“The body”: a challenge for patients with eating disorders and their therapists

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Learning objective

To obtain new insights/therapeutic skills valuable for the approach of body image in therapy.

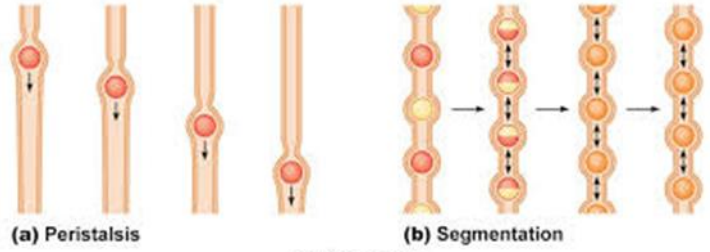
What happens when you eat?

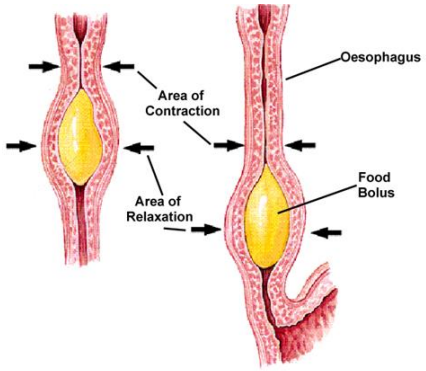
- **Physical consequences of eating:**
  - The food sinks into the oesophagus, the stomach to the intestine.
    - The reaction of our body after a meal is a relay of processes.

- **Psychological consequence of eating**
  - The food is going to the head
    - Chaos related to food, weight and appearance
    - Influencing the thoughts (dysfunctional thinking) , emotions, (unhelpful) behavior

Physical consequence of disordered eating

- A disturbance in the movement pattern of the stomach (gastric motility). [a reduced motor function of the lower part of the stomach & a reduced relaxing power (adaptive relaxation) of the upper portion of the stomach.





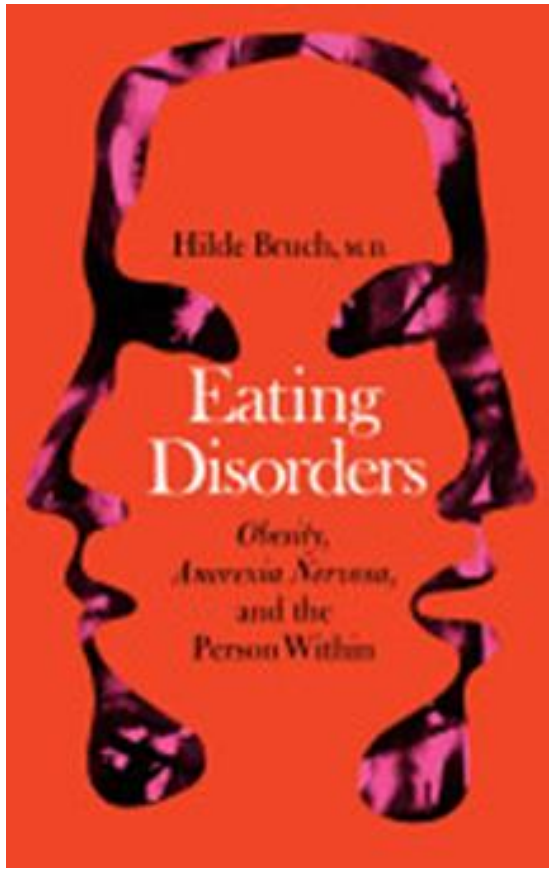
- Intestinal gas: mean of 150 ml

- Body fat (BF): a pursuit of a fatless body

Mean BF female under 30 year: 26%-30 BF.
Mean 21% BF = fertility.
Mean 18% BF= the point of amenorrhea.
Under 10% BF= life-threatening.
No relation between BF and BMI.

Cornerstones for body image approach in eating disorders

Once upon a time, there was…



Perceptual and Conceptual Disturbances in Anorexia Nervosa

HILDE BRUCH, M.D.

THE CONDITION which Morton[1] in 1689 described as "a nervous consumption," and which Gull[2] in 1874 rediscovered and named "anorexia nervosa" has such a distinct, even dramatic, clinical picture that it is puzzling that with increasing observation and study its clinical description has become blurred and less well defined. Bliss and Branch[3] reviewing the historical development of the concept and the clinical aspects of anorexia nervosa in 1960, failed "to find in the literature a neat solution for differentiating it from other forms of undernutrition."

For their own study, they decided to consider a loss of 25 lb. as a suitable definition of the condition, if the drop in weight was attributable to psychological causes. This overgeneral, colorless definition is a far cry from Morton's "Skeleton only clad with skin," and from Gull's puzzlement: "It is curious to note the persistent wish to be on the move, though the emaciation was so great." The definition of Bliss and Branch virtually amounts to an abolition of anorexia nervosa as a distinct clinical entity.

In my experience with disorders of food intake, in undernutrition as well as in overnutrition, I have come to the opposite conclusion, namely that it is essential to delineate differences in the clinical course and psychological manifestations of various forms of eating disorders.[4] Without clear-cut distinctions, investigations are meaningless, and appropriate treatment impossible.

Subjects

The following report is based on observations extending over 10 years of 12 patients (3 males and 9 females) whose conditions closely resembled the original picture of anorexia nervosa. Progressive loss of weight had been the outstanding symptom that had led the patients, or more often their families, to seek medical aid. In most cases, the onset was reported as having occurred suddenly in a seemingly well-functioning individual who did not feel sick in spite of the weight loss and who continued to be active. Psychiatric consultations had been arranged only secondarily, in view of the absence of organic causes. I saw only 1 patient within the first year of the illness; the others had been sick, and several had been unsuccessfully in treatment, for 3–6½ years. They had become sick between 11 and 20 years of age; when I first saw them, they were from 14½ to 21 years old. Six patients were seen in private practice, and 6, including the 3 male patients, were hospitalized at the New York State Psychiatric Institute.

From the Department of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, N. Y.

Presented at the 15th Annual Meeting of the American Psychosomatic Society, Atlantic City, N. J., Apr 30, 1961.

I wish to acknowledge the collaboration of Drs. S. Frazier, R. Clavin, B. Lerner, R. S. McGraw (deceased), A. Mesnikoff, and C. Roland.

Received for publication Mar. 25, 1961.

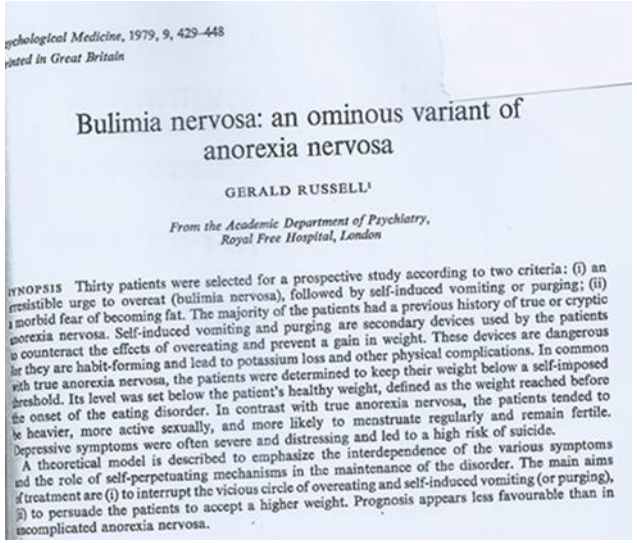
An amelioration of a dysfunctional body image is necessary for effective treatment of ED [Bruch, 1973]

Anorexia nervosa

- Patient refuses to maintain normal body weight
- BMI less than 17.5
  - weight/ height^2
- an intense fear of gaining weight or of becoming fat.
- Disturbance in the way one's body weight or shape is experienced.

Bulimia nervosa

- Person binge eats.
- Feels out of control while eating
- Self-evaluation is unduly influenced by body shape and weight
  - Fear of being fat
  - Believes self-worth requires being thin.
- Recurrent inappropriate compensatory behaviour: excessive exercise



ychological Medicine, 1979, 9, 429–448
inted in Great Britain

Bulimia nervosa: an ominous variant of anorexia nervosa

GERALD RUSSELL[1]

From the Academic Department of Psychiatry, Royal Free Hospital, London

YNOPSIS Thirty patients were selected for a prospective study according to two criteria: (i) an resistible urge to overeat (bulimia nervosa), followed by self-induced vomiting or purging; (ii) a morbid fear of becoming fat. The majority of the patients had a previous history of true or cryptic norexia nervosa. Self-induced vomiting and purging are secondary devices used by the patients o counteract the effects of overeating and prevent a gain in weight. These devices are dangerous or they are habit-forming and lead to potassium loss and other physical complications. In common with true anorexia nervosa, the patients were determined to keep their weight below a self-imposed hreshold. Its level was set below the patient's healthy weight, defined as the weight reached before he onset of the eating disorder. In contrast with true anorexia nervosa, the patients tended to e heavier, more active sexually, and more likely to menstruate regularly and remain fertile. Depressive symptoms were often severe and distressing and led to a high risk of suicide.

A theoretical model is described to emphasize the interdependence of the various symptoms nd the role of self-perpetuating mechanisms in the maintenance of the disorder. The main aims f treatment are (i) to interrupt the vicious circle of overeating and self-induced vomiting (or purging), ii) to persuade the patients to accept a higher weight. Prognosis appears less favourable than in ncomplicated anorexia nervosa.

Binge Eating Disorder DSM V

A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:

i. Eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

ii. A sense of lack of control over eating during the episode

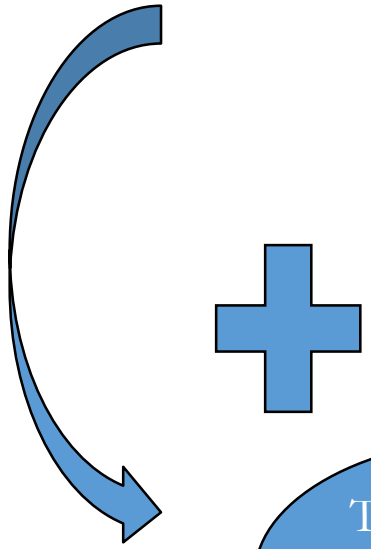
B. The binge eating episodes are associated with three (or more) of the following:

- eating until feeling uncomfortably full
- large amounts of food when not feeling physically hungry
- eating alone because of feeling embarrassed
- feeling disgusted with oneself, depressed, or guilty afterwards

Talking about body image

Internal experience and practising exercises

Enlarge the comfort zone

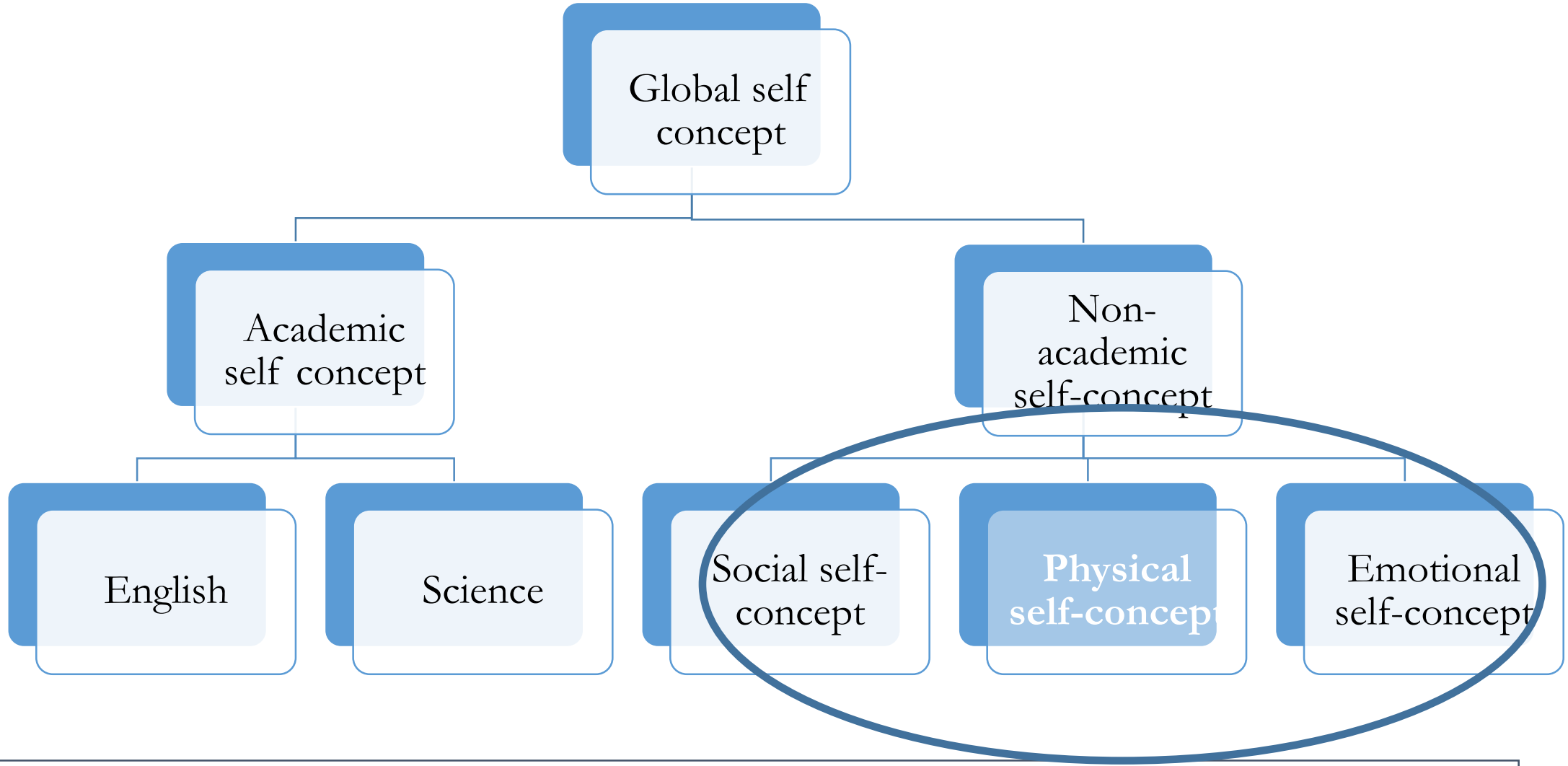


Talking about body image

Body image therapy as a tool to break through the disturbed body image and the hyperactivity in patients with eating disorders.

Body image therapy focuses on the perception, the emotions and the behavior and the healthy possibilities

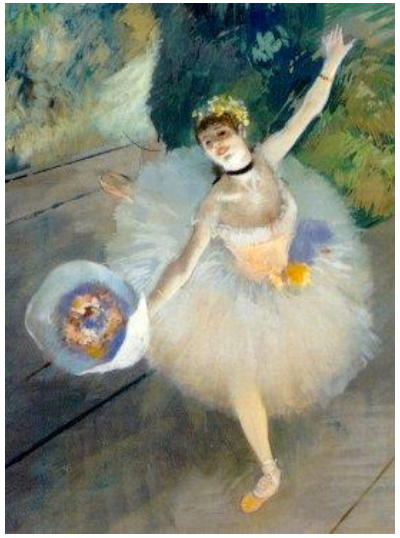
Self- concept: multidimensional & hierarchical structure



(Shavelson et al., 1976; Marsh, 1997; Fox, 1989; Fortes et al., 2004; Kowalski et al., 2003; Morin et al., submitted)

Self concept (theory of Marsh, Fox e.a.)

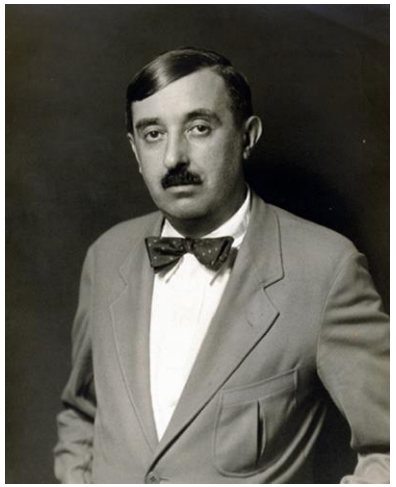
- **Physical self concept** / Impression / Physical self/ living in the body
- **Psychological self concept** / Emotional self concept / Expression/ living in relation
- **Social self concept** / Communication /Environment / Relations/ living in society



Edgar Degas
1834-1917

Body image
Body experience

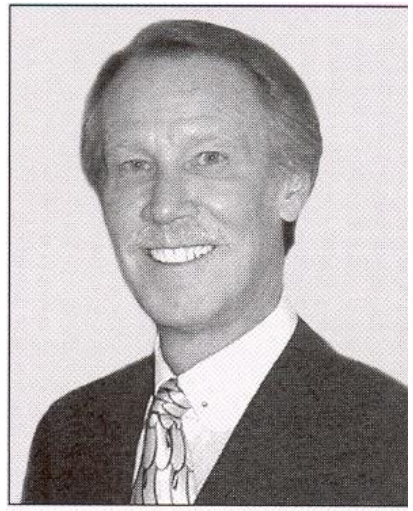
P. F. Schilder (1886-1940)



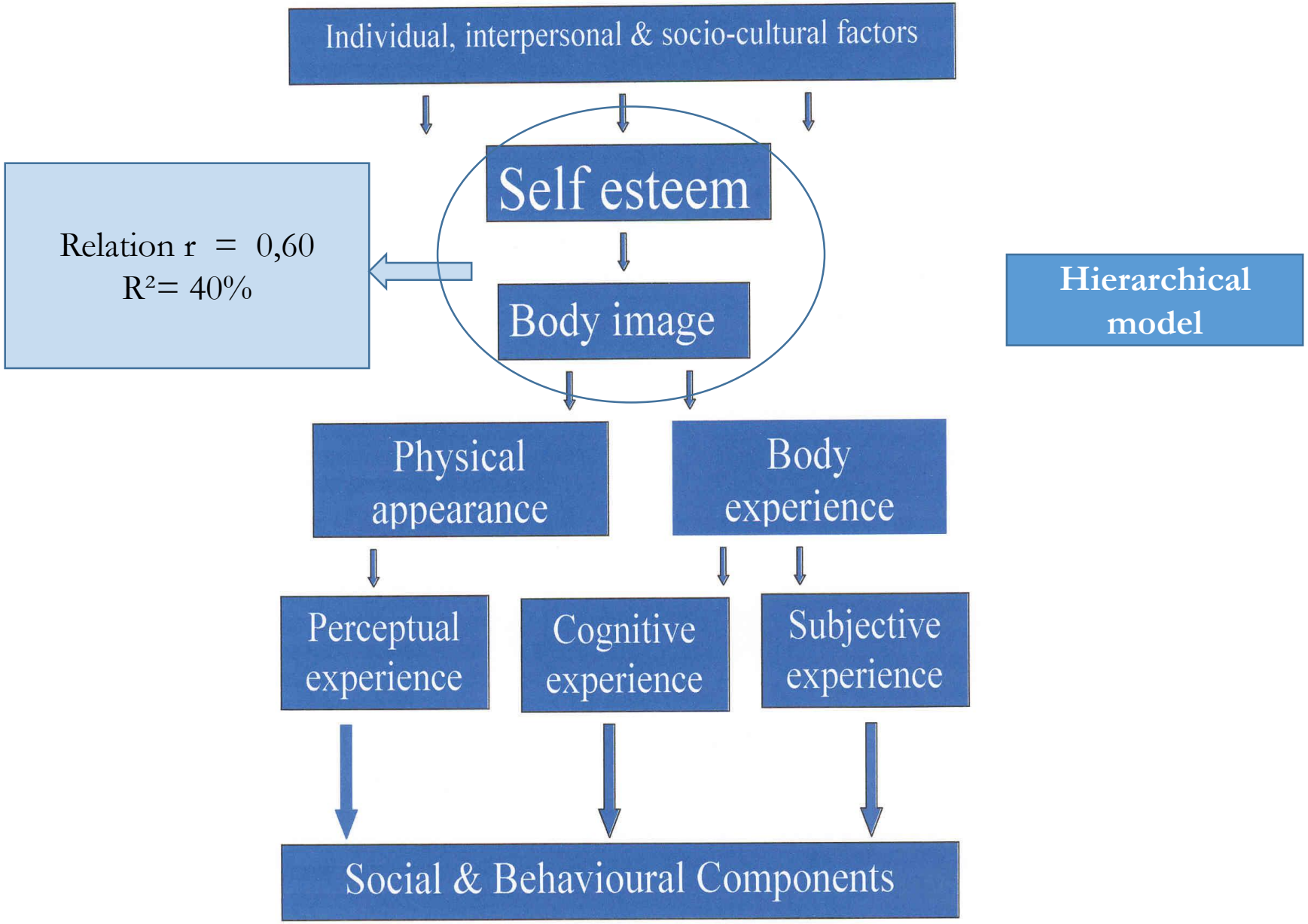
The picture of our own body which we form in our own mind or the way the body appears to ourselves"

Schilder, 1935

Thomas Cash (°1947)



« Body image is a multi-faceted concept that refers to persons' perceptions and attitudes about their own body, particularly but not exclusively its appearance» (2003)



Hierarchical model

A complex experience

- Patients are able to estimate correctly neutral objects
- Patients are not able to estimate their own body size
- Patients are able to estimate correctly the body size of others.
- Patients estimate their ideal body size larger than the real body size
- When patients measure themselves, they are surprised by the true dimensions of the body size.
- Gut feeling is based on wrong assumptions

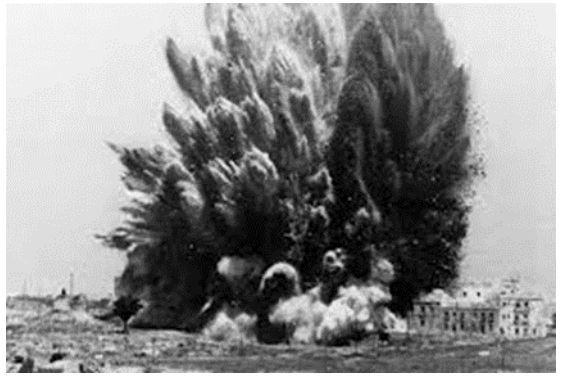
TAKE CARE OF
YOUR BODY.
IT'S THE ONLY
PLACE YOU HAVE
TO LIVE IN.

When fear and anxiety become a disorder?

When do you become your own terrorist?

Metaphor : war

John Locke,
"Association of ideas"
1690

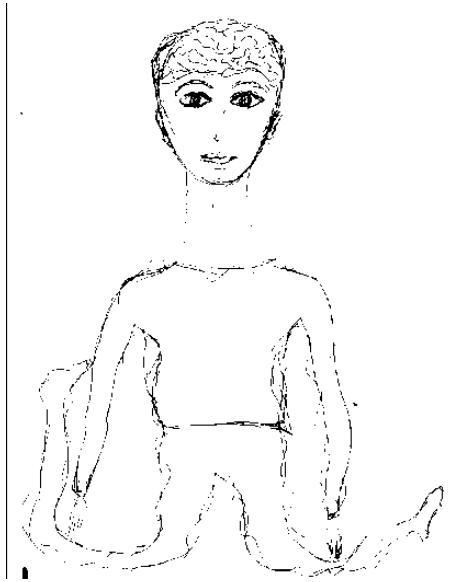


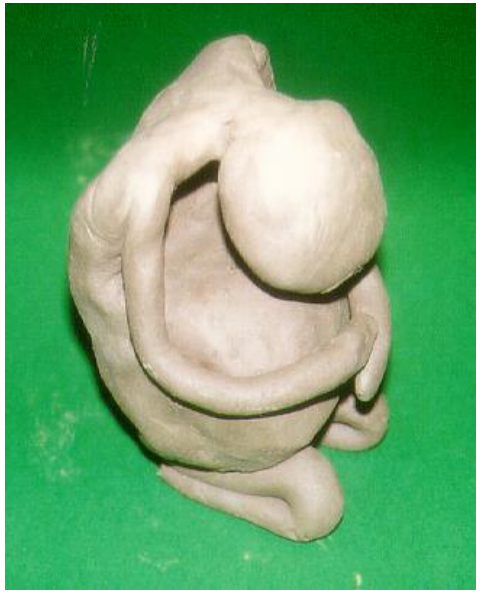
Chaos
Anxiety,
Anger
Hopelessness
Violence,
Fear, horror , terror
Fight & Flight
Agitation,
Enemies,
Loss of control
pain
Distress, sorrow,
Waiting,
Lack of perspectives

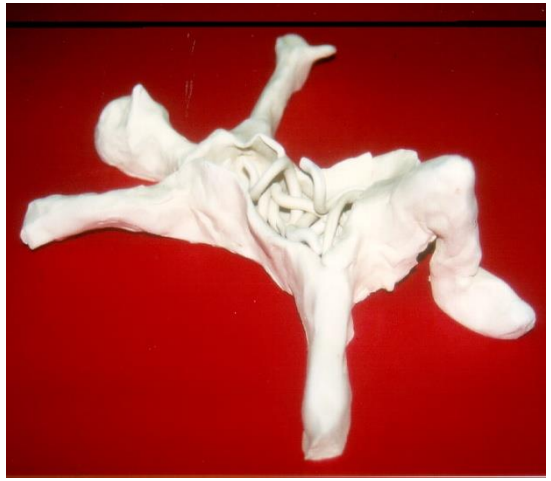
No More War!

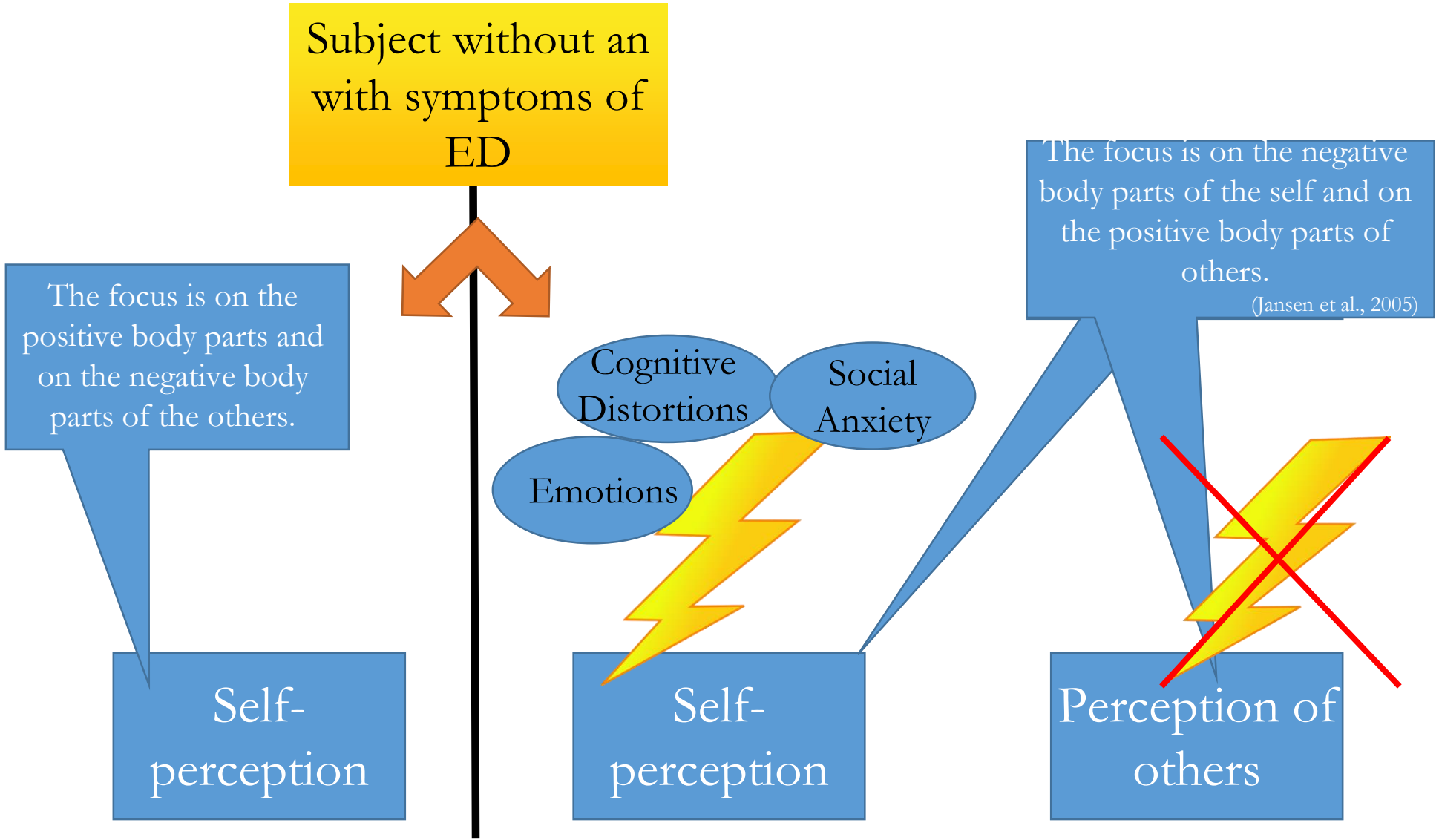
The armistice: war is over.
One has to be on the alert against unforeseen situations.
There is freedom. One can be more relaxed
One needs time to become familiar with the new situation.
One can start making plans for the future.
One can rebuild a new life
To feel free in their body
To live comfortably in their body

Sun,
Relax,
Peace,
Dreams,
Love
Space,
Freedom,
Happiness,
Satisfaction,
Unconcern,
Structure,
Future,








Subject without an with symptoms of ED
The focus is on the positive body parts and on the negative body parts of the others.
Self-perception
Cognitive Distortions
Social Anxiety
Emotions
Self-perception
The focus is on the negative body parts of the self and on the positive body parts of others.
(Jansen et al., 2005)
Perception of others

A sum !

- 5 x 4 = 20
- 48 + 8 = 56
- 32 -11 = 21
- 12 x 3 = 39
- 55 : 5 = 11
- 45 + 21 = 66
- 76 – 9 = 68
- 7 x 8 = 56
- 64 : 8 = 8
- 15 x 4 = 60

- 5 x 4 = 20
- 48 + 8 = 56
- 32 -11 = 21
- 12 x 3 = 39
- 55 : 5 = 11
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- 64 : 8 = 8
- 15 x 4 = 60

2 mistakes
8 Correct answers

Body image and physical activity

Anorexia nervosa restrictive type

The relation between questionnaires measuring the attitude of body image the physical activity

r = 0.50

Drive for exercise !

- Compulsive exercise, compulsive physical activity, diffuse restlessness, drive for activity, elevated physical activity, excessive exercise, excessive physical activity, exercise addiction, extensive exercise, high level exercise, hyperactivity, motor restlessness, over-activity, restlessness, over-exercise

Drive for exercise/Hyperactivity

- A voluntary increase in physical activities, not motivated by pleasure or the desire to be healthy, but out of concern with body weight (burning calories, ignoring hunger) and appearance.

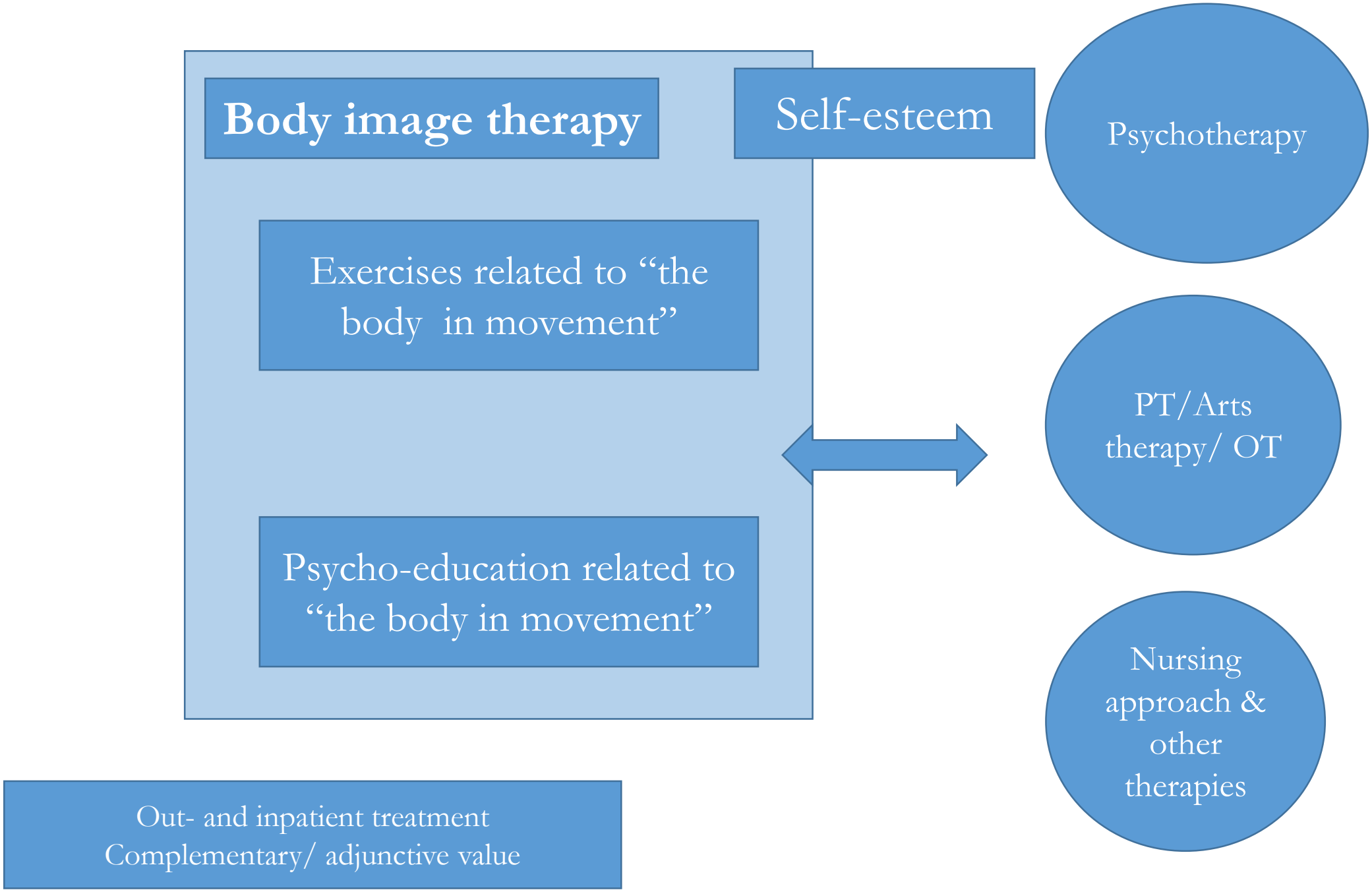
Psychological mechanisms

- Effective method to spend calories and lose weight
- Form of emotion-regulation to diminish negative feelings
- Escape form feelings of emptiness
- Behaviour that has become stereotyped ritualised, compulsive

The therapy

= not spectacular

= step by step


Body image therapy
Self-esteem
Psychotherapy
Exercises related to "the body in movement"
PT/Arts therapy/ OT
Psycho-education related to "the body in movement"
Nursing approach & other therapies
Out- and inpatient treatment
Complementary/ adjunctive value

What is body image therapy? Definition

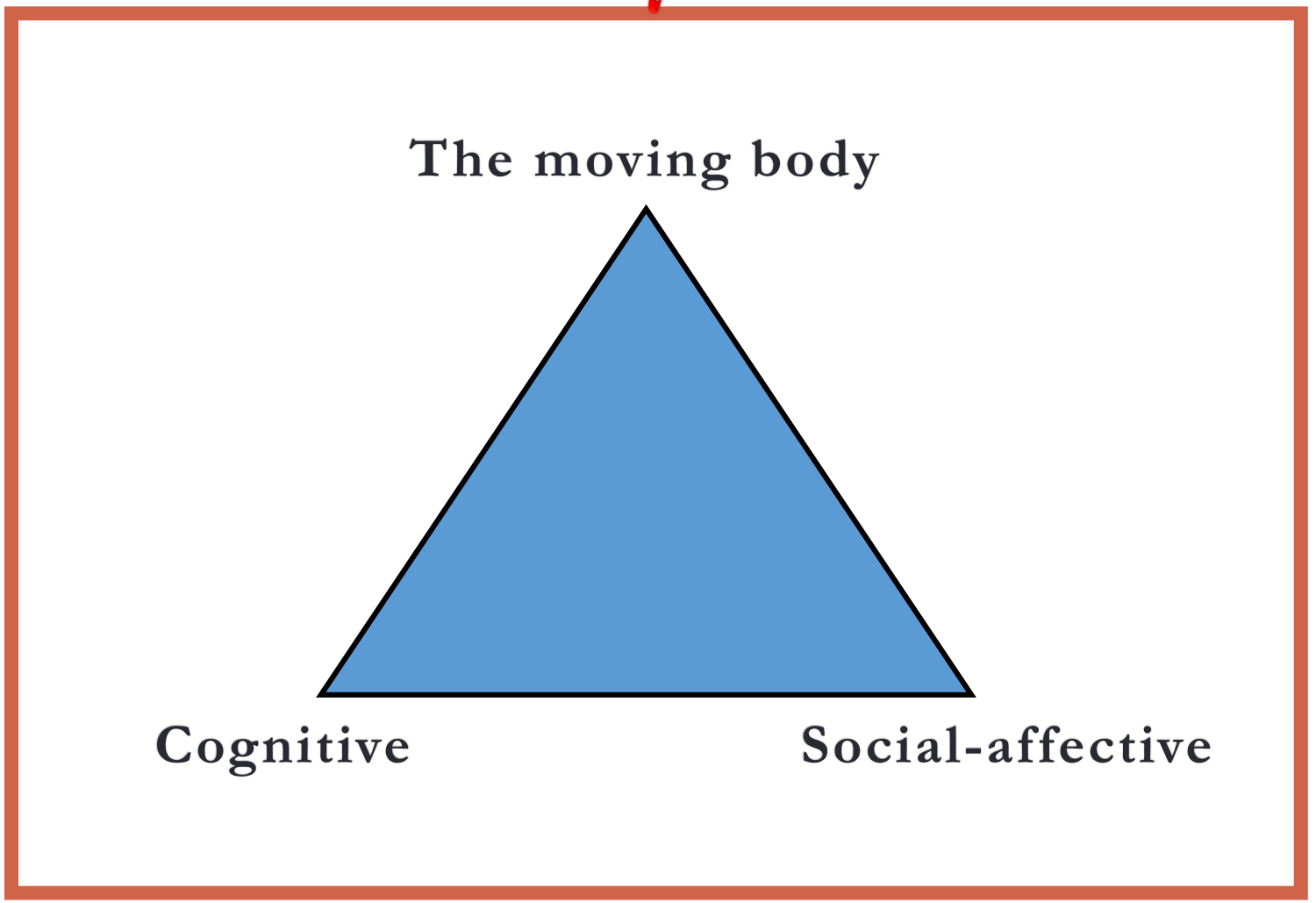
- a method of treatment
- **"The body in movement"**
- a body image assessment
- in a methodical way
- in consultation with the patients
- to realise clearly formulated goals

"Who is the best placed within the available possibilities to fit with the person who asks for help to achieve in the short term positive results?"

The core of body image therapy in eating disorders is to optimize wellbeing and empowering the individual by promoting body and movement awareness bringing together physical and mental aspects and based on the available scientific and best clinical evidence.

Psychosocial context

INPUT



OUTPUT

- Physiological & motor dimensions
- Sensory dimensions
- Cognitive dimensions
- Affective dimensions
- Behavioural dimensions
- Communicative dimensions
- Relational dimensions
- Symbolic dimensions

The problem

The treatment goals [G]

Assessment [A]:
Observation & Evaluation

The treatment [T]
(The activities)

The evaluation [E]

"GATE"

What are the goals for a body oriented therapy?

General information

The patient is the architect of her own therapy!

The patient is the architect of her own luck and care !

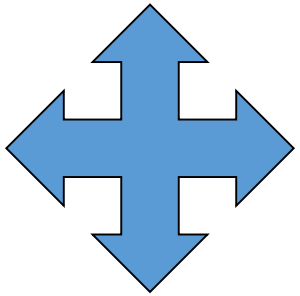
General goals for body oriented therapy in ED

- (Re-)building a realistic self-image
  - Get tuned in to the body
  - Awareness of the changes
  - Acceptance of the changes
  - To live comfortably in their body
- Curbing hyperactivity, tensions and impulses
- Communication: Developing social skills

The theory of lenses (Probst, 2007)

Neutral lens
"How do I really look?"

External
Lens
"How do others
see me?"



Ideal
Lens
"How would
I like
to look?"

Internal lens
"How do I see myself?"

Probst, M., Pieters, G., Vancampfort, D., Vanderlinden, J. (2008). Body experience and mirror behaviour in female eating disorders patients and non clinical subjects. Psihologijske Teme - Psychological Topics, 17

“Individualized concretely formulated research goals…”

Conditions for good goals !

“SMART”

Specific – **M**easurable – **A**cceptable – **R**ealistic - **T**ime

Stepwise approach

- At home.
- Seven floors: to take the stairs.
- with the goal to decrease the shortness of breath

- Next week: If you don't feel pain, you will take 3 times a week the elevator and climb stairs from the sixth floor to the seventh floor,
- You succeed if you are not short of breath. At that moment you will take the elevator to the fifth floor.

- This change in behavior will influence in a positive way my health.

- It has been proven that more exercise and climbing stairs leads to better physical health and less breathlessness,

- Within 6 months, you want to do all floors without breathing problems.

The problem

“GATE”

The treatment goals [G]

Assesment [A]:
Observation & Evaluation

The treatment [T]
(The activities)

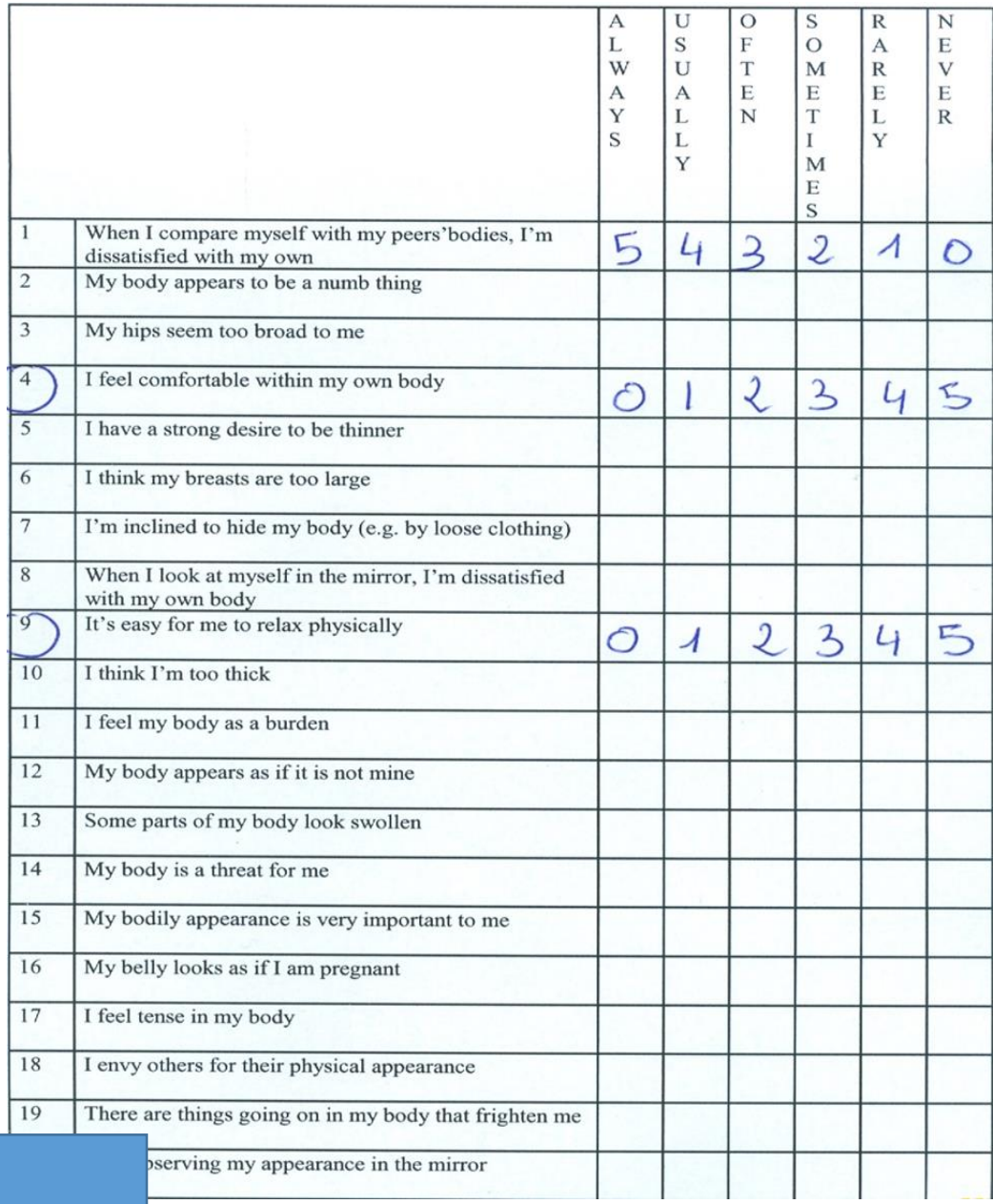
EDI- Drive for thinness
EDI- Body Dissatisfaction
Body Shape Questionnaire
Body Attitude Test

The evaluation [E]

The Body Attitude Test

- 20 items 6 point scale
- Min: 0; Maximum 100
- never, rarely, sometimes, often, usually and always
- cut-off 36 ED – non clinical population.
- Factor structure
  - a. negative appreciation body scope
  - b. lack of familiarity
  - c. dissatisfaction concerning the prevention
  - d. rest factor
- Reliability: intern consistency, test-retest- split half
- Validity: construct & criterion validity
- Cutt-off scores
- Translated & validity in different languages

Norms for clinical and non-clinical groups; males / females



		ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
1	When I compare myself with my peers'bodies, I'm dissatisfied with my own	5	4	3	2	1	0
2	My body appears to be a numb thing						
3	My hips seem too broad to me						
4	I feel comfortable within my own body	0	1	2	3	4	5
5	I have a strong desire to be thinner						
6	I think my breasts are too large						
7	I'm inclined to hide my body (e.g. by loose clothing)						
8	When I look at myself in the mirror, I'm dissatisfied with my own body						
9	It's easy for me to relax physically	0	1	2	3	4	5
10	I think I'm too thick						
11	I feel my body as a burden						
12	My body appears as if it is not mine						
13	Some parts of my body look swollen						
14	My body is a threat for me						
15	My bodily appearance is very important to me						
16	My belly looks as if I am pregnant						
17	I feel tense in my body						
18	I envy others for their physical appearance						
19	There are things going on in my body that frighten me						
	bserving my appearance in the mirror						

Probst, M., Vandereycken, W., et al. (1995). Eating Disorders, 3, 133-145
Probst, M. et al. (2008). International Journal of Eating Disorders, 41 (7), 657-665.

		ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
1	When I compare myself with my peers'bodies, I'm dissatisfied with my own	X					
2	My body appears to be a numb thing	X					
3	My hips seem too broad to me	X					
4	I feel comfortable within my own body						X
5	I have a strong desire to be thinner	X					
6	I think my breasts are too large	X					
7	I'm inclined to hide my body (e.g. by loose clothing)	X					
8	When I look at myself in the mirror, I'm dissatisfied with my own body	X					
9	It's easy for me to relax physically						X
10	I think I'm too thick	X					
11	I feel my body as a burden	X					
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17	I feel tense in my body	X					
18	I envy others for their physical appearance	X					
19	There are things going on in my body that frighten me	X					
20	I am observing my appearance in the mirror	X					

Extreme response style
Response set: "Cry for help?"; social desirability?; defense mechanism?

		ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
1	When I compare myself with my peers'bodies, I'm dissatisfied with my own	X					
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6	I think my breasts are too large		X				
7	I'm inclined to hide my body (e.g. by loose clothing)		X				
8	When I look at myself in the mirror, I'm dissatisfied with my own body		X				
9	It's easy for me to relax physically	X					
10	I think I'm too thick	X					
11	I feel my body as a burden	X					
12	My body appears as if it is not mine	X					
13	Some parts of my body look swollen			X			
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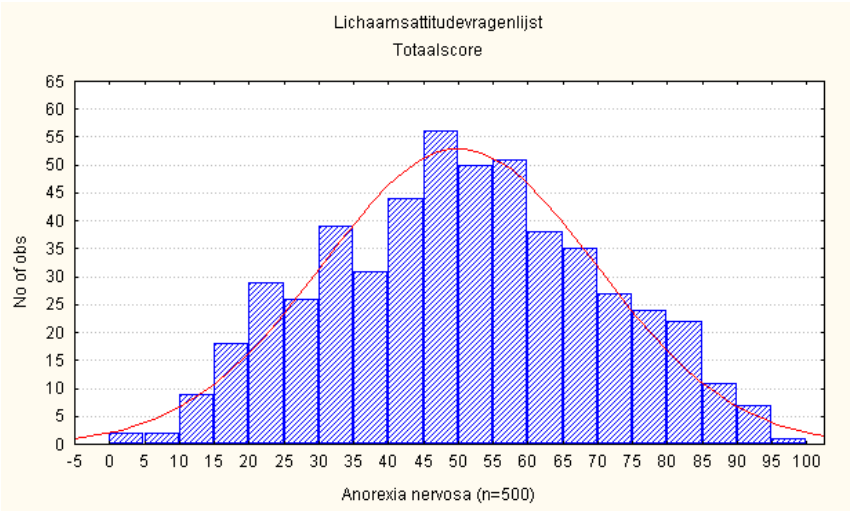
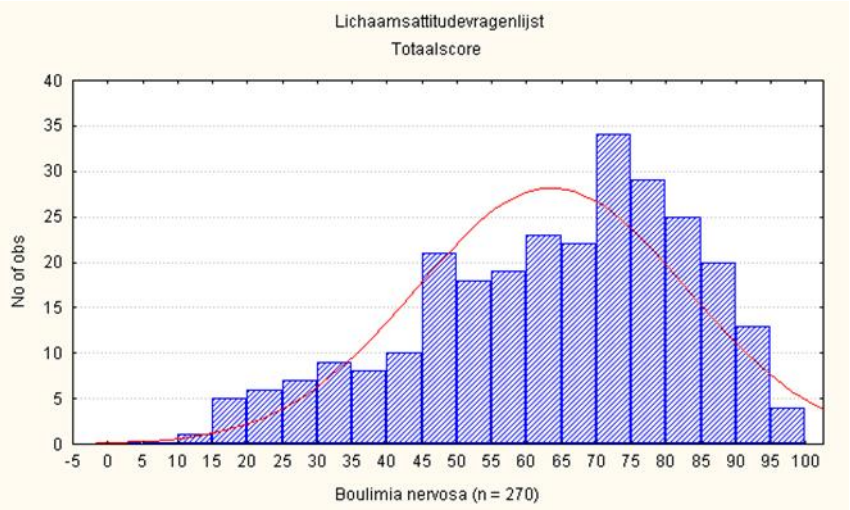
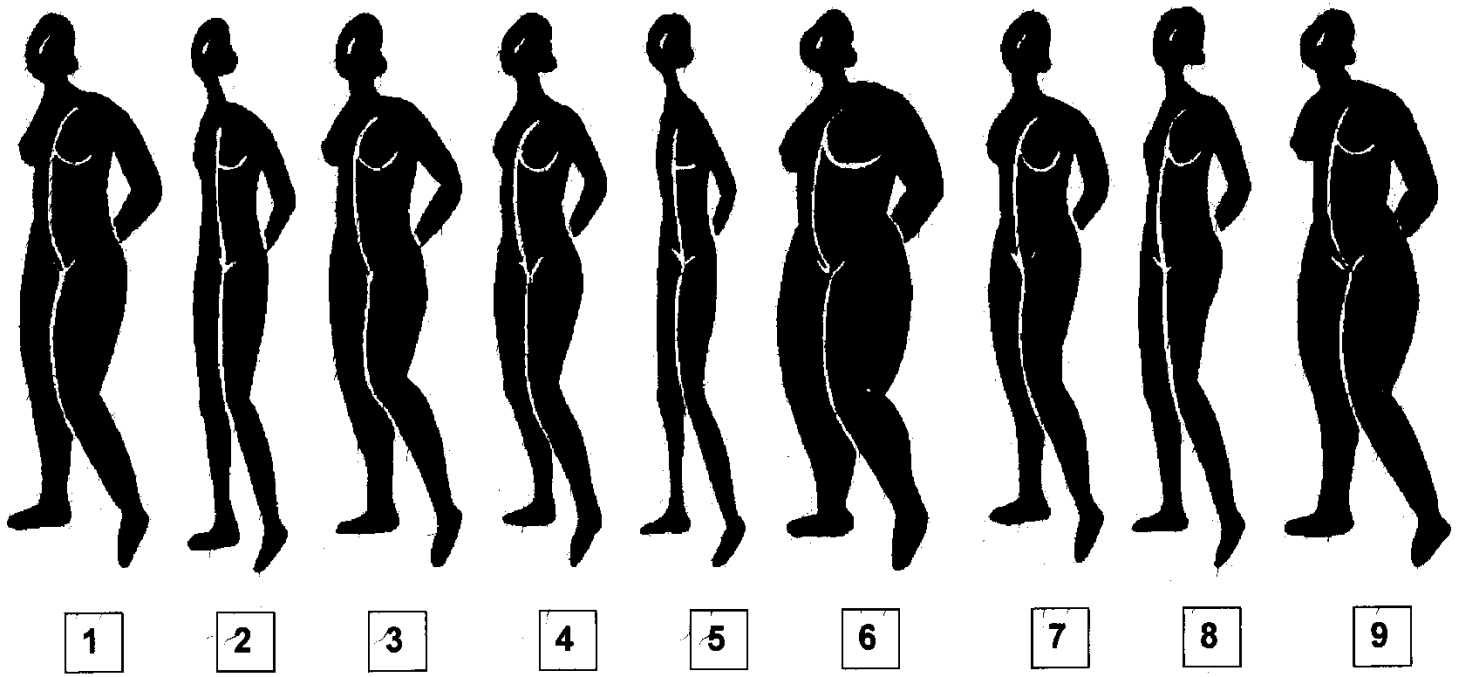
8	When I look at myself in the mirror, I'm dissatisfied with my own body				X		
9	It's easy for me to relax physically				X		
10	I think I'm too thick				X		
11	I feel my body as a burden				X		
12	My body appears as if it is not mine				X		
13	Some parts of my body look swollen				X		
14	My body is a threat for me				X		
15	My bodily appearance is very important to me				X		
16	My belly looks as if I am pregnant				X		
17	I feel tense in my body				X		
18	I envy others for their physical appearance				X		
19	There are things going on in my body that frighten me				X		
20	I am observing my appearance in the mirror				X		

BAT:


Lichaamsattitudevragenlijst
Totaalscore
No of obs
Anorexia nervosa (n=500)


Lichaamsattitudevragenlijst
Totaalscore
No of obs
Boulimia nervosa (n = 270)

Silhouette test (Beebe, 1999)



The problem

“GATE”

The treatment goals [G]

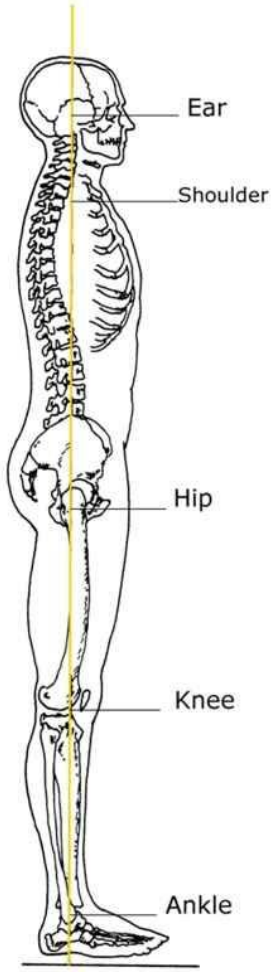
Assesment [A]:
Observation & Evaluation

The treatment [T]
(The activities)

The evaluation [E]

Postural awareness
Breathing exercises
Relaxation exercises
Sensory & body awareness
Massage
Physical activity, yoga, tai chi
Dance & expression
Mirror exercises
Problem solving exercises in group
Guided imagery exercises
Self-confrontation
Psycho-education

Posture



- As consequences of extreme and prolonged weight loss different complaints about defects and deformities of the trunk and posture problems arise
- Scoliosis, lumbar lordosis and kyphosis, wing stand shoulder blades.
- During recovery : attention for posture and balance of the strength of the various hypo-and hypertonic muscle groups

Body/movement awareness

- *"Body awareness is the ability to pay attention to ourselves to feel our sensations and movements online, along with the motivational and emotional feelings that accompany them in the present moment, without the mediating influence of judgmental thoughts".[Fogel 2009]*

- **Focus:** external and internal support, touch, power, balance, Stretching - tension – relaxation, rhythms,

- Mensendieck, Feldenkrais, Alexander, BBAM, Pilates, KBT,

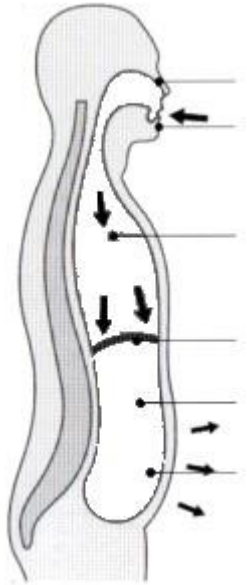
Relaxation exercises

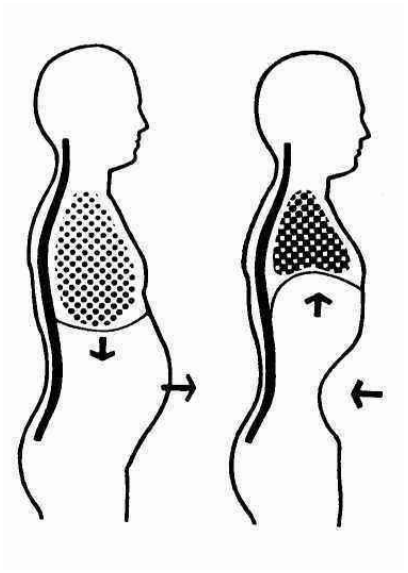
- Relaxation of Bernstein & Berkovec, based on the progressive relaxation

- Autogenuous training
- Tai chi
- Massage
- Yoga
- Mindfulness

Breathing exercises

- especially those aimed at a lowering respiration frequency, amplifying abdominal respiration, and lengthening expiration - are often included in relaxation training.
- *The objective is not just to regulate respiration, it also facilitates learning how to sense one's own body.*





Sensory awareness training

- These exercises aim at *discovering the body* through the senses in a non-threatening manner.
- *Being conscious of internal sensations* has a direct effect on the ability to recognize feelings. It is also the step to perceiving a mutual relation between bodily sensations and feelings.
  - ***Body boundary exploration*** concentrates on tactile awareness of the difference between one's body and the outside world.
  - ***"Body scanning"*** ("trip around the body") is a tactile exercise to explore the external manifestations of the body through touching and feeling of the body boundaries
  - **Mindfullness exercises**

Intervention

- Mild, non judgemental, curious, respectful way
- To be more aware or familiar with the body
- The whole body & body parts (frontal and profile image)
- Psycho education
- The mental image
- Relation with self esteem
- Confrontation with their own
- Responsibility
- Discussion

Invitation
2 x /week: At 9 AM and 1PM
½ hour & ¼ hour discussion

Probst, M., & Diedens, J. (2016). The body in movement. In I. Jauregui Lobera (Ed), Eating disorders. Zagreb: Intech

Negative thought: “My belly is too fat”

Alternative thoughts:

- My belly isn’t fat at all, perhaps I' am wrong
- With this low weight, my belly cannot be fat
- I have a small size in clothing so my belly cannot be fat
- Others never make any remarks about my belly
- Perhaps I am too critical regarding my looks

- 1 year = 365 days * 24 hours * 60 minutes = 525600 minutes or 8760 hours
- How many minutes do you think somebody else will see your belly?
- 1% percent means 5256 minutes or 87 hours

Guidelines for physical activity?

- An immediate suspension of all physical activity?

- Is this the solution?
  - No!
  - Better = Appropriate physical activity
    - Under supervision
    - Without supervision
  - Benefits
    - Strength
    - Self-efficacy

Alternatives for a suspension

- A dialogue with the patient
- Psycho-education
- Finding a acceptable balance for the patient and the treatment taking in consideration the context of the patient

  - BMI: <14: basic physical activity (light housekeeping activities)
  - BMI: 14-16: mild physical activity under professional supervision
  - BMI: 16-18: the patient receives more responsibility; the role of the professional is coaching
  - BMI: >18: the patient receives all the responsibilities

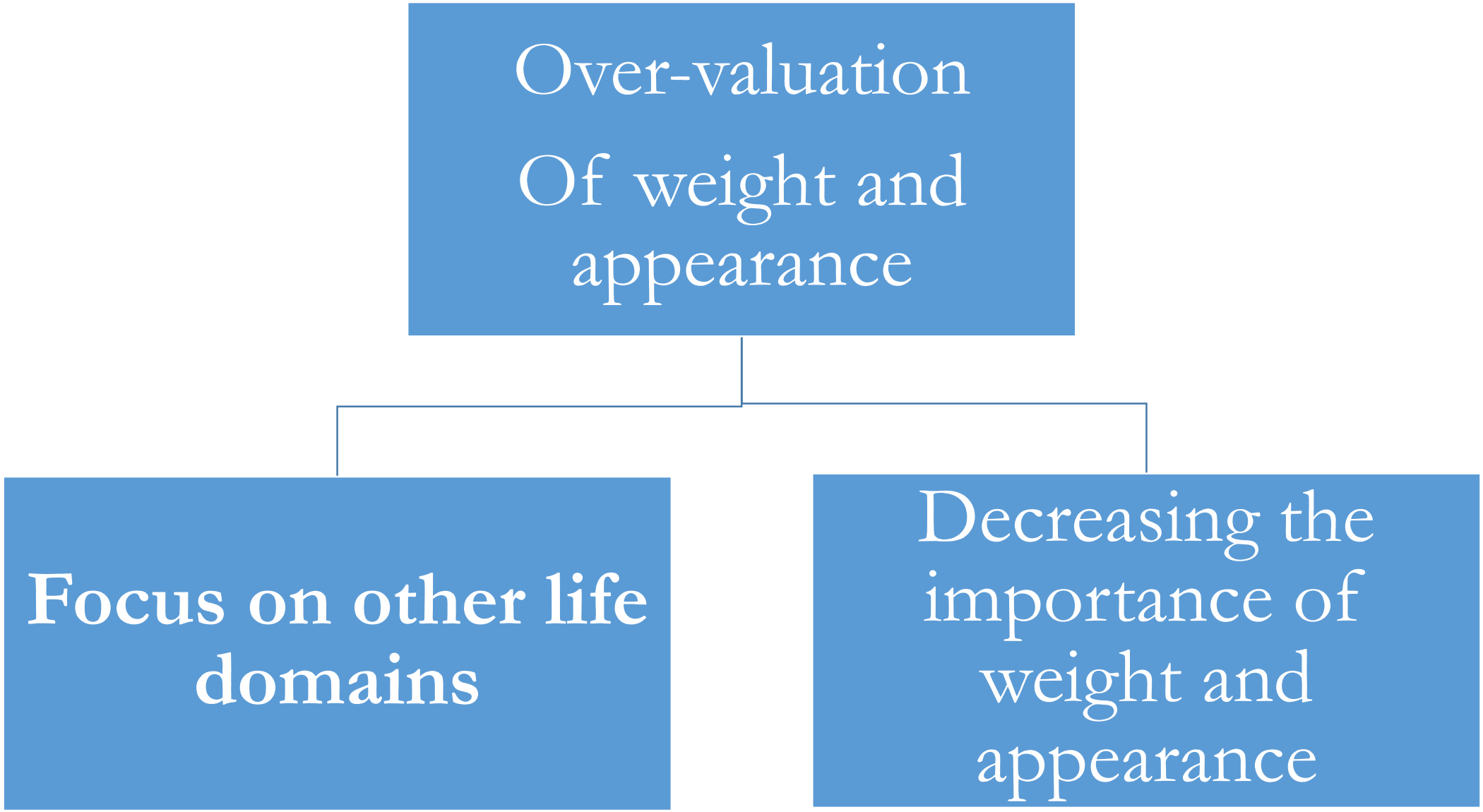
Therapeutic guidelines

- Don’t believe that the behavior will change if patients deny their problems
- A soft or a more strict approach, it is always searching for a balance and sometimes therapists are confronted with their limits and with feelings of impotence/ powerlessness.
- The attitude of body oriented therapist is in the first place focused on the present healthy possibilities of the subject (=‘care’) to influence the psychological, social and somatic functioning.

Themes for Psycho-education

- **The body**
  - The misconception about the (functioning) body
  - The misconception about hunger (feelings of hunger), fat distribution
- **Exercises**
  - What constitutes exercises?
  - The misconceptions about exercises (feelings about exercise)
  - To explain the energy balance

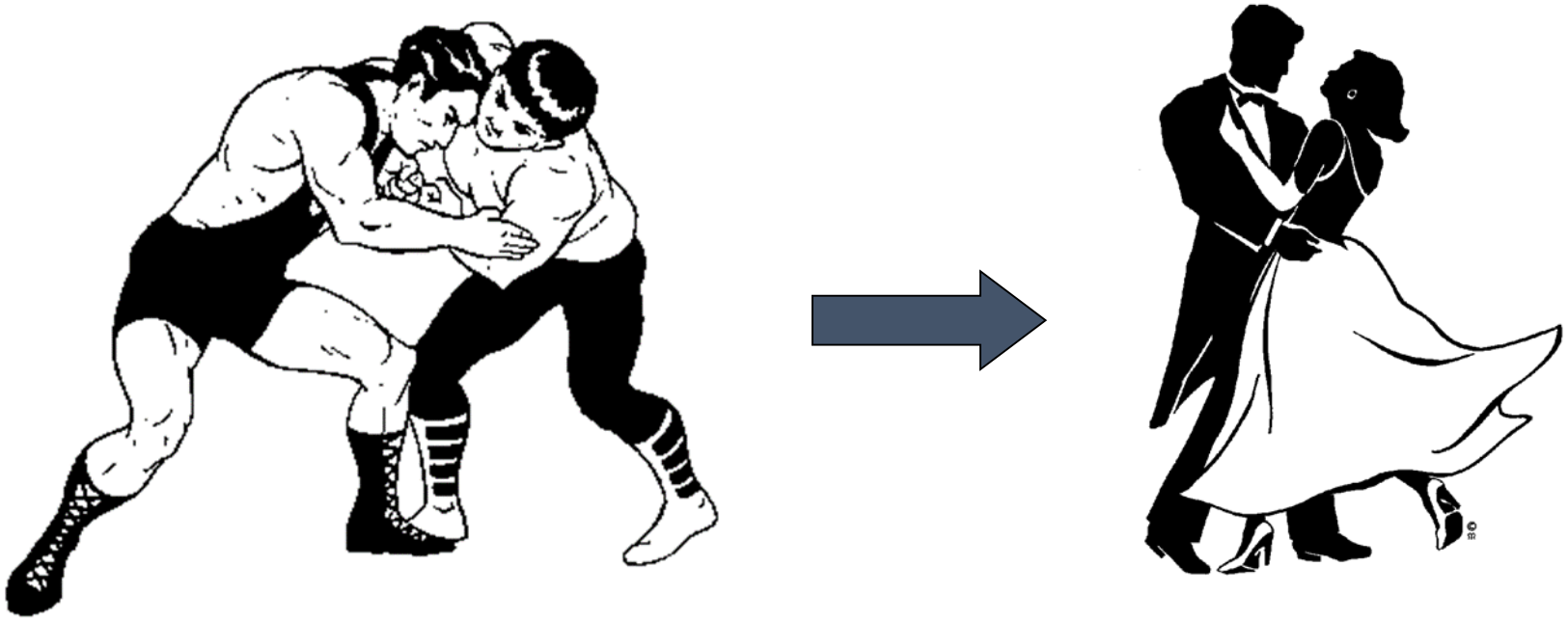
Probst, M., Goris, M., Vandereycken, W. (2001). The American Journal of Clinical Nutrition, 73, 190-197


Over-valuation
Of weight and appearance
Focus on other life domains
Decreasing the importance of weight and appearance

Patients have to convince themselves!
Twice a day, everyday; Speaking in the I-form

- **I will ask myself**: what do I really gain from preoccupation with what I believe are defects in my shape?
- **I will think** of three reasons why my assumption that thinner people are happier and "better" is ridiculous.
- **I will repeat** these of myself whenever I feel the urge to compare my body shape with that of another person.
- **I will exercise** for the joy of feeling my body move and function effectively, not to purge fat from my body or compensate for calories eaten
- **I will not avoid activities** I enjoy, even if they call attention to my weight and shape.
- **I will constantly remind** my self that I deserve to do things I enjoy (e.g., dancing, swimming, sunbathing) no matter what my shape!

Body Mind relationship



Dearest Belly

When I look at my body, you are the part that I hate the most. I don’t know why you're so important in my life. You decide who I am and how I feel. It's just like you encourage me every day, and after every meal, to vomit. I sometimes think you’re so fat! Why can’t you just stay thin? I hate to be confronted with you day after day. Because I hate you so, you obstruct a part of my healing. Why do I have the feeling that everything I eat is stored in my belly? There is not an hour that goes by without thinking of you. I don’t want this anymore. I want to go on, whether or not you want to help me out. I won’t let you live my life, but from now on I take matters into my own hands. I was a happy woman and I still have everything to be that happy woman again. You can’t take that away from me. You're a part of me that will always be difficult for me, but gradually I will try to accept you. Give me some time and I really hope that we can be buddies for life in the future. What do you think?

Love

Bianca.

Dear Bianca,

Why do you worry so much about your belly? I'm just a body part, just like any other. I don't want you to worry about me. Everyone has a belly. It's normal that your stomach isn't very tight and you have a full feeling after your meals. A belly has its own shape, but that is typically female. You should be happy that you look so beautiful. Accept me as I am and you'll see that I won't change so much. Instead of beating or pinching me, try to give me some extra attention sometimes by rubbing me with a body lotion. I really like.

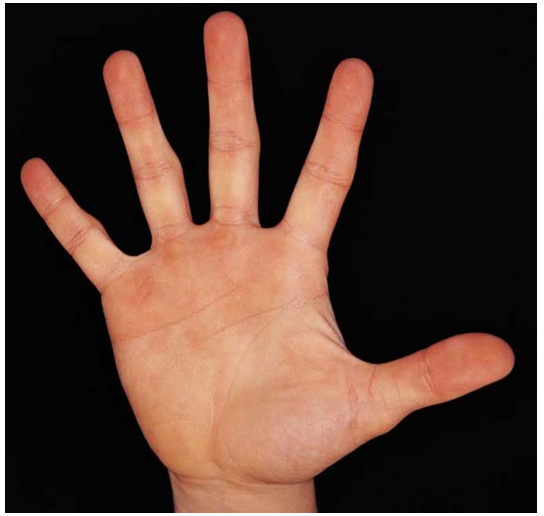
As you write in your letter, you were once a very happy woman. You can still be that. Do not worry about how you want me to be, but accept me as I am. Once you stop worrying about me, we can be good friends. I would love to see you happy again in the near future. Didn't I hear you talking to you boyfriend about getting babies, how you long for your first child? I'd be honored to feel your baby inside me. Think about that. If you want children, you have to let go and accept me as I am!

I know you can, and that you will soon be the happy girl who you were before. We continue working on our friendship.

Greetings

Your Belly

Cash, 1995 (adapted)

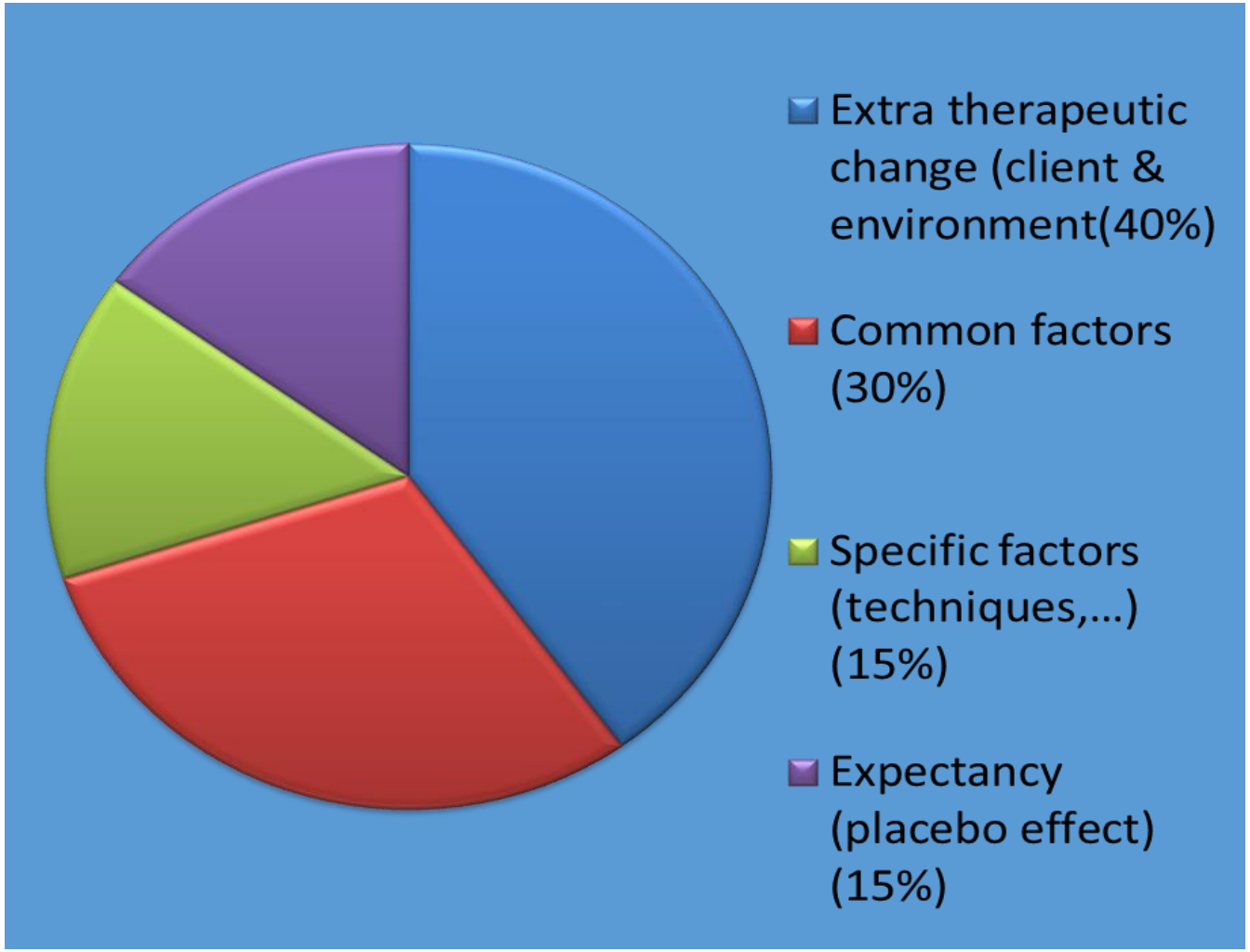


- Therapeutic guidelines
  - Try to understand the body dissatisfaction of the patient
  - Invite patient to make the history of body dissatisfaction/self esteem
  - Identify and correct the cognitive errors/ identify qualities
  - Invite patient to start a dialogue with your body/ Teach them to know themselves
  - Help patient to perceive the body in an adequate way/ teach them to convince themselves
  - Teach patient not to avoid confrontation with her body
  - Stimulate patient to live today in harmony with her body!/ teach them to be proud of themselves
  - Try to decrease their perfectionism and motivate them to increase interpersonal relationships

Take home messages

- BOT can have an added value for patients with eating disorders
- If you underpin your therapy with a scientific theory
- The exercises of themselves are not therapeutic; don't copy/paste.
- Don't expect spectacular outcome.
- Therapy is a long-lasting process; step by step; and small steps
- Be critical and don't believe to much yourself.
- Be not afraid about silence;
- Use in communication the ideas of "motivational interviewing"

Changes in therapy



Lambert and Barley, 2001

Common factors

Client characteristics
e.g. positive expectations

Therapist qualities
e.g. allegiance to a theory

Change processes
e.g. practice of new behaviours

Treatment structures
e.g. rituals

Relationship
e.g. alliance therapist -client

The problem

“GATE”

The treatment goals [G]

Assesment [A]:
Observation & Evaluation

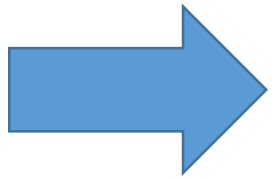
The treatment [T]
(The activities)

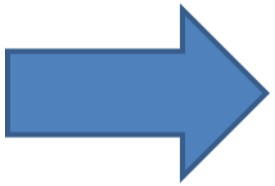
The evaluation [E]

Source of knowledge

Scientifically derived = is a set of interrelated facts presenting a systematic view of some phenomenon in order to describe, explain, and predict its future occurrence

Professional practice = knowledge gained through experience





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TESTED

REVIEW

A systematic review of physical therapy interventions for patients with anorexia and bulemia nervosa

Davy Vancampfort[1,2], Johan Vanderlinden[1], Marc De Hert[1], Andrew Soundy[3], Milena Adámkova[4], Liv Helvik Skjaerven[5], Daniel Catalán-Matamoros[6], Amanda Lundvik Gyllensten[7], Antonia Gómez-Conesa[8], and Michel Probst[1,2]

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Routledge Taylor & Francis Group

Physiotherapy for patients with anorexia nervosa

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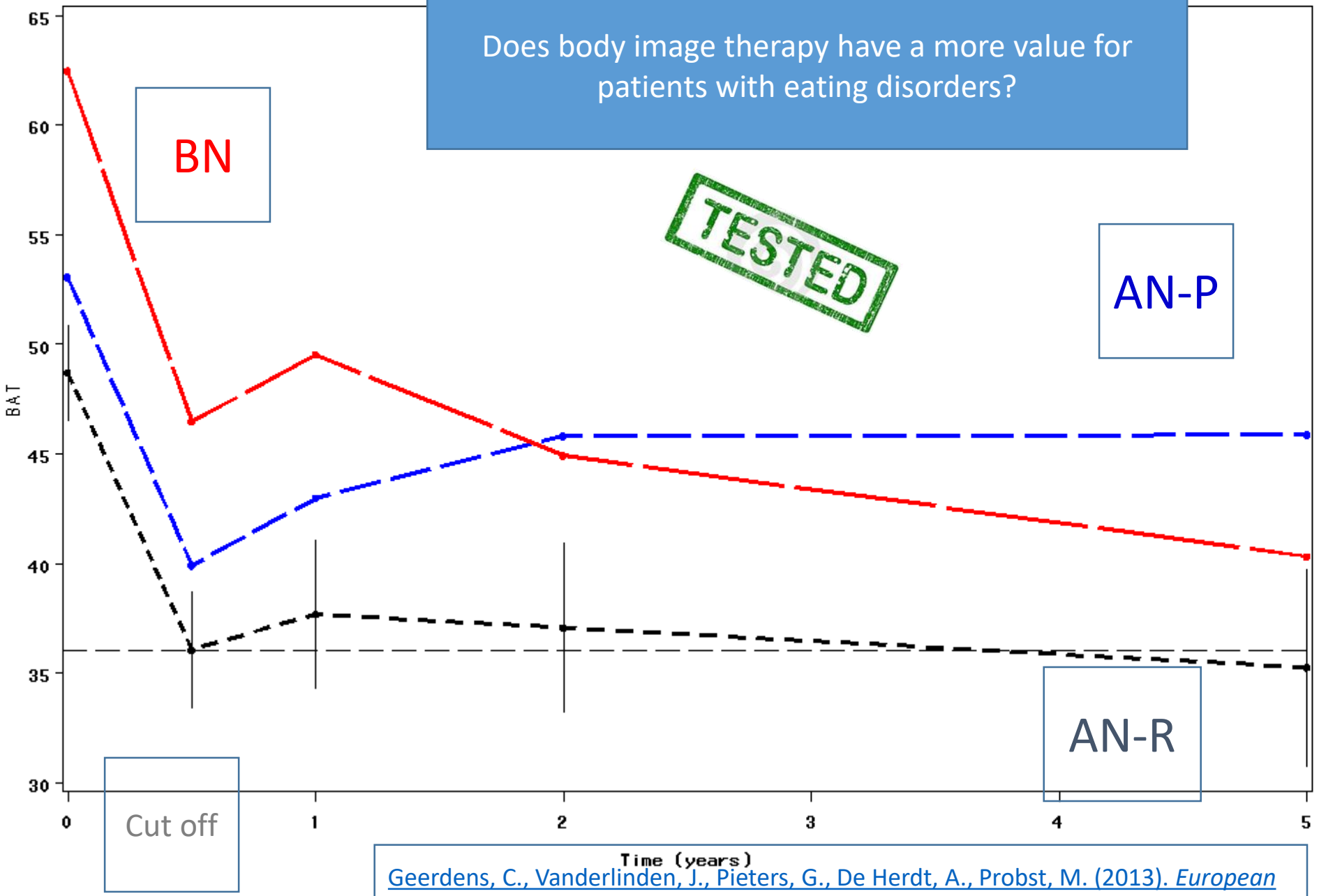
Does body image therapy have a more value for patients with eating disorders?



Geerdens, C., Vanderlinden, J., Pieters, G., De Herdt, A., Probst, M. (2013). *European Eating Disorders Review, 21* (3), 224-229.

Subjective experience of ED patients with PT

- 82% of patients (N=100) indicated that they were satisfied with the body image therapy.
- The confrontation exercises prove very valuable and influence in a positive way the problems
- Patients with eating disorders experience the body image therapy as valuable
- Patients mentioned that it should be part of a treatment for patients with eating disorders.

Probst, M. (2007). Onderzoek in de psychomotorische therapie: de perceptie van de psychomotorische therapie door patiënten met eetstoornissen. In: Simons J. (Eds.), Actuele themata uit de psychomotorische therapie. Leuven: Acco, 133-151.

‘Body oriented therapy is not finding a solution, it is about starting a dialogue between the patient and his/ her body”

References

- Geerdens, C., Vanderlinden, J., Pieters, G., De Herdt, A., Probst, M. (2013). Missing data in long-term follow-up of patients with eating disorders using the Body Attitude Test. European Eating Disorders Review, 21 (3), 224-229.
- Probst, M., Van Coppenolle, H., Vandereycken, W. (1995). Body experience in anorexia nervosa patients: an overview of therapeutic approaches. Eating Disorders, 3, 186-198.
- Probst, M., Vandereycken, W., Van Coppenolle, H., Vanderlinden, J. (1995). Body Attitude Test for patients with an eating disorder: psychometric characteristics of a new questionnaire. Eating Disorders, 3, 133-145.
- Probst, M., Goris, M., Vandereycken, W., VanCoppenolle, H. (2001). Body composition of anorexia nervosa patients assessed by underwater weighing and skinfold-thickness measurements before and after weight gain. The American Journal of Clinical Nutrition, 73, 190-197.
- Probst, M., Pieters, G., Vanderlinden, J. (2009). Body experience assessment in non-clinical male and female subjects. Eating and Weight Disorders, 14 (1), e16-e21.
- Probst, M., Pieters, G., Vanderlinden, J. (2008). Evaluation of body experience questionnaires in eating disorders (in female patients AN/BN) and non-clinical subjects. International Journal of Eating Disorders, 41 (7), 657-665.
- Probst, M., Pieters, G., Vancampfort, D., Vanderlinden, J. (2008). Body experience and mirror behaviour in female eating disorders patients and non clinical subjects. Psihologijske Teme - Psychological Topics, 17 (2), 335-348.
- Probst, M., Goris, M., Vandereycken, W., Pieters, G. (2008). Body composition in girls and young women with anorexia nervosa: Comparison of different equations. International Journal of Eating Disorders, 41 (2), 180-183.
- Probst, M., Diedens, J. , Van Damme, T. (2017). Physiotherapy in and patients with eating disorders 241-252 In: Probst, M. & Skjaerven, L. (Eds.), Physiotherapy in mental health and psychiatry, a scientific and clinical based approach, chapt 5.2.4, (pp. 241-252). Edingburgh: Elsevier.
- Vancampfort, D., Probst, M., Adriaens, A., Pieters, G., De Hert, M., Stubbs, B., Soundy, A., Vanderlinden, J. (2014). Changes in physical activity, physical fitness, self-perception and quality of life following a 6-month physical activity counseling and cognitive behavioral therapy program in outpatients with binge eating disorder. Psychiatry Research, 219 (2), 361-366.
- Vancampfort, D., Vanderlinden, J., De Hert, M., Soundy, A., Adámkova, M., Skjaerven, L., Catalán-Matamoros, D., Lundvik Gyllensten, A., Gómez-Conesa, A., Probst, M. (2014). A systematic review of physical therapy interventions for patients with anorexia and bulemia nervosa. Disability and Rehabilitation, 36 (8), 628-634.

“Searching for Utopia” (Jan Fabre)

For more information & articles
http://www.kuleuven.be/wieiswie/en/person/u0003430

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Thank you for your attention !