CHAPTER 8

Shape Concern, Shape Checking, Feeling Fat and Mindsets

At the heart of most eating disorders is the distinctive "core psychopathology," the over-evaluation of shape and weight and their control; that is, the judging of self-worth largely, or even exclusively, in terms of shape and weight and the ability to control them. As described in Chapter 2, most other features of these disorders appear to be secondary to this psychopathology and its consequences (e.g., under-eating leading to low weight; rigid and extreme dietary restraint leading to binge eating). It is for this reason that this psychopathology occupies a central place in most patients' formulation and is a major target of treatment. Clinical experience and research evidence suggest that unless it is successfully addressed, patients are at substantial risk of relapse.

Most features appear to be secondary to the core psychopathology.

In this chapter strategies and procedures for addressing the concerns about shape and weight are described. This aspect of treatment takes time to deliver and change is gradual. Therefore, when designing Stage Three it is best to ensure that it is started early. It has six main elements:

1. Identifying the over-evaluation and its consequences
2. Enhancing the importance of other domains for self-evaluation
3. Addressing shape checking and avoidance. Weight checking and avoidance were addressed in Stage One
4. Addressing "feeling fat"
5. Exploring the origins of the over-evaluation
6. Learning to control the eating disorder mindset

Generally the first four elements are introduced in this order, and early on, as they take time to implement and have their effect. The last two are best left until near the end of

Stage Three. Once this psychopathology has begun to be addressed, it should remain a permanent item on the session agenda.

Identifying the Over-Evaluation and Its Consequences

The starting point is educating the patient about the rather complex and abstract topic of self-evaluation. The therapist then helps the patient identify his or her particular scheme for self-evaluation. Finally the implications of this scheme are discussed and a plan for addressing the over-evaluation is devised.

As therapists are often unsure about how to broach the subject of self-evaluation, an illustrative dialogue is provided below.

THERAPIST: *We've decided that today we are going to focus primarily on your concerns about your shape and appearance. I'd like to go back to why we are doing this. If we look back at the diagram that shows the things that you and I have identified as driving your eating problem [the therapist refers to the patient's formulation], you can see that your concerns about your shape and weight occupy a central position. Clearly we need to focus on them in addition to your eating as they seem important in keeping your eating problem going and they really worry you.*

PATIENT: *Yes, my shape is the main thing I worry about. It really bothers me . . . the fact that I am always worrying about my shape . . . and the fact that it is so awful. I hate it.*

THERAPIST: *Well, to start with we need to talk about the way we all evaluate or judge ourselves — something most of us don't even think about. All of us have a system, or way, of judging ourselves. If we are meeting our personal standards in the areas of life we value, we feel reasonably good about ourselves, but if we are not we feel bad. Typically people judge themselves according to various things; for example, relationships with others are often important . . . say, how one is doing in one's relationships with one's parents (and children, if one has any) and one's relationships with friends. Other things that may be important are how one is getting on at work and at important pastimes . . . say, sports, singing, music, cooking, or whatever. And one's appearance too may be important. Now, if things are going well in these various areas of life, one feels fine, but if they are not, one feels bad. Indeed, feeling bad is the best clue as to an individual area's importance. If one feels really bad if an aspect of life is not going well, this strongly suggests that this aspect is very important to one's self-evaluation. Does this make sense?*

PATIENT: *Yes, I think so. The way I look, for example, it makes me feel really bad. I won't go out some days.*

THERAPIST: *Exactly. So this indicates that your shape or appearance is very important in how you see, or judge, yourself. Now a good way of representing all this is to draw a pie chart, with the various slices representing the various aspects of life that are important to you in terms of how you judge yourself as a person, and the bigger the slice the more important it is. Now what I would like us to do is to try to draw your pie chart.*

What we first need to do is list the things that are important in the way you judge, or evaluate, yourself. What might they be?

The therapist then helps the patient generate a list of areas of life that are important to his or her self-evaluation. Sometimes it is necessary to help patients distinguish things in their life that they regard as "important" in general (i.e., because they are widely regarded as such; e.g., work) but do not in practice influence the way they view themselves, and things that truly have an impact on the patient's self-evaluation. If the patient finds it difficult to generate such a list, the therapist should provide typical examples, perhaps by saying *"Some people judge themselves in terms of the quality of their relationship with their partner, what they manage to achieve at work, their musical accomplishments, their appearance, etc."* In the great majority of cases the list will include shape (i.e., appearance) and weight, and the ability to control them, but as mentioned earlier in a minority of cases there is over-evaluation of controlling eating for its own sake and not for the sake of controlling shape or weight. If shape, weight or controlling eating are not mentioned by the patient, the therapist should mention them, perhaps along these lines: *"And what about your appearance, your shape and weight and controlling your eating, are they important? Should we include them?"*

Having generated a list, the therapist should go on to explore with the patient the relative importance of the identified domains of self-evaluation, the best clue to their relative importance being the magnitude (in terms of intensity and duration) of the patient's response to things going badly in each area. In this way the various areas can be ranked. Therapists should ensure that they establish how patients really evaluate themselves, not how they think they ought to evaluate themselves. If the patient seems hesitant, the therapist might add: *"Most people with eating problems are not happy with their means of self-evaluation, but it is important that we characterize it accurately so that we can understand it and its effects."* Finally, the therapist and patient draw out a tentative pie chart, the size of each slice representing the relative importance of that area of life in the patient's self-evaluative scheme. A representative pie chart is shown in Figure 8.1, the pie charts of patients with eating disorders typically being dominated by a large slice representing the over-evaluation of shape and weight and their control. This is quite unlike the type of pie chart drawn by healthy young people without an eating disorder (illustrated in

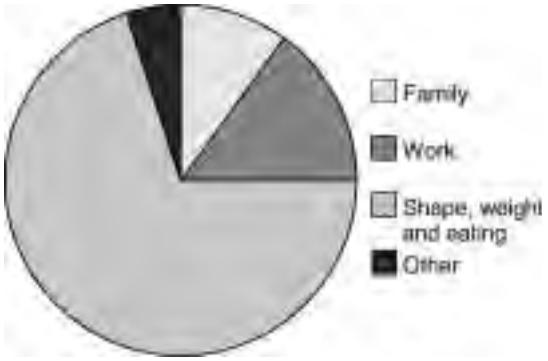

FIGURE 8.1. The pie chart of patient A.

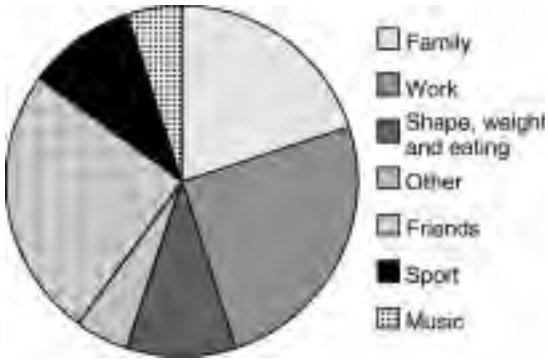

FIGURE 8.2. A pie chart of a young woman without an eating problem.

Figure 8.2). Finally, the therapist should ask for the patient's view on his or her pie chart. Many patients are embarrassed and ashamed about the importance they place on their shape and weight. They should be reassured that this over-evaluation is typical of people with eating problems and is something that they can change.

As homework, patients should be asked to review their pie chart each day and think whether it accurately represents the true state of affairs based on their day-to-day attitudes and behavior. To this end it can be helpful for patients to redraw their pie chart at the end of each day (on the back of the day's monitoring record). At the next session the pie chart should be discussed further and the size of the slices adjusted as needed. Generally, any revision takes the form of expanding the size of the slice representing the importance of shape and weight.

Next, the patient should be asked to consider the implications of his or her scheme for self-evaluation (as represented by the pie chart) and think whether there might be any problems inherent to it. This discussion should lead to the identification of the main adverse consequences of over-evaluating shape and weight and their control:

1. *Having a pie chart with a dominant slice is "risky."* In this context the therapist might say:

> *"It is like having all your eggs in one basket. This is fine so long as everything is going well in this regard, but if it isn't, one is in trouble. A parallel can be drawn with top athletes who also tend to have a dominant slice in their pie chart, one concerned with their athletic performance. If, unexpectedly, they can no longer compete, say as a result of injury or illness, they tend to have great trouble adjusting to this change in their circumstances because all their self-evaluative 'eggs' have been in one single basket."*

2. *Having a pie chart with a dominant slice narrows one's life and is self-perpetuating.* It results in the marginalization of other aspects of life. Nothing else much matters. It leads to life being seen from this perspective only. As a result interests, aptitudes and relationships can get ignored and life gets reduced to controlling shape, weight and eating. In this regard it can be helpful to ask patients to take a long-term perspective on the consequences of having such a dominant slice. They can be asked what they would like to

have achieved by the time they reach old age. They may not wish to have attained a flat stomach to the detriment of other aspects of their life (see following vignette).

Vignette

A contributor to *Overcoming Binge Eating* (Fairburn, 1995) wrote:

> *"As I grow into middle age I realize with great sadness how much energy I have directed toward controlling my weight and eating and the misery of the regular and consequent binges. I could be doing something productive with my energy — building relationships, reading, writing. I don't know what I might do, but I don't want my epitaph to be 'Jane wished she was thin.'" (p. 132)*

3. Judging oneself on the basis of appearance and weight, and one's ability to control them, is inherently problematic. The therapist might say:

> *"In your case the problem is not only one of having most of your eggs in one basket, it also lies in the nature of the basket itself. It is not a good one. This is because success in this area of life is elusive and apparent failure ever present. This is for a number of reasons, some of which we will discuss in great detail later, but briefly, it is problematic basing one's self-evaluation on one's appearance and weight because:*
>
> *"a. One's shape, weight and eating are not fully under one's control. We only have a limited ability to control our eating (and hence our shape and weight), because it is under strong physiological control. One can manipulate it in the short-term but to do so on a long-term basis requires considerable and sustained effort, and one pays a price as a result* [see below]. *Similarly, one's overall body shape or physique is only partially under one's influence. It is mainly something one just has to accept.*
>
> *"b. There will always be lots of people who seem more attractive (i.e., successful in your eyes) than you. In part this is because of the way people with eating problems judge their appearance, which is prone to make them see themselves as unattractive; and in part it is because of the way they compare themselves with others, which has the same negative effect. We will discuss both these topics later. The result of these two processes is that people with eating problems repeatedly feel that they are failing.*
>
> *"c. Judging yourself in this way leads you to do things that harm you, such as . . .* [the therapist lists applicable examples, such as undereating, binge eating, self-induced vomiting, laxative misuse, etc.], *and it maintains your eating problem. And doing these things also impairs the quality of your day-to-day life."* [The therapist may highlight the main sources of impairment detected on the CIA questionnaire completed in Stage Two.]

This discussion leads naturally to the final step in the consideration of self-evaluation, namely the creation of an "extended formulation" that includes the consequences of the over-evaluation. The therapist starts this process by asking the patient what he or she does, or experiences, as a result of the importance he or she places on shape, weight and appearance. The goal is to derive a figure resembling that shown in Figure 8.3, with the therapist adding and emphasizing the feedback arrows, saying something along these lines:

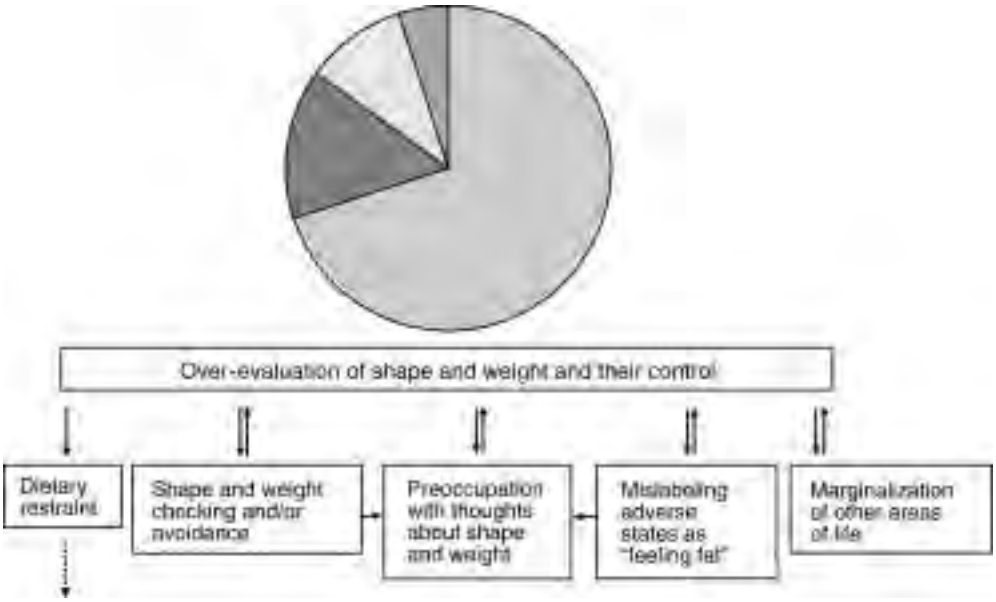

FIGURE 8.3. The over-evaluation of control over shape and weight: an "extended formulation."

From *Cognitive Behavior Therapy and Eating Disorders* by Christopher G. Fairburn. Copyright 2008 by The Guilford Press. This figure is available online at www.psych.ox.ac.uk/credo/cbt_and_eating_disorders.

> *"These things that you do, or that happen, as a result of your concerns about your shape and weight, and your wish to control them, are themselves likely to maintain your concerns. For example, repeatedly checking your body will intensify your dissatisfaction with your shape. Similarly, avoiding seeing parts of your body or avoiding knowing your weight will result in your fears and concerns persisting unquestioned. We haven't yet discussed 'feeling fat,' but it tends to be equated with 'being fat' and so keeps one unhappy with one's appearance. The point is that it is vital that we tackle these consequences of your concerns because they maintain your dissatisfaction with your shape and weight. As you can see there is a set of vicious circles here, and tackling these things is the best way of breaking into them."*

Finally, in collaboration with the patient, the therapist devises a plan for addressing the concerns about shape and weight and their control. This involves employing two complementary strategies, both of which are important:

1. *Enhancing the importance of other domains for self-evaluation* (i.e., increasing the size and number of other slices in the patient's pie chart)
2. *Reducing the importance attached to shape and weight and their control* (i.e., decreasing the size of the shape and weight slice). The most potent way of doing this is to tackle the expressions of the over-evaluation. In terms of shape, they are shape checking, shape avoidance and feeling fat. With respect to weight, they are frequent weighing and the avoidance of knowing one's weight, both of which were addressed in Stage One. In terms of control over eating, they are dietary restraint and dietary restriction (see Chapters 9 and 11 respectively).

Enhancing the Importance of Other Domains for Self-Evaluation

The over-evaluation of shape and weight results in the marginalization of areas of life that might contribute positively to self-evaluation.

The over-evaluation of shape and weight results in the marginalization of areas of life that might contribute positively to self-evaluation. There are two aspects to the marginalization: First, the other areas are few in number (i.e., there are few other slices in the patient's pie chart); and second, they are of limited importance (i.e., the slices are small in size). The goal therefore is that patients begin to engage in other areas of life, and that these areas become more important in their self-evaluation.

Enhancing the importance of other domains has an additional benefit. Eating disorders generally begin in mid-to-late adolescence. Those cases that persist into adulthood will have generally been present for many years. During this time the patient's life will have been dominated by the eating disorder while other interests, activities and aptitudes will have fallen by the wayside. While the patient's life has been taken up with dieting, exercising and concerns about shape and weight, his or her contemporaries will have been doing the many things that people their age do. Thus patients with eating disorders miss out on important normative age-related experiences and develop secondary interpersonal deficits as a result. Assisting them to develop previously marginalized domains for self-evaluation often has the added benefit of helping them catch up developmentally.

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There are six steps in helping patients engage in, and begin to value, other aspects of life:

1. *Explain the rationale for doing this.* For example, the therapist might say:

> *"You have said that you are unhappy with the way your current pie chart looks. In particular you have said that you would like the eating, shape and weight slices to be smaller. One way of achieving this is by engaging in other aspects of life, areas that have been pushed aside. Investing time doing this will result in these other areas becoming more important and more relevant to how you judge yourself as a person."*

2. *Identify new activities in which the patient might become involved.* A clue may come from activities or interests that the patient had prior to developing the eating disorder. The patient might have been a tennis player or painter, or been interested in hiking or acting. It does not matter what the activity was or how good the patient was at it, it is simply valuable to consider previous interests and activities. A "brainstorming" approach is best here with all possibilities being listed even if they seem (to the patient) silly or intimidating. Some patients are hesitant and so rule out quite promising possibilities, and many have difficulty thinking of activities, having spent so much time preoccupied with thoughts about eating, shape and weight. Sometimes good ideas can come from patients' considering what their friends or work colleagues do in their spare time.

3. *Agree on one, or possibly two, activities that the patient will try.* These can be anything so long as they are feasible and not single one-off events. It is best if they involve others as they are more likely to become self-perpetuating. Furthermore, contact with others can help patients "catch up" interpersonally.

4. *Ensure that the patient actually does start to engage in the activity identified*. The therapist should ask the patient to record the activity in the last column of his or her monitoring record, and barriers to engaging in it should be reviewed and solutions sought. A problem-solving approach is often best. (With some patients problem-solving will have been taught in the context of addressing event-triggered changes in eating [see Chapter 10]. In others the technique will need to be introduced at this point.) Therapists should not refrain from being active in helping hesitant patients get started. For example, if the patient is considering joining some type of dance class, it would be quite appropriate for the therapist to help the patient work out ways of identifying suitable classes and the steps involved in joining them. This is because the priority is to get the patient started. Thereafter the therapist should step back.

5. *Review progress week by week* (as a permanent item on the session agenda). The therapist should be encouraging and facilitative. Patients should be helped to use problem-solving to overcome any difficulties they encounter. Over the course of treatment additional new activities may be identified and adopted, while others may be dropped. Toward the end of treatment it is worth asking patients to draw their pie chart again, as doing so provides an opportunity to review progress and praise patients for the changes that they have made. What is usually found is that the "slice" representing shape and weight has shrunk in size and new slices have appeared.

Addressing Shape Checking and Avoidance

At the same time as enhancing the importance of other domains for self-evaluation, the therapist should target the patient's over-evaluation of shape and weight. Often it is best to begin by addressing shape checking, as this tends to be particularly influential in maintaining dissatisfaction with shape, but before doing so it is worth noting with the patient that one form of body checking has already been addressed, namely weight checking. This was tackled in Stage One in the context of "in-session weighing" (see page 62). Almost invariably patients will have found in-session weighing helpful because (after a few weeks) it will have decreased their level of concern about weight (i.e., the number on the scale). They should be told that equivalent benefits will result from addressing shape checking.

The importance of tackling shape checking and shape avoidance has only recently been appreciated. The reason is quite simple: Few clinicians were aware of these phenomena. This lack of awareness was due in part to patients' not disclosing the behavior unless directly asked; indeed, many patients are not even aware that they do it. Strangely, the behavior has been right under our nose, as it were, as it is not uncommon for patients to check their shape during treatment sessions. (This will become apparent if therapists observe carefully what patients are doing with their hands. Some repeatedly touch their arms, shoulders or collar bones to check that they can feel their bones, and many do this without being aware of it.)

Educating Patients about Shape Checking and Avoidance

The initial step is to educate the patient about shape checking and shape avoidance and their effects, stressing the following three general points:

1. Everyone checks their body to some extent, but many people with eating problems repeatedly check their bodies and often in a way that is unusual. Such checking can become so "second nature" that they may not be fully aware that they are doing it; for example, when taking a shower some people are also shape checking. In people with eating problems such shape checking needs to be addressed, as it tends to maintain their dissatisfaction with their body and appearance.
2. Some people with eating problems avoid seeing their bodies and dislike other people seeing them too. Often these people engaged in repeated shape checking in the past but switched over to avoidance because the checking became too distressing. Shape avoidance may take the form of avoiding looking in the mirror, not wearing tight clothes, covering the stomach (e.g., with the arms), and not looking at photographs. It is problematic because it allows concerns and fears about shape and appearance to persist in the absence of knowledge about what one actually looks like. Therefore it too needs to be tackled.
3. Shape checking and avoidance can co-exist. Some patients repeatedly check parts of their body and avoid others, or switch from checking to avoidance and back.
4. Comparing oneself with others is a special form of shape checking. People with eating problems do this repeatedly and in a way that makes them seem unattractive relative to other people. This too must be addressed.

Assessing Shape Checking

Next, the therapist needs to assess the patient's shape checking. Although there are various standard body checking questionnaires (see Recommended Reading, page 192), we find that asking patients to record each time they check their body (using an adaptation of the usual monitoring record; see Figure 8.4) is more informative clinically, not least because some forms of shape checking become so second nature that patients are not fully aware that they do them. For this reason scores on questionnaires can be spurious. As recording shape checking can be very distressing, it is best to ask patients to do it for just two 24-hour periods, one (if the patient works) being a working day and the other being a day off work. The therapist may say something along these lines:

> *"To find out what shape checking you are doing, please record every time you check your body or compare someone else's body with your own. It is best to do this recording on one workday and on one day when you are not working, as they may differ. Here is an adaptation of our usual record for doing this. You may find that you have a lot to write down. Don't worry about this. It may also be quite upsetting: Indeed, you may feel like leaving some things off. Try to write everything down as we need to know exactly what you are doing."*

To help patients record their shape checking it is best to discuss the types of behavior that should be recorded. Common examples include looking in the mirror (or at reflective surfaces) at particular body parts, measuring body parts with a tape measure or the hands, pinching or touching body parts, assessing the tightness of particular items of

Day Friday **Date** April 20th

Time	Food and drink consumed	Place	*	V/L	Checking (what done, time taken)	Place	Context and comments
6:30	Glass water	Kitchen			Looked at reflection in mirror (2 mins.)	Kitchen	My face looks really fat
7:00					Looked in mirror while getting dressed – stood sideways (2 mins.) Pinched my fat rolls (5 mins.)	Bedroom	Ughh my stomach is so gross
7:10	Banana, bowl of cheerios	Kitchen					Fine
8:30					Checked to see if my backside looks big in this skirt (5 mins.)	Bathroom at work	How can I be so fat already? I have only eaten breakfast!
10:00	Cereal bar	At desk	*		Looked down at stomach while having snack (2 mins.)	Desk	Cannot believe that my stomach is so big – it is making me grossed out to look at it – why can't I just be skinny?
1:15	Peanut butter and jelly on whole wheat (2 slices of bread)	Park			Watched thin runners in the park (15 mins.)	Park	Shouldn't have had peanut butter, it is so fattening. I SHOULD be running during lunch like all of those other people!
3:00	Apple	Desk					At least I was able to just have an apple and not eat the cake in the office kitchen
6:30	Veggies (large plate) and tuna fish	Kitchen				Living room	Good dinner – feeling in control
7:30					Read US Weekly about latest celeb diet (15 mins.)		I am so jealous of these women – if only I had a personal trainer and more willpower.
9:00	One small pot of yogurt	Living room			Looked at my thighs as they spread out when sitting down (1 min.)	Living room	I am so sick of this! I hate myself.

FIGURE 8.4. A body checking monitoring record (patient A).

clothing (e.g., waistbands of pants) and accessories (e.g., watches or rings), and looking down at one's body (e.g., at one's thighs or stomach when sitting). Some patients may also do these things in an unusual way so it is important to ask for details of what is done, how it is done (e.g., looking in the mirror sideways) and for how long. Patients should also record their thoughts and feelings during and after checking. All this should be recorded "live" as far as possible. Male patients tend to be especially concerned about their build and muscularity but less concerned about their weight.

At the next session the therapist should review in detail what has been recorded, asking the patient if the selected days were typical ones to ensure that most forms of checking have been identified. It is common for patients to be shocked at how often they check their shape.

Questioning Shape Checking

Having identified the various forms of body checking, patients should be asked to consider why they check themselves in this way and what the consequences are.

QUESTION 1: *"What are you trying to find out when you check your body? Do you think you can find it out this way?"*

— Most patients have not really considered what they are trying to find out from their shape checking but will have some ideas. They may say that they check their shape in order *"To find out what my shape is like."* If this is the case it is helpful to explain that scrutiny is prone to magnify apparent defects (see page 107). Given this, they are unlikely to be able to discover more about their true shape by repeatedly looking at their body. Education may also need to be provided regarding aspects of shape that are normal (e.g., having a slightly protruding abdomen) as patients may have picked up inaccuracies from media images.

Other patients say that they are checking *"To see if my shape is changing"* (or *"To see if I am getting fat"*). In this case it is helpful to discuss how most forms of body checking do not generate sufficiently reliable quantitative information to detect change. Instead they simply provide an impression about shape. Checking oneself in the mirror is a good example. We cannot with any accuracy compare one "look" say first thing in the morning with another "look" a few hours later because we do not have a photographic memory of the type that would enable us to contrast the first image with the second.

QUESTION 2: *"Why are you checking yourself so frequently? Do you think you might be checking yourself too often?*

— Usually patients have difficulty answering this question and eventually come up with a reply along the lines that *"To check that my shape hasn't changed."* The therapist should respond by asking whether the patient thinks that his or her shape is changing so rapidly as to justify their frequency of body checking (often in the absence of any weight change), which clearly he or she does not. In this way patients can be helped to arrive at the conclusion that it does not make sense to check their shape so often. Occasionally patients express the concern that their abdomen changes in shape through the day. It is helpful to point out that this is an example of a normal fluctuation in shape that is *not* indicative of weight gain nor is it perceptible to others. To illustrate this point,

patients may be asked if they have ever met a friend and noticed that the person has just eaten a large meal. Patients should be told that the only way of determining whether their body is likely to be changing in size is to examine how their weight is changing over time. (See page 63 for guidance on how to interpret weight data.)

QUESTION 3: *"Do you ever look at parts of your body that you like?"*

— Almost invariably the answer is *"No."* This leads naturally to asking patients whether their checking makes them feel better about themselves.

QUESTION 4: *"Do you feel better after checking your body?"*

— Again, almost invariably the answer is *"No."* Occasionally patients (usually those who are underweight) say that it is reassuring to check their body because it reminds them of how "thin" they are. Even if this is the case, they will usually agree that it is unhelpful because it keeps them preoccupied with their shape.

QUESTION 5: *"Do you think your body checking has any adverse effects?"*

— In discussing the patient's answer to this question, the therapist will want to emphasize the following points:

- The shape checking of people with eating problems generally involves the repeated studying of aspects of appearance that are disliked. This is bound to maintain body dissatisfaction as it involves a negatively biased appraisal of one's shape and it keeps concerns about appearance at the front of one's mind (at the expense of thoughts about other aspects of life). Few patients feel better about their appearance after shape checking.
- As with all forms of shape checking, what one discovers depends to a large extent upon how one looks. If one studies in detail certain aspects of one's appearance, apparent "flaws" that would normally go unnoticed become prominent and, once noticed, they are hard to forget or ignore. Even the most attractive person would find flaws if he or she looked for them.
- Scrutiny is prone to magnify apparent defects. For example, people with a phobia of spiders tend to think spiders are larger than they really are. This is because when looking at spiders they tend to focus down on them and their unpleasant characteristics while not looking at the surrounding environment. As a result they have no reference points for scale or size. Another example is what happens when one stares at a blemish on one's skin. The more one looks at it, the more prominent it becomes. In the same way scrutinizing aspects of one's body that one dislikes is prone to make them seem "worse." In short, if you look for fatness, you will find it.

Scrutiny is prone to magnify apparent defects.

"If you look for fatness you will find it."

Addressing Shape Checking

The therapist and patient should then go on to categorize the identified forms of checking into two groups: behavior that is probably best stopped, and behavior that

needs to be adjusted. The strategies used to achieve these goals differ. In addition, the therapist will want to discuss two particularly common forms of shape checking: mirror use and comparison-making.

Examples of behavior that is best stopped include using a tape measure to check the circumference of the thighs; checking that there is a gap between the thighs when standing with the knees placed together; and, when lying down, placing a ruler across the ileac crests (pelvis) to check that the surface of the abdomen does not touch it. Such behavior tends to undermine self-respect and, after a few weeks, stopping it is experienced as a relief. Patients are usually able to do this if the rationale is well explained and they are provided with support. There is generally no need to phase out the behavior.

Other forms of behavior that are worth stopping include pinching parts of the body to assess their "fatness"; repeatedly touching the abdomen, thighs and arms; feeling bones; checking the tightness of rings and watch straps; and looking down when sitting to assess the extent to which one's abdomen bulges out over the waistband of one's pants or the degree to which one's thighs splay out. Generally these forms of behavior have to be phased out. To do so, patients need to become aware of doing them in real time and then learn to question themselves before doing so (i.e. "think first"), the goal being to gain control over the behavior and become better at interpreting what they find. As with reducing the frequency of weight checking in Stage One, the modification of habitual shape checking results in a short-lived increase in preoccupation with thoughts about shape, but this is subsequently followed by a marked reduction in these thoughts and the associated concerns. Some patients are concerned that if they reduce their frequency of body checking, they will not notice themselves getting "fatter" because they will no longer be keeping an eye on their shape. These patients need to appreciate that they have not been getting accurate information from what they have been doing, and that (as discussed above) the only way of determining whether their body is likely to be changing is to examine changes in their weight over time.

For many patients simply recognizing how unhelpful body checking is can be sufficient to help them curb or stop the behavior. However, other patients struggle to do this. In these cases it can be helpful to ask them to identify the situations in which they are most prone to body check (e.g., when undressing, when sitting down, after eating, during an aerobics class) and then help them identify and practice means of resisting the urge to do so (e.g., by undressing away from mirrors).

A different strategy needs to be used with more normative forms of shape checking, such as looking in mirrors.

Addressing Mirror Use

Looking at oneself in the mirror is a particular form of shape checking that has the potential to provide highly credible, but misleading, information about appearance. We all tend to believe what we see in the mirror, yet assessing oneself in the mirror is a far more complex act than is generally realized. To illustrate this point, consider the size of your image when you look at your-

Mirrors have the potential to provide highly credible, but misleading, information about appearance.

self in a full-length mirror. Is its height the same as your true height? If not, what height is it? And what about the width of the image? (To find out the answer, ask a friend to mark the top and bottom of your reflection as you see it on your mirror [when standing back so that you can see your head and feet] and measure how far apart they are. You will find that your image in the mirror is half your size in all dimensions, yet you have probably not noticed this before.) The fact that you have not noticed this remarkable discrepancy should help to persuade you (and your patients) that mirror reflections are not quite what they seem and that a lot of mental processing is involved "behind the scenes."

To a large extent what one "sees" depends upon how one looks. This point is well illustrated by asking patients whether they have ever had the experience of accidentally catching sight of themselves in a reflection (e.g., a shop window). Many will acknowledge that, at first glance, they saw themselves as they really are and that, only once they realized who it was, did they view themselves negatively. In addition, many patients will acknowledge that how they are feeling emotionally seems to influence what they look like in the mirror.

What one sees depends upon how one looks.

Problematic mirror use, especially scrutiny, is likely to play a major role in the maintenance of many patients' body dissatisfaction. The addressing of mirror use is therefore of great importance. As always, the first step is to find out exactly what patients are doing. Below are the key questions to ask:

- How often do you look in the mirror?
- How long do you take?
- What exactly do you do?
- What are you trying to find out?
- Can you find it out this way?
- How many different mirrors do you use?

Patients then need to be educated about mirrors and how to interpret what they "see." The key questions (and answers) are listed below:

QUESTION: *"What are good reasons to look in the mirror?"*

— To check one's hair and clothing.
— Women may need a mirror to apply or remove make-up, and men need a mirror to shave.

QUESTION: *"Is there any other good reason to look in the mirror?"*

— No. For people with an eating problem there are no reasons to look in the mirror other than those listed above.
— Mirrors are "risky" things for people with an eating problem. They are best used judiciously.

QUESTION: *"How many mirrors does one need at home?"*

— One for the face and another full-length one.
— It is best to get rid of the rest unless they are purely decorative. It is difficult to avoid excessive mirror use if there are a large number of mirrors at home.

QUESTION: *"How can one avoid the 'magnification' that comes from scrutiny?"*

— Ensure that one does not focus on body parts that one dislikes. Look at the rest of your body, including more neutral areas (e.g., hands, feet, knees, hair). In addition, look at the background environment as this helps give a sense of scale.

QUESTION: *"Is it ever necessary to study oneself naked in the mirror?"*

— Not really, unless one is going to admire oneself!
— People with eating problems are most unlikely to admire themselves. Rather they are at risk of focusing on disliked parts and scrutinizing them.

As with the other forms of shape checking, patients need to become aware of their mirror use in real time and question themselves before doing it, the goal being that they modify the behavior and become better at interpreting what they find. This is not to say that total avoidance is to be recommended; rather, the advice is (for the meantime) to restrict the use of mirrors to the purposes listed above.

Addressing mirror use takes, at a minimum, several sessions. It can have a remarkable effect, as illustrated by the vignette below.

Vignette

A quotation from a patient whose mirror use had been extreme:

> *"I'm feeling more positive about my appearance generally. It feels quite odd because sometimes I look in the mirror and . . . it's almost like re-recognizing myself. Although I haven't lost any weight or tried to lose any weight, I feel smaller. I don't feel like a tiny person — I just think that I've lost the image I was carrying around in my head . . . that of an overweight person."*

In the context of addressing mirror use, it is worth asking patients whether they have difficulty choosing what to wear if they are going out. Some spend an inordinate amount of time doing this and will try on three or more outfits in front of a mirror. This is typically accompanied by a progressive decrease in mood, increase in shape dissatisfaction and drop in self-confidence (with every outfit). Sometimes it will result in them abandoning the whole enterprise and staying at home. In such cases patients should be advised to choose their outfit before trying it on (e.g., by laying outfits out on the bed) and to commit themselves to the decision. It is also important to encourage patients not to get dressed in front of the mirror.

Addressing Comparison-Making

A particular form of shape checking that actively maintains concerns about shape is making repeated comparisons with other people. This is seen mainly in patients who are of average or low weight. The nature of these comparisons typically results in patients concluding that their body is unattractive relative to that of others.

The general points about body checking also apply to comparison-making, but there are some additional points that need emphasizing. As noted above, patients'

appraisal of their shape often involves scrutiny and selective attention to body parts that are disliked. The scrutiny is liable to result in the magnification of perceived defects and the selective attention increases overall dissatisfaction with shape. In contrast, patients' assessment of other people is very different. They tend to make superficial and often uncritical judgments about them. Furthermore, when making these comparisons they tend to choose biased reference groups composed of people of the same gender and age (or younger) who are thin and good-looking. These people are selected from those they encounter in their day-to-day life and from people in the media (e.g., as seen in magazines, newspapers, television, films, Internet). When making these comparisons they fail to notice others who are less thin and good-looking. Thus the playing field is uneven with there being an inherent bias (unfavorable to the patient) in the way that shape is being assessed and in the subject of the comparison.

There are eight steps involved in addressing comparison-making:

1. *Explain the rationale for doing this.* See above.
2. *Identify when and how the patient makes comparisons.* The monitoring records can be used for this purpose. Information of the following type is needed:

- Who was the subject of the comparison? How were they selected? Were they representative of people of the patient's age and gender, or were they a select and atypical subgroup?
- How was the person assessed? What body parts were the focus of the comparison and how were they evaluated?

3. *Help the patient consider whether the comparison was inherently biased in terms of both the person chosen and how his or her shape was evaluated.* Two points are worth highlighting:

- Comparing oneself with people portrayed in the media is problematic since they are an unusual subgroup and their images may well have been manipulated.
- Most ways of assessing one's body are idiosyncratic: It is difficult, if not impossible, to get the same perspective on someone else's body. For example, looking down at how much one's thighs splay out when sitting down is a view one has only of oneself: One never sees another person's thighs from this vantage point. The same applies to looking in the mirror, feeling one's stomach, touching one's bones, and pinching one's flesh. It is also not possible to study other people in the same amount of detail as one can study oneself.

4. *Design homework tasks to explore any bias in comparison-making.* For example, patients may be asked:

- To be more scientific when choosing someone with whom to compare themselves. Instead of selecting thin people, the therapist may ask them to select every third person (of their age and gender) whom they encounter. What they will discover is that people's bodies vary a great deal and that attractiveness is not directly related to thinness.
- To scrutinize other people's bodies. The goal is to demonstrate the point that *"What you see depends (to an extent) upon how you look."* One way of doing this is for the patient to go to a changing room (e.g., of a swimming pool or gym), select someone nearby of about the same age who is reasonably attractive, and

then (unobtrusively) scrutinize his or her body focusing exclusively on the parts that the patient is most sensitive about. The longer the scrutiny, the better. What patients will discover is that even attractive people have apparent flaws, be they dimpled thighs or buttocks ("cellulite"), a protruding stomach, or wobbling flesh.

5. *Explore the implications of any detected bias* in terms of the validity of the patient's views about his or her appearance relative to others. The goal is that patients become aware in real-time that their comparison-making is yielding misleading information about other peoples' bodies in relation to their own.

6. *Discuss how patients are comparing themselves with others in terms of a single domain (i.e., appearance)* rather than personality, intelligence, aptitudes, etc. It may be worth considering why the patient neglects these attributes, possibly in the context of the historical review (see page 117). The distinction between appearance and attractiveness should also be explored (see page 166).

7. *Explore the consequences of the comparison-making.* For example, does the patient consider this to be a good use of his or her time and helpful in terms of getting over the eating disorder? Also, spending a significant amount of time looking at other peoples' bodies (either in person or in the media) is likely to maintain preoccupation with shape and weight. In addition, it encourages the marginalization of other aspects of life. Some forms of this behavior are best stopped altogether (e.g., looking at pro-anorexia websites) or stopped for the meantime (e.g., buying fashion magazines; watching fashion TV channels).

8. *Modify comparison-making.* The goal is to reduce its frequency, heighten real-time awareness of any inherent bias, and broaden patients' focus of attention so that when they look at other people, they do not focus exclusively on their shape but also observe shape-neutral features (e.g., the person's hair and shoes) and other characteristics (e.g., the person's behavior, sense of humor). A further goal is to heighten awareness of the diversity of people's shapes.

Generally addressing comparison-making is relatively straightforward. One complication that can crop up stems from patients comparing their shape with that of the therapist. This does not occur if the therapist is older than the patient or of the opposite gender, but it does happen if the patient and therapist are the same gender and similar in age. Such comparison-making tends not to be mentioned, but it may be observable from the way that the patient looks at the therapist. Occasionally it is spoken out loud. For example, a patient said to one of us, *"It is not appropriate for you to tell me to gain weight when you are underweight yourself."* After giving the matter careful thought, the therapist decided to disclose her BMI, which was about 22, whereas the patient had thought it was below 18. (See page 29 for a discussion of the body shape of therapists.)

Addressing Shape Avoidance

Shape avoidance can be profoundly impairing. As well as maintaining dissatisfaction with shape (through assumptions not being challenged), it may result in patients not being able to socialize or be physically intimate with their partner, and in not being able to go swimming, use public changing rooms, or buy new clothes.

"Exposure" in its technical and literal sense is the strategy here. Patients need to get

used to the sight and feel of their body and to learn to make even-handed comparisons with the bodies of others. They need to get used to others seeing their body too. Dressing and undressing in the dark will need to be stopped; they will need to be able to use mirrors (following the guidelines above); and they will need to abandon wearing baggy, formless clothes. Participation in activities that involve a degree of body exposure can be helpful too, for example, swimming. Other activities that require body awareness and acceptance are of value, including applying body lotion (see the following vignette; one patient referred to this as "positive touching"), having a massage and yoga.

Vignette

A patient was unable to touch or look at any part of her body. Her avoidance was so extreme that she could not properly wash herself.

The therapist and patient decided that she would start to address the problem by beginning to wash an area of her body that she felt was just about "bearable." At first she was only able to do this with a sponge. Gradually she was able to wash her entire body with a sponge. Then she was encouraged to use her hands. When she felt that she could fully wash herself, she moved on to applying body lotion in a "conscious" way, saying out loud the name of each body part and looking at it. Over a few months the patient became more comfortable touching and seeing her body. She came to realize that it was nothing like she had imagined it.

Depending upon the extent of the problem, tackling body avoidance may take many successive sessions. As there is a risk that patients will switch over to repeated body checking, they need help establishing normative forms and levels of body checking.

Addressing "Feeling Fat"

"Feeling fat" is an experience reported by many women, but the intensity and frequency of this feeling appear to be far greater among people with eating disorders. Feeling fat is an important target for treatment since it tends to be equated with being fat, whatever the patient's true shape or weight. Hence feeling fat is not only an expression of over-concern with shape and weight but it also maintains it. It is important to stress that some people with obesity have this experience too, but many do not despite being dissatisfied with their shape. (See Cooper, Fairburn, & Hawker [2003] for detailed information on addressing the shape concerns of people with obesity.) Whatever the patient's BMI, feeling fat should be addressed if it is a prominent feature.

Feeling fat tends to be equated with being fat.

There has been very little research on feeling fat: Indeed, remarkably little has been written about it. What is noteworthy is that the experience fluctuates in intensity from day to day and even within a day. This is quite unlike most other aspects of the core psychopathology (including body dissatisfaction), which tend to be relatively stable as is

In patients with eating disorders feeling fat is often the result of mislabeling of certain emotions and bodily experiences.

body weight and true "fatness." It is our view that in patients with eating disorders feeling fat is often the result of the mislabeling of certain emotions and bodily experiences. Why this occurs is not clear, but it could be a consequence of these patients' longstanding and profound preoccupation with shape.

In general the addressing of feeling fat is best left until inroads have been made into shape checking and avoidance, but this is not invariably the right strategy. With patients in whom feeling fat is particularly prominent or distressing, the therapist should reverse the order and address it first.

There are six steps in addressing feeling fat:

1. *Establish whether patients feel fat at times* (explaining that one is not talking about whether they believe they *are* objectively fat, but whether they *feel* fat) and ask whether this is a problem. It is almost invariably seen as such. Explain that it would be useful to learn more about their experience of feeling fat. To encourage their curiosity it can be helpful to highlight the fact that the term is "feeling" fat, although obviously "fat" is not an emotion.

2. *Educate patients about feeling fat*. It should be stressed that the experience of feeling fat may be masking other feelings or sensations that are occurring at the same time, and that it is important not to equate feeling fat with being fat (i.e., the shape of one's body) as the two are quite different. Even very thin people can feel fat while many people who are objectively overweight do not feel fat — although they may well say that they are "fat" and are dissatisfied with their weight (i.e., they do not have fluctuating feeling of fatness). Patients should be asked whether there are times when they have particularly intense feelings of fatness and other times when they are less aware of feeling fat. If this is the case (which is likely), the therapist should point out that while feelings of fatness fluctuate from day to day and within each day, one's body shape barely changes within such a short time frame. (It can be useful to illustrate this point with a simple schematic diagram; see Figure 8.5.) Therefore something else must be responsible for the fluctuations in the feelings of fatness.

3. *Ask patients to monitor when they have particularly intense feelings of fatness.* Asking them to monitor every time they feel fat does not work as the feeling tends to be ever present in the background. This monitoring of intense feelings of fatness can be done as part of the normal recording process with the right-hand column of the monitoring record being used for the purpose. When patients record feeling fat, they should also think (and record) what else they are feeling at the time. They should ask themselves questions such as *"How am I feeling mentally and physically? Has something just happened that might have triggered this feeling?"*

4. *In the next session, review each occurrence of feeling fat in terms of the context in which it occurred and the presence of any possible masked feelings or sensations.* Over the following week patients should be asked to record in greater detail the context in which subsequent feelings of fatness occur, the goal being to improve their identification of masked feelings and their triggers.

By the following session it should be clear that the patient's experience of feeling fat tends to be triggered either:

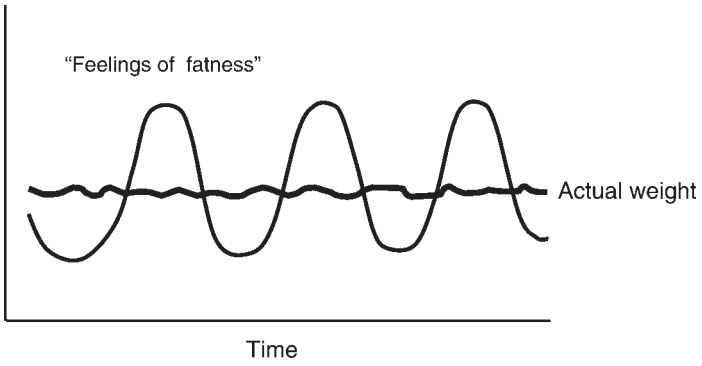

FIGURE 8.5. A schematic diagram illustrating fluctuating "feelings of fatness."

i. by the occurrence of certain negative mood states, or
ii. by forms of behavior or physical sensations that heighten body awareness.

Examples of these types of stimulus include:

- Feeling bored, depressed, lonely or hungover
- Body checking and comparison-making
- Feeling full, bloated, hot or sweaty; feeling one's stomach bulge over one's pants; feeling one's body wobble or thighs rub together; feeling that clothes are tight.

Note that these are normal body sensations that are heightened under certain circumstances.

5. *Thereafter patients should practice:*
   i. Identifying when they have intense feelings of fatness.
   ii. Asking themselves the question *"What am I* really *feeling right now, and why?"* In this way common triggers may be identified and noted down on the monitoring record.
   iii. Addressing the triggers, generally using the problem-solving approach described in Chapter 10.

Vignette

A patient tended to feel fat if she felt full when eating out with friends. It emerged that she thought that after eating her stomach protruded to such an extent that it was visible to others. The therapist suggested that she try sticking out her stomach on purpose and, after a while, ask her friends if they had noticed anything unusual. It emerged that they hadn't.

6. *With regard to body sensations, therapists should help patients appreciate that the problem is their negative interpretation of these sensations, rather than the sensations per se.* It can be help-

ful to ask patients to record in real time the occurrence of these sensations and practice re-labeling them correctly. (See also "Feeling Full," page 85.)

Vignette

A patient reported profound feelings of fatness (and revulsion) during a journey on the London Underground. The therapist and patient concluded that it might have been either due to the patient's body wobbling or it being extremely hot. The patient was asked to monitor her subsequent feelings of fatness and the circumstances under which they arose. It emerged that they occurred when she was hot. In hot weather she became more aware of her body, and the heightened body awareness led her to feel fat. It was agreed that it was important for her to correctly identify triggers for feeling fat, and that feeling fat should not be viewed as being indicative of *being* fat; rather, it suggested that she was too hot. This reinterpretation of the experience proved to be a turning point in her treatment.

Addressing "feeling fat" often takes many successive weeks and, once begun, it needs to be a recurring item on the session agenda. Generally the frequency and intensity of "feeling fat" progressively declines and patients' "relationship" to the experience changes such that it is no longer equated with being fat. This change is important since once it has happened "feeling fat" tends to lose its significance and as a result no longer maintains the patient's shape concerns.

Vignette

Below is a quote from a patient describing a change in her "relationship" to feeling fat:

> *"It's as if I suddenly saw the absurdity and ridiculousness of it all. It's not as if the thoughts have gone away, but I find I simply don't engage with them anymore. It's as if I can suddenly see myself as I am, and I'm not fat. It's as if feeling fat has suddenly evaporated. So I am laughing at these feeling fat moments, and not feeling fat. Something's really shifted."*

Effects of These and Other Cognitive Behavioral Interventions

This complex set of inter-related and complementary strategies and procedures results in the progressive erosion of the main expressions of the over-evaluation of shape (i.e., shape checking, shape avoidance and feeling fat) and weight (i.e., weight checking and avoidance). By removing their reinforcing effect on the core psychopathology (i.e., the feedback pathways shown in Figure 8.3) this in turn has a gradual but profound impact on the core psychopathology, an effect that continues even after treatment has ended. This effect is augmented by the increase in the importance of other domains of life, by

the addressing of dietary restraint and restriction (see Chapters 9 and 11 respectively), and by tackling event-related changes in eating (see Chapter 10).

It is most important that therapists appreciate that the effects of these interventions take time to be fully expressed.

It is most important that therapists appreciate that the effects of these interventions take time to be fully expressed. As part of our research we follow patients over time, and doing so has made it clear that the over-evaluation of shape and weight slowly, but progressively, declines over 6–9 months post-treatment so long as patients continue to *"Do the right thing"*; that is, continue to behave in line with the ways identified during treatment (and specified in their maintenance plan; see Chapter 12). It is as if the mind needs time to catch up with the change in the patient's behavior and adjust to its implications. Therapists can say to patients *"If you continue to 'Do the right thing', your thinking will slowly catch up."*

As always in CBT-E, this work is supplemented with generic cognitive behavioral interventions (such as the addressing of prominent cognitive biases). Later in Stage Three two additional strategies complement this work:

1. Exploring the origins of the over-evaluation
2. Learning to control the eating disorder mindset

Exploring the Origins of Over-Evaluation

Toward the end of treatment it is helpful to explore the origins of the patient's sensitivity to shape, weight and eating. This can help make sense of how the eating problem developed and evolved. In addition, it can highlight how it might have served a useful function in its early stages and the fact that it may no longer do so.

To help patients review the past (termed in CBT-E the "historical review"), they should be asked to consider four periods in their life:

1. Prior to the onset of the eating disorder (which may be defined as their life up to 12 months before the onset of sustained attempts to restrict eating or the regular occurrence of binge eating or purging)
2. The 12 months immediately prior to its onset
3. The 12 months after its onset
4. Since then

Within each time period patients should consider whether any events or circumstances might have sensitized them to their shape, weight or eating, or reinforced existing concerns. These may then be tabulated in a life chart (see Figure 8.6). In this way hypotheses can be built up about why the eating problem developed and evolved in the way that it did. Typically the events in the first period are of a type that might increase the salience of shape, weight and eating, whereas those in the second (the 12 months leading to the onset) tend to be disruptive triggers but non-specific in nature. Often the patient will have been unhappy and may have had difficulty adjusting to a change in circumstances (e.g., moving from one city to another and changing school; parental separation or death). The third period, if it was characterized by dieting, is often described in posi-

Time period	Events and circumstances (that might have sensitized me to my shape, weight and eating)
Before onset of eating problem (up to age 16)	• *Mother very anxious about eating throughout my childhood* • *A bit overweight age 9* • *Always have been on the tall side and a bit clumsy (have felt too "big")* • *Friend developed anorexia; slightly jealous*
The 12 months before onset (when I was 16)	• *Moved to new city and house* • *New school* • *Unhappy; no friends*
The 12 months after onset (when I was 17)	• *Started to cut back on my eating* • *Felt good and in control* • *Fights with my mom* • *Lost weight rapidly for a while*
Since then (17 – 26)	• *Started purging (18)* • *Binge eating (18/19)* • *Went to college (19)* • *Regained weight (19); out of control; awful* • *Eating problem just as it is now (20 to present)* • *Dropped out of college (23)* • *Psychotherapy and antidepressants (24)*

FIGURE 8.6. A life chart (patient A).

tive terms and frequently there is reference to having felt "in control." The fourth period is generally the one during which the eating disorder became self-perpetuating and the processes outlined in the formulation began to operate. It is at this point that the eating disorder became more or less autonomous.

Very occasionally specific events are identified that appear to have played a critical role in sensitizing patients. Commonly these involve patients having been humiliated about their appearance. In these instances the therapist should help the patient re-appraise the critical event from the vantage point of the present.

This review of the past needs to be done sensitively and under the guidance of the therapist. It is best if it takes place in-session as a major item on one session agenda, and is followed up with a detailed review at the next session. Between the two sessions patients should be asked to think over what has been discussed.

Obviously it would be naïve to assume that the factors and processes identified in the historical review necessarily operated in the way specified or could constitute anything like a full explanation for the eating disorder. Nevertheless, reviewing the past in this way seems to benefit patients, and particularly so in the later stages of treatment when they can see that their eating problem is beginning to die away. It serves to distance them still further from the problem; it tends to enhance their understanding of the processes currently operating; and it has a valuable "depathologizing" function.

Learning to Control the Eating Disorder Mindset

> The task of psychological treatments is to change the "mind" that gets automatically switched on by particular contexts, and, ultimately, to give individuals, themselves, greater control over the switching in and out of different minds-in-place. (Teasdale, 1997, p. 91)

The core psychopathology of eating disorders may be viewed as a "mindset" or a frame of mind that has multiple effects. For example:

- It leads patients to filter external and internal stimuli in a distinctive way (e.g., preferentially noticing thin people; interpreting clothing being tight as evidence of fatness).
- It results in the characteristic forms of behavior seen in people with eating disorders (e.g., rigid and extreme dietary restraint; self-induced vomiting; laxative misuse; driven exercising).
- It results in the mislabeling of various physical and emotional experiences as "feeling fat."

The core psychopathology of eating disorders may be viewed as a "mindset" or a frame of mind.

These consequences of the eating disorder mindset tend to reinforce it through the mechanisms described in the composite transdiagnostic cognitive behavioral formulation (see Figure 5.1, page 53) and in its extended form (see Figure 8.3, page 101). As a result the mindset becomes locked in place. Similar processes appear to occur in depression:

> Normally, the mind-in-place changes over time, old minds being "wheeled out" and new minds being "wheeled in" as circumstances change. In contrast, in mood disorders, such as depression, patients seem to get stuck in one mind, so that their thinking seems to be dominated by a limited number of recurring themes. (Teasdale, 1997, p. 101)

The cognitive behavioral strategies used in CBT-E are designed to address the key features of the eating disorder and the processes that are maintaining them. As a result the mechanisms that have been holding the eating disorder mindset in place are gradually eroded. This has the effect of allowing healthier and more situationally appropriate mindsets to move into its place. At first this happens only transitorily, but as the maintaining mechanisms are further eroded it happens more and more often. In patients who are making good progress such shifts in mindset typically become evident in the last third of treatment. The first signs are often reported spontaneously: For example, patients may describe (sometimes with surprise) that they were not preoccupied with food and eating on one particular day; that they were able to eat out with no difficulty; that they could watch a film without worrying about what they had eaten; or that they went out without worrying about their appearance. Such reports are evidence that the mindset is slipping out of place.

It is at this point that patients should learn about mindsets and how to control them. When introducing the topic, an analogy that we find useful is to compare the mind to a DVD player, saying something along these lines:

"Think of your mind as a DVD player and that it has a variety of DVDs that it can play. It can play one titled 'Work' and when playing it you will be in a work frame of mind. You will be seeing the world from that perspective and will be thinking mainly about work-related matters. You will have other DVDs too . . . we all have. You will have a 'Friends' one for when you are with your friends, and it will process information quite differently. You will have a 'Parents' one that will come into place when you are with your parents, and again it will result in your thinking differently and behaving differently too. We all have a range of DVDs to suit different occasions. All this is perfectly normal.

"The trouble is that if one has an eating problem one also has an 'eating disorder' DVD and, unlike the others, once it has fully developed it tends to get locked into place so that it keeps playing whatever the circumstances. As a result, wherever you are, you think eating disorder thoughts and you engage in eating disorder behavior (e.g., body checking, avoiding eating). With effort you can force the right mind (or DVD) into place to suit the circumstances (e.g., the 'Work' one when trying to work), but the eating disorder one is liable to keep popping back and displacing it. Does this account of things fit your experience in any way?"

Most patients relate to this type of explanation: It matches their experience. This is especially so in the later stages of treatment when their eating disorder mindset is less firmly in place and as a result is liable to be displaced at times. Indeed, this possibility may be raised along these lines:

"In the later stages of treatment, once the main things that have been keeping the eating problem going have been disrupted, most people notice that there are times when they are not 'playing' their eating disorder DVD . . . that they are able to focus on other things; that they are not thinking eating disorder thoughts; that they are (for a while) not doing eating disorder things. Are you experiencing anything like this?"

Another rather easier way to raise the topic is to capitalize on a recent setback if there has been one. For example, a patient may have had an episode of binge eating after a gap of a few weeks. Typically the binge will have activated the eating disorder mindset and put it firmly back in place. In fact, it is likely that the "DVD" was activated a day or so prior to the binge (perhaps by an adverse shape-related event) resulting in the patient's resumption of rigid dieting and so becoming vulnerable to binge eat. Patients notice setbacks of this type and can see the contrast between the period prior to the setback, when their eating disorder DVD was not in place, and their state during the setback, which they often experience as being *"Back to square one."* At these times their DVD will be "playing" just as it did prior to treatment.

Having introduced the topic of minds-in-place, the therapist should explain that now their eating disorder mindset (DVD) is no longer locked in place by the eating disorder maintaining mechanisms, they are in a position to influence whether or not they play it. More specifically, they can learn:

1. To identify stimuli that are likely to put the eating disorder mindset or DVD back in place
2. To recognize the first signs that their eating disorder mindset is coming back into place (i.e., to recognize the first "track" of the eating disorder DVD)
3. To displace the mindset (i.e., press the "eject" button)

It is not possible for patients to do these things early in treatment, as at that point their eating disorder mindset is firmly locked in place and they have no other state with which to contrast it.

Identifying Stimuli That Put the Mindset Back in Place

At first, when patients have only recently begun to experience periods when they are not "playing" their eating disorder DVD, they are vulnerable to have it triggered by a wide variety of stimuli. These tend to be of the following nature:

- Shape or weight-related events (especially those that are adverse)
  — E.g., an increase or decrease in weight; an apparent increase in "fatness" (e.g., due to clothing feeling tight or mirror scrutiny); feeling fat; critical comments from others
- Adverse eating-related events
  — E.g., breaking a dietary rule (e.g., eating an avoided food, exceeding a calorie limit); binge eating; feeling full
- Other personally salient adverse events
  — Negative events in general, especially those that threaten self-esteem
- Persistent negative mood states
  — These may be secondary to adverse circumstances or an expression of a clinical depression

This propensity of the eating disorder mindset to be reactivated should be discussed with patients. They can be assured that their mindset will become less likely to be triggered the longer it has not been "in place" (i.e., the eating disorder DVD will move down their stack of DVDs and become less accessible), but for the meantime they are at risk. It is therefore useful for them to learn what types of stimuli are most likely to serve as triggers and to be on the lookout for them in real time. Such in-the-moment awareness can be sufficient to inoculate them against the influence of these stimuli, although it can be supplemented with help countering them (e.g., help reinterpreting feeling fat or feeling full).

Recognizing the Mindset Coming Back into Place

However good the patient is at identifying potential triggers of his or her eating disorder mindset, there will invariably be circumstances when it comes back into place. Once this happens the eating disorder becomes activated and the patient starts to have eating disorder thoughts and feelings and begins to engage in eating disorder behavior. Within a day or two, eating disorder maintaining mechanisms will start to lock the mindset in place, and as time passes it will become progressively more difficult for the patient to dislodge it.

Therefore patients need to learn to spot the eating disorder mindset coming into place, and the earlier this can be done the easier it is to displace. Essentially they need to recognize what comes up on the "screen" when they start to play their eating disorder DVD. In the case of disorders such as depression, this is difficult because the initial

changes are not readily observed. The case of eating disorders is quite different because these patients' behavior changes quickly and in distinctive and recognizable ways.

It is the therapist's task to help patients identify these early changes (their so-called "relapse signature") and to recognize that such changes are early warning signs of their eating disorder mindset coming back into place. One good way of doing this is to review the details of a recent setback.

Vignette

A patient reported a recurrence of binge eating after a break of some weeks. The therapist reviewed in detail the context in which this occurred. It emerged that the morning before the setback began the patient had an extended shape-related conversation with an old friend. After this she ate a very small lunch, spent twice the normal time in the gym and engaged in some old forms of body checking while there. She omitted her afternoon snack, ate an evening meal of diet food and had no evening snack. As a result she was set up to binge the following day.

By going over this course of events in some detail the therapist and patient decided that future early warning signs were likely to be a change in her food choice, skipping snacks, an increase in her exercising and reversion to old forms of body checking.

Displacing the Mindset

As noted above, displacing the eating disorder mindset is relatively straightforward if it is done soon after it has been activated, but it becomes progressively more difficult as more maintaining mechanisms start to operate and begin to lock it in. In principle, the patient needs to do two things:

1. *"Do the right thing"* (generally the opposite of the behavior driven by the eating disorder mindset).
2. Engage in distracting interpersonal activities.

"*Do the right thing"* refers to following what has been learned in treatment about overcoming the eating disorder. In the case of the patient described in the vignette, if she had recognized her eating disorder mindset while at the gym (by this time she had changed her food choice, reverted to old forms of body checking, and increased her exercising), she could have paid particular attention over the following few days to sticking to a pattern of regular eating (i.e., not skipping the afternoon and evening snacks), eating an evening meal not composed of diet food, and avoiding problematic forms of body checking. This would have prevented the eating disorder maintaining mechanisms from starting to operate.

At the same time patients should seek out ways of getting involved in activities that are engaging and likely to displace the eating disorder mindset. The best activities are interpersonal in nature. They might include arranging to see a friend, going out to a party, or having someone round. Doing this is likely to be difficult as it may well run

counter to what the patient feels like doing, but it is important if the mindset is to be firmly dislodged.

Practicing spotting the mindset coming back into place and dealing with it effectively is of great value: it is less useful to simply think about these things in the abstract. It is therefore helpful if patients experience occasional setbacks later in treatment as this gives them an opportunity to utilize these strategies and procedures and subsequently review their efforts with the therapist.

Recommended Reading

Recommended reading for Chapters 5–12 can be found at the end of Chapter 12.

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