist helps the client make them less judgmental and less negative
- Exposure therapy can help the client experience fewer symptoms and achieve more satisfaction with their body (Gupta, 2012).

## Cognitive Restructuring

- Identifying and questioning irrational and unhelpful thought patterns, illogical thinking and automatic negative thoughts and reconstructing them in a more positive way
  - Catastrophising
  - Mind Reading
  - Personalizing
  - Blaming Others
  - All or Nothing Thinking

## Cognitive Restructuring

- “I don’t know if I can stick to this program, it never works for me”
  - “What evidence do you have to support this statement?”
  - “What’s the alternative view to this statement?”
  - “Is it possible to see this situation from a different standpoint?”
  - “How would this benefit you if you tried to see this from a less negative standpoint?”
  - “What words or phrases would you use then?”

continued

## Cognitive Restructuring

- Cognitive structuring involves Socratic questioning as a part of its technique
- Cognitive restructuring asks the person to imagine various outcomes and possibilities, analyze own emotions and feelings, find alternatives, identify cognitive errors and evaluate labels attached to various feelings and situations.

continued

## Cognitive Restructuring

Aims to address faulty cognitions about weight, diet and shape. When used in conjunction with behavioral interventions (eating previously avoided foods, using adaptive behavior as an alternative to purging and/or decreasing/increasing weight), the cognitive principles are designed to result in changes in mood and a decrease reliance on previously entrenched behaviors”(Claes & Muehlenkamp, 2013).

continued

## Interventions

- Changing beliefs
- Art therapy: exploring thoughts and feelings through painting, drawing, creating or constructing
  - Reflects current life situation
  - Discuss feeling and realizations about it
  - Reconstructing underlying assumptions and beliefs

“What do you look like after a meal?”

continued

## Behavioral Experiments

- Information gathering (surveys)
- Experiential exercises (interoceptive exposure)
- Planned experiments

continued

## Behavioral Experiments

### Steps

- 1) Client is asked to participate in behavioral experiment
- 2) One of the clients deep rooted beliefs is examined (e.g. "I cant cope if I go somewhere expected to eat.")
- 3) The planning (going to café with close friend), the plan is discussed in detail

continued

## Behavioral Experiments

### Steps

- 4) Experiment takes place (e.g. client is in café paying attention to own feelings, noticing how well they are able to cope)
- 5) Post-experiment meet up (e.g. discussion about coping strategies and new beliefs)

continued

## Behavioral Experiments

- Experiment gives validation that a person cannot predict what outcome will be with 100% accuracy
- Benefits: helps manage emotions better, try out healthier, alternative ways of behaving, challenges false beliefs, reinforces how predicting the future is unhelpful
- \*Provides hard evidence to client and able to promote greater cognitive, emotional, behavioral change rather than verbal cognitive techniques used in isolation

continued

## Behavioral Experiments

- Reduce likelihood of patient saying “I can understand it logically, but I still don’t feel it” – a common frustration for people with ED (Gowers and Green, 2009).
- Other experiments: testing if bad things will happen if client behaves in a certain way (try a bit of food on the ‘forbidden list’), seeing whether client can cope with his own emotions in a certain situation (meet family who disapproves of behavior)

continued

## Behavioral Experiments

- Other experiments: testing whether client is able to ignore certain factors if they engage in a particular behavior (ignoring other people's looks when client wears a particular clothing)

continued

## Case Study: a sample session

- Emma, 19 years old: life stressors, sees her father every second weekend, father drinks heavily, new job as a HR manager, stressful, yells at staff, 12 hour days, bingeing and purging behavior.



continued<sup>ed</sup>

## Case Study

- Mrs. S: 25 year old female, married for 5 years, lives with in-laws, educated, homemaker, from an upper social class family.
  - c/o weight loss, recurrent episodes of vomiting, menstrual irregularities, precipitating factor: husband makes a comment about her weight.
  - Physical checkup: within normal limits, except low hemoglobin, admitted for inpatient care.
  - Psychiatrist: Mrs. S revealed an incident during early days where he commented on her thighs stating she would be more beautiful if she lost weight, her in-laws agreed. Since then, her food intake decreased. Avoid eating in front of family, hide and eat in the bathroom at times. Discharged: CBT Therapist.
  - Assessment and interventions: Complete a role checklist, self-assessment of activities, socratic questioning, cognitive restructuring, challenging negative thinking and global generalizations, interpersonal skills training (assertiveness), systemic desensitization, relaxation training, breathing exercises, visualization, arts and craft activities, journal and diary writing

continued<sup>ed</sup>

## Summary

- Occupational Therapists
  - Assess the underlying emotional, psychological problems of patients which caused the ED
  - Help patients re-engage in occupations they enjoy doing prior to the onset of ED
  - Prepare patients for the stressful real world situations which are likely to trigger relapses.

continued

## Summary & Suggestions

- Ask the client to participate in experiment planning it thoroughly
- Rating strength of belief before and after
- Making sure the experiment is manageable (graded appropriately)
- Discussing beliefs suitable for the experiment
- Discussing how their thinking, beliefs and emotions got affected by the experiment results

continued

## Summary & Suggestions

- Treatment plan can last for as many sessions as needed (minimum is usually 5 weekly or bi-weekly)
- Initial session is “Assessment” reviewing prior history and previous treatment
- If it is their first treatment, why they relapsed, what previously worked and what didn't, reasons for reverting to old eating habits
- Paperwork (consent, personal detail forms, eating diary)

continued

## Summary & Suggestions

- Socratic questioning and cognitive restructuring
- Psychoeducation
- Beginning of sessions- recap and catch up, “How did the past week go? Anything significant occur since our last session?”
- 3 parts: “What’s going well?” “What’s wrong?” and “What shall we do about it?”

continued

## Summary & Suggestions

- “What are we going to do about it?”
  - Mirror exercise (evaluating body image in front of mirror)
  - Homework for the client (adding an extra snack on plate, trying a new food)
  - Behavioral experiment

## Summary & Suggestions

- Conclude session with a plan for week ahead
- Each week, review action plan
  - What client wants to achieve
  - LTGs and STGs
  - Current state or weight of client
  - Current levels of motivation

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## Questions?

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