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Cognitive Behavior Therapy for Adolescents with Eating Disorders.
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CHAPTER 12

Body Image Module

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The overvaluation 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—is the distinctive "core" psychopathology of most eating disorders. Indeed, as described in Chapter 2, most other expressions of eating disorders appear to derive directly or indirectly from this psychopathology, and for this reason it occupies a central place in most patients' formulation and is one of the most important targets of treatment; unless it is successfully addressed, patients are at considerable risk of relapse (Fairburn, Cooper, Shafran, Bohn, Hawker, et al., 2008). Overvaluation of shape and weight should be differentiated from body dissatisfaction, as the former is more closely associated with self-esteem than the latter, and better distinguishes individuals with eating disorders from those without. Note, however, that in some younger patients, the core psychopathology is the overvaluation of control over eating per se, rather than a desire to control eating with the aim of influencing shape and weight. The strategies and procedures for addressing the overvaluation of control over eating are described in Chapter 13, but follow principles similar to those described here.

Addressing this psychopathology takes time; change is gradual, although more rapid than in adults. Therefore, in patients who are not underweight, it is best to start this work early in Step Two. Once this has begun, it should remain a permanent item on the session agenda. In underweight patients, however, the Body Image module is usually implemented when they regain a certain amount of weight and manifest concerns about shape and weight hindering weight restoration.

The strategies for addressing concerns about body image are as follows:

1. Identifying the overvaluation and its consequences.
2. Creating the extended personal formulation.
3. Enhancing the importance of other domains of self-evaluation.

4. Addressing shape checking and avoidance. Weight checking and avoidance were addressed in Step One.
5. Addressing "feeling fat."

Generally, these elements are introduced in this order, but at which point in the treatment each is introduced will need to be decided case by case. In some patients, they are introduced early on in Step Two, as some expressions of body image (e.g., shape checking) may be enhancing body dissatisfaction, thereby hindering weight regain. In other patients, the Body Image module will be introduced when patients are getting close to their low healthy weight threshold and their body shape has changed accordingly. In patients who are not underweight, on the other hand, the Body Image module is introduced early on, as its procedures take time to implement and have an effect.

IDENTIFYING OVERVALUATION AND ITS CONSEQUENCES

In our clinical experience, adolescent patients welcome discussion of self-evaluation. With the use of age-appropriate words and a pie chart (to illustrate their individual self-evaluation system), most adolescents are able to understand this complex and abstract topic.

The therapist should start the discussion by explaining that most people tend to evaluate themselves on the basis of the success they achieve in areas of life that they consider important. In adolescents, common self-evaluation domains are relationships with family members and friends, and achievements at school, in sports, and in other activities. The therapist should explain, for example, that if people give a lot of importance to the school domain, they feel good when they get a high grade, but feel bad when they get a low grade. Then, if they assign importance to their relationships with others, they feel good when they are appreciated, sought out, and involved in activities by peers, but feel sad or frustrated when they receive criticism or perceive disinterest by others.

The therapist should also explain that people have many domains by which they judge themselves, but not all the domains are ascribed the same importance. Patients should also be helped to discriminate between domains that they regard as important because they are generally thought to be so (e.g., grades) but do not in fact influence how they judge themselves, and the things that really impact their self-worth. To this end, the therapist should explain that if a young person feels bad for a long time when an aspect of her or his life is not going well, it is likely that this is an important self-evaluation domain. For instance, if people evaluate themselves on the basis of the grades they get at school, it is probable that, when they get a grade that does not meet their expectations, they tend to have a strong and lasting negative emotional reaction and, if the failure persists, may develop a negative self-image.

The therapist, after having checked that patients have clearly understood this concept, encourages them to come up with a written list of the things that could affect them in this way (i.e., their important self-evaluation domains). At this stage, patients may even omit shape, weight, and their control from the list, and it will be the therapist's job to bring this up. A dialogue to illustrate how this may be approached follows:

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THERAPIST: Well, I see you've included school, family, and friends, and a romantic relationship on the list. Do you think that anything might be missing?

Patient: No, they are all there . . . I can't think of other important areas in my life.

THERAPIST: Let's try to think about it together, analyzing the reason you're here and the work we're doing together. Why did you decide to start the treatment?

PATIENT: Umm . . . because I want to get rid of all my fears . . . I want to be free to live life as I wish and not be conditioned by a fear of weight gain, the shape of my body, or what I can or can't eat.

THERAPIST: I see. Why are you so scared of your weight or the shape of your body changing? Let's have a look at your formulation to better understand it. Do you remember? We talked about it together.

PATIENT: Yes, I remember. I'm afraid because for me my weight and the shape of my body are so very important . . . they have become more important than all the other things in my life.

THERAPIST: That's right! So, don't you think that we should add this to the list you wrote?

PATIENT: Yes, you are right. I have to add my weight and body shape. I don't know why I did not think of it before. Actually, I took it for granted; they are the most important things in my life.

THERAPIST: OK, then let's add that to the list.

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The next stage of the process is to collaboratively generate a pie chart illustrating the relative importance that patients give to their individual self-evaluation domains. To this end, the therapist should refer to the list and inquire which they consider more and less important. They should be asked how badly they would feel (in terms of intensity and duration) if things were to go badly in each domain. This enables the various items to be ranked, but bear in mind that it is important to establish how patients really judge themselves, rather than an indication of how they think they should do so.

Once the items have been ranked, the therapist and patient can draw a provisional pie chart to illustrate their self-evaluation scheme. The size of each slice of the "pie" will represent the relative importance that patients give to each domain. In Figure 12.1, an example of a pie chart produced by an adolescent patient with an eating disorder is shown on the left, while one produced by an adolescent without an eating disorder is shown on the right. Before wrapping up, the therapist should ask patients what they think about the pie chart they have made. Most adolescents readily identify with it, as it provides them with a clear understanding of what is going on. In fact, they also often state that they give too much importance to shape, weight, and eating control without any prompting.

Then, it is time to assign the homework. Patients should be asked to have a look at their pie chart each day, and to think about whether or not it accurately represents how they actually think and behave day to day. It may be helpful to suggest that they

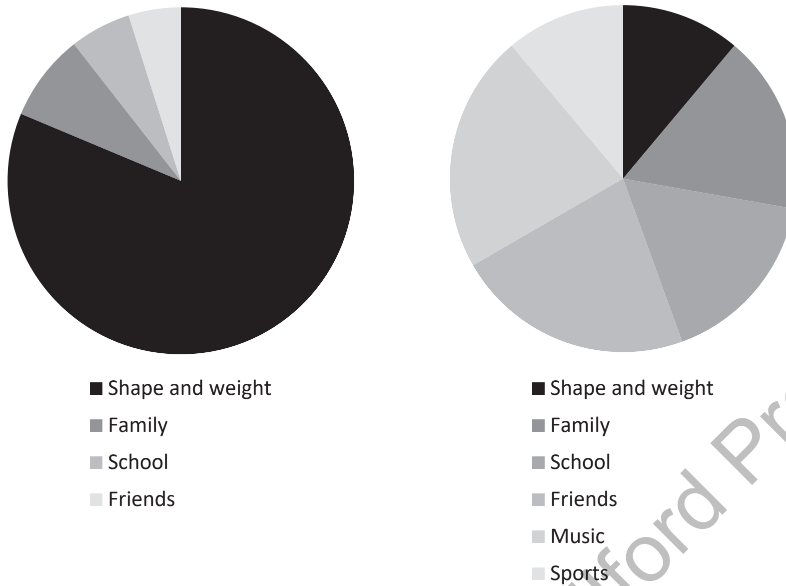

FIGURE 12.1. An example of a pie chart of an adolescent patient with an eating disorder (on the left) and one without an eating disorder (on the right).

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produce a new pie chart every evening (on the back of the day's monitoring record). Some adolescents are creative in doing this homework (e.g., they may use different colors for the various slices of the pie). The first pie chart should be discussed further at the next session, and a new one drawn so that the size of the slices represent their importance as perceived by the patients after their week of reflection. It is common at this stage for patients to increase the size of the slice representing the importance they give to shape, weight, and eating.

The next step is for patients to consider the implications of how they judge themselves, using their pie chart as a reference. They should be encouraged to think about whether this type of self-evaluation scheme may be problematic. In the ensuing discussion, patients should be helped to identify the unwanted effects of evaluating themselves in such a manner. These are usually as follows:

- *Having a pie chart with a dominant slice is "risky."* The therapist, while actively involving the patient in the discussion, should emphasize that a self-evaluation system of this type works well, as long as things are going well. However, when something begins to slip, it inevitably produces a negative self-evaluation. Using the pie chart as a reference, the therapist reflects with the patient that when something goes wrong in the control of shape and weight, as this is the principal domain, this will inevitably lead to the whole system of self-evaluation collapsing. The end result is for patients to judge themselves negatively overall, as the other domains are too small to make up for perceived failure in this one. In other words, "It's like putting all your eggs in one basket."

- *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. Success in this area of life may be difficult to achieve, and it is problematic for several reasons.

"Your shape, weight, and eating are not fully under your control. We only have a limited ability to control our eating (and hence our shape and weight), as it is under strong physiological control. You can manipulate it in the short term but to do so on a long-term basis requires considerable and sustained effort, and you pay a price as a result. Similarly, your overall body shape or physique is only partially under your influence. It is mainly something you just have to accept.

"There will always be other people who seem more attractive (i.e., successful in your eyes) than you. Both the way people with eating disorders judge themselves and the way they compare themselves with others make them see themselves as unattractive. We discuss these topics later on, but for the moment it is important that you understand that as a result of these two processes you are likely to repeatedly feel that you are failing."

- *Judging oneself in this way leads a person to do things that harm her or him.* The therapist should list appropriate examples, such as undereating, excessive exercising, binge eating, self-induced vomiting, and so on. Such behavior thereby maintains the eating problem and interferes with day-to-day life. The therapist may highlight the main sources of impairment detected on the CIA questionnaire completed at the end of Step One.

- *Excessive focus on one dominant slice of the pie makes it difficult to have a well-rounded, happy life and is self-perpetuating.* Being concerned almost exclusively with shape, weight, and eating control marginalizes other areas of life, reducing the interests of the individual to her or his body alone. The therapist should therefore emphasize how, in this way, the commitment that could be dedicated to other important areas of life (e.g., relationships, school, hobbies) and those that contribute to developing a functional, stable, and well-rounded self-evaluation system, is inevitably limited.

During the course of the treatment, the therapist should ask patients to periodically redraw their pie chart to assess their progress in terms of self-evaluation.

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CREATING THE EXTENDED PERSONAL FORMULATION

After the above discussion, it is only natural to progress to the creation of an *extended* formulation—that is, a personal formulation that illustrates the consequences of the patient's individual type of overvaluation, in addition to the behaviors already included in the provisional formulation. The therapist starts this process by asking patients what they do or experience as a result of the importance they place on shape, weight, and eating control. The goal is to create a diagram that will permit identification of the key mechanisms maintaining their overvaluation of shape, weight, and/or eating control to address as part of the treatment. The following is a session transcript in which the therapist begins to create the extended personal formulation with the patient:

THERAPIST: Now that we have created your pie chart and evaluated its implications, let's try to understand together what its expressions are, and how these reinforce your eating problem. In your opinion, how does this self-evaluation system affect your daily life? Is there anything that makes you see that shape, weight, and their control are extremely important to you?

PATIENT: Certainly! The fact that controlling my body has become more important to me than my school grades, and even if I don't concentrate and pay less attention in class, it is not that important to me now. Also, I don't accept invitations from friends to eat out or go to a party anymore, for fear of eating certain foods or, in any case, more than usual.

THERAPIST: I see! This is an expression of the pie chart that we can call "marginalization of other areas of life." (*Draws an arrow under "excessive importance of shape, weight, and their control in my self-evaluation" and writes "marginalization of other areas of life."*)

PATIENT: OK.

THERAPIST: Now we also have to consider that this marginalization, in turn, tends to maintain the overvaluation. (*Draws an arrow from "marginalization of other areas of life" to "excessive importance of shape, weight, and their control in my self-evaluation."*)

PATIENT: That is what we said when we discussed the pie chart. The less importance I give to the other areas of my life, the more attention I pay to controlling my shape and weight.

THERAPIST: Very good. This explains why it will be important for you to increase the number and relative importance of the other areas of your life. However, now let's try to think of other expressions of overvaluation. Are there, in your opinion, any behaviors you do, excluding dieting, that express the importance you give to the control of your shape and weight?

PATIENT: Umm . . . I look at myself in the mirror all the time and I often look at the thighs of my classmates, which are so thin. Could these be some expressions?

THERAPIST: Yes, that's right. This behavior, which we call shape checking, is a typical expression of the importance that you give to the shape of your body. We can write "shape checking" under "overvaluation of shape, weight, and their control." If you don't mind, I would also like to give you a brief outline of how shape checking maintains the overvaluation. We can discuss this topic in more detail later on if you would like.

PATIENT: OK. I am interested.

THERAPIST: Good. In general, when people think that controlling their shape is unduly important, they tend to do some distinctive forms of shape checking. Typically, they focus their attention on the parts of their body that they don't like, and by doing so, they tend to amplify their perceived defects and concerns about body shape. Moreover, by comparing their body shape with that of others, as you also often do, in particular, if it is done rapidly and superficially, tends to confirm the belief that some body parts are "wrong"

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and need to be changed. Many people who place a lot of importance on body shape tend to compare themselves only with skinny people or those with skinny thighs, which leads them to conclude that they are "fat" and their thighs are enormous. The result is an increase in concerns about body shape.

The therapist continues this discussion, trying to identify all of the expressions of the overvaluation of shape, weight, and their control, and explains the various maintenance mechanisms involved. At the same time, the therapist draws the patient's extended personal formulation on a sheet of paper (see Figure 12.2).

Two-Prong Strategy for Addressing Overvaluation

The therapist should explain to patients that two complementary strategies will be adopted (see Figure 12.3) to address their dysfunctional self-assessment system (Fairburn, Cooper, Shafran, Bohn, Hawker, et al., 2008):

1. Increasing the importance of other domains of life (i.e., increasing the size and number of other slices in the patients' pie chart).
2. Reducing the importance of shape, weight, and their control (i.e., decreasing the size of the "shape and weight" slice) by directly tackling the principal expressions of their overvaluation (i.e., shape checking, shape avoidance, and feeling fat). Frequent weighing or avoiding weighing should already have been addressed in Step One of the treatment, while undereating and being underweight and dietary restraint are addressed in other specific modules (see Chapters 11 and 13, respectively).

Commonly, adolescent patients immediately acquiesce to these goals. With adolescent patients who are not underweight or only slightly underweight, we immediately start working on enhancing the importance of other domains of self-evaluation. However, with patients who are severely underweight we prefer to introduce this procedure after a period of weight regain, because many of the effects of being underweight prevent them from engaging in other domains, especially those that are interpersonal in nature. In this case, we usually start by working on body

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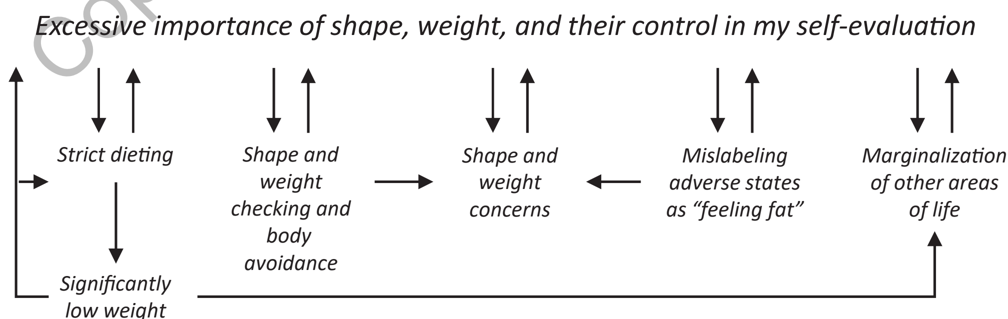

FIGURE 12.2. An example of a personalized extended formulation of an underweight adolescent patient with an eating disorder.

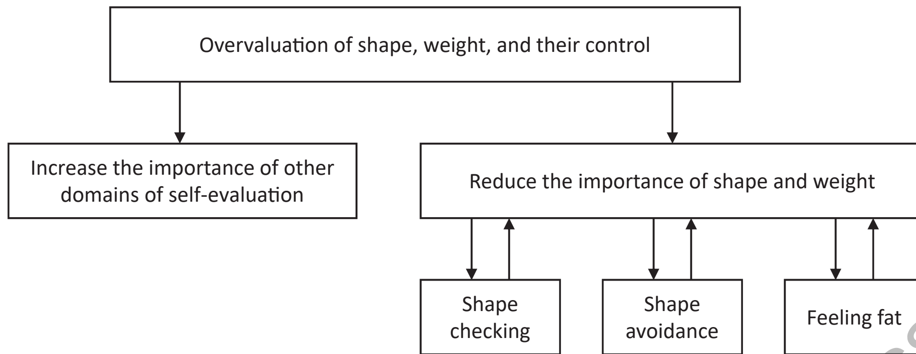

FIGURE 12.3. Two-prong strategy to address the overvaluation of shape, weight, and their control.

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checking, as decreasing body dissatisfaction may remove some obstacles to weight restoration. Later, when the negative effects of being underweight are reduced, we introduce enhancing other self-evaluation domains, and tackle body avoidance and feeling fat.

ENHANCING THE IMPORTANCE OF OTHER DOMAINS OF LIFE

The goal is that patients begin to engage in other aspects of life (e.g., school, social life, hobbies), and that these things become more important "slices" in the patients' self-evaluation scheme. There are five steps to helping patients engage in, and begin to value, other aspects of life (at each step the therapist should play an active, proactive, and encouraging role, to emphasize its importance, and to stimulate patients to change; Fairburn, Cooper, Shafran, Bohn, Hawker, et al., 2008):

1. *Explain the rationale for doing this.* The first step is, as usual, to explain to the patients why the procedure is important, clearly stating and clarifying that to increase the number and importance of other domains of life will help them no longer be solely focused on their shape and weight, and will give them the opportunity of having other life experiences that may indirectly help reduce the importance they attribute to shape, weight, and their control.

2. *Identify new activities in which the patient might become involved.* The therapist should encourage patients to reflect on old interests and activities they did before the onset of the eating disorder and/or things that they might like to try. In this phase, it is important to examine all the possibilities to give patients a wide choice. Many adolescent patients are tentative, ruling out even quite promising possibilities, and many have difficulty thinking of activities because, even before the onset of the eating disorder, they were engaged in relatively few. Sometimes good ideas can come from considering what their friends do outside of school.

3. *Agree on one or two activities that the patient will try out.* It may be useful to involve friends or peers in this, as patients will be more likely to stick with an activity

if they are doing it in company. This will also give them a chance to work on their interpersonal skills.

4. *Ensure that the patient sticks to the plan.* Once a promising activity (or two) has been identified, the therapist should seek to ensure that they actually start to engage in it. This can be achieved by encouraging hesitant patients to get started and asking them to record their progress in the last column of their monitoring record.

5. *Review progress week by week.* This should be a permanent item on the session agenda. The therapist should be encouraging, and the patients should be prompted to use a proactive problem-solving procedure to overcome any difficulties they might experience (see "Problem Solving: Steps One–Four" in Chapter 14). Note that there is no point in beating a dead horse; patients should abandon an activity after three "unsuccessful" attempts, and be encouraged to identify and adopt another one in its place. Additional activities may also be added later on, while others may be dropped. Toward the end of treatment, it is worth asking patients to redraw their pie chart, as doing so provides an opportunity to review their progress in this regard. Typically, the "slice" representing shape and weight has shrunk in size, and new slices have been added. Naturally, the therapist should praise the patients for any changes that they have made.

In helping the patients to develop other domains, the therapist should be encouraging, but maintain the pressure to change. It is also important to be specific with regard to homework and restate the rationale at intervals (e.g., "success breeds success"). It is also common for this procedure to be associated with other benefits, such as paving the way to new opportunities, resulting in the development of new relationships, improving self-esteem, and helping patients to "catch up' socially and developmentally.

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VIGNETTE

The patient, discussing with the therapist the implications of her pie chart (drawn on the back of her monitoring record), states that she is very upset about how her eating disorder has marginalized other areas of her life. She also reports that now, having only a few residual binge-eating and purging episodes, she has a lot of free time that she does not know how to occupy. She also reports that when she is at a loose end she has noticed that her concerns about shape, weight, and eating control increase. She says that before the onset of her eating disorder she was very popular, had lots of friends, a boyfriend, and played volleyball, but now she spends most of her time alone. Discussing this helps her to understand that having a pie chart with a dominant slice means that her life is very narrowly focused, and that this is self-perpetuating. However, the patient is reluctant to identify and engage in any activities, because she believes that there is really nothing worth doing. She has fallen out of touch with her friends and her boyfriend, and no longer enjoys playing volleyball. She admits that she is afraid of not being accepted by her old friends because she had previously ruined all of her relationships. However, with some reluctance she accepts the importance of addressing her marginalization, and agrees to call an old friend to see whether she would like to meet up, and to enroll in a dance class. In

the subsequent sessions, the patient reports that she is pleased to be in contact with an old friend again, and that she has developed new and interesting friendships in her dance class.

ADDRESSING SHAPE CHECKING

It is common for adolescents to check their body to some extent, but many young people with eating disorders repeatedly do so, often in a way that is unusual. Such checking can become so "second nature" that they may not actually be fully aware that they are doing it (e.g., they automatically compare themselves with other people they see while walking down the street). Since shape checking tends to be particularly influential in maintaining dissatisfaction with shape and in encouraging dieting in adolescents, it is best to address this aspect of body image first. The procedure has six main steps.

1. *Explaining the rationale.* The therapist should remind patients of (a) the two reasons for addressing overvaluation and (b) the content of their extended formulation. Moreover, if applicable, it is worth informing patients that they have already addressed one form of body checking—namely, weight checking—in Step One during in-session weighing. Almost invariably, patients will have found in-session weighing helpful, as it will have assuaged their concerns about weight (i.e., the number on the scale). Patients should also be informed that shape checking needs to be addressed directly because it maintains body dissatisfaction, and consequently encourages dietary restraint and the adoption of other extreme weight-control behaviors. They should be told that, as with weight checking, they may experience a short-lived increase in concerns about shape, but similar benefits will result from addressing shape checking.

2. *Identifying the various forms of shape checking.* Next, the therapist needs to assess the patients' shape checking. Since recording shape checking can be distressing, and patients are often unaware that they are engaging in this behavior, it is best to ask them to do it in real time in detail only for two 24-hour periods (using an adaptation of the usual monitoring record; see Figure 12.4): one being a school day (if the patient attends school) and the other being a day off from school.

The therapist should also help patients to identify the various form of shape checking, discussing the types of behavior that should be recorded. Common examples include:

- Scrutinizing particular body parts in the mirror (or reflective surfaces)—a form of shape checking that is very common in adolescents.
- Measuring their bodies using a tape measure.
- Pinching or touching body parts, assessing the tightness of particular items of clothing (e.g., pants or skirt waistbands) and accessories (e.g., watches or rings).
- Looking down at their thighs or stomach, for example, when sitting.
- Comparing themselves with others.

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For young male patients, it is build and muscularity rather than weight that tend to be of concern.

3. *Reviewing the adapted monitoring records.* Next, the therapist evaluates with the patients the reasons for and consequences of shape checking, by asking the following questions (Fairburn, Cooper, Shafran, Bohn, Hawker, et al., 2008):

- "What are you trying to find out when you check your body? Do you think you can find it out this way?" Usually, patient replies are something like the following:
  - "To find out what my shape is like." In this case, the therapist should emphasize that checking the shape of the body tends to magnify imperfections, and that some aspects of body shape are normal (e.g., having a slightly protruding abdomen).
  - "To see if my shape is changing" (or "To see if I am getting fat"). In this case, the therapist should make patients reflect on the fact that checking body shape does not provide reliable data, but only inaccurate impressions. For example, in the mirror you can often see differences between how you look in the morning and the afternoon because we are not blessed with a photographic memory of our body.
- "Why are you checking yourself so frequently? Do you think you might be checking yourself too often?" Usually the patient's answer is "To check that my shape hasn't changed." In this case, the therapist should ask whether the patient thinks that her or his body shape can change so quickly as to justify such frequent checks and, if necessary, explains that the shape of the body cannot change within a few hours in the absence of significant changes in weight. If the change in the shape of the belly is a concern, the patient should always keep in mind that the fluctuations in abdomen shape are normal, and assess whether or not this corresponds to a change in weight.
- "Do you ever look at the parts of your body you like?" In most cases, the patient answers "No."
- "Do you feel better after checking your body?" The majority of patients respond "No." In this case, the therapist should help the patients reflect on why shape checking does not make them feel better, in order to highlight how this behavior maintains and accentuates concerns about body shape. Some patients may respond "Yes. It reassures me because it reminds me that I am thin." In this case, the therapist should emphasize that the result of this, however, is actually to maintain and accentuate concerns about body shape.
- "Do you think your shape checking has any adverse effects?" Usually, patients have not reflected on this aspect, and are not aware that shape checking has numerous negative consequences. In these cases, the therapist should remind patients that shape checking is unhelpful for the following reasons:
  - It maintains concern about the shape of the body because the parts of the body that one does not like are continuously scrutinized.
  - It makes even the most attractive people find "flaws," as what we see depends largely on how we view ourselves.
  - It amplifies apparent defects because we tend to focus on what we do

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Day *Wednesday* **Date** *May 4*

Time	Food and drink consumed	Place	*	V/L/E	Shape checking (type, time taken)	Context and comments
	Today's plan					
7:30	1 cup of skim milk with cereal 1 glass of orange juice	Kitchen				
10:30	1 apple	School				
1:30	1 plate of pasta with tomato sauce 1 cup of vegetable with oil and vinegar 2 crackers 1 apple	Kitchen				
4:30	1 small cup of fruit yogurt 2 cookies	Kitchen				
7:30	1 beef steak 1 cup of vegetable with oil and vinegar 1 slice of bread 1 banana	Kitchen				
6:45 7:00	1 glass of water	Bathroom			I looked at myself naked in the mirror from the front, sides, and behind, especially my belly, butt, and legs (5 minutes). I looked at my stomach in the mirror while I was dressing. I changed my outfit three times (10 minutes).	My belly and butt are covered in cellulite and my stomach has rolls of fat. I am disgusting. My stomach is so fat, I feel sad.

7:30	1 cup of skim milk with cereal 1 glass of orange juice	Kitchen				
9:00		School			I looked at Anna's flat stomach (a very rapid look).	She has a perfect body, not like me; I look pregnant.
10:30						I skipped the apple. I am so fat.
1:30	1 plate of pasta with tomato sauce 1 cup of vegetable with oil and vinegar 2 crackers 1 apple	Kitchen				I stuck to my plan.
2:00		Bathroom				I checked if my belly had grown with a tape measure (2 minutes). It has gotten bigger.
4:30	1 small cup of fruit yogurt	Kitchen				I skipped the two cookies that I planned because my belly is too big.
7:30	1 beef steak 1 cup of vegetable with oil and vinegar 1 slice of bread 1 banana	Kitchen				
9:00		Bedroom			I looked at some beautiful skinny models on the Internet (20 minutes).	They all have a flat stomach, not like me. I feel depressed.
9:20				E		200 push-ups.

FIGURE 12.4. An example of a monitoring record of an adolescent patient with an eating disorder who is monitoring shape checking.

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not like, rather than looking at the bigger picture. As a consequence, we have no reference points for size or scale.

While most adolescent patients rapidly understand the contribution of body checking in maintaining their eating disorder and are prepared to address it, a subgroup is ambivalent, as they value this behavior. Common objections expressed by such patients and examples of therapists' responses follow:

PATIENT: Body checking does not have an important role in maintaining my eating problem.

THERAPIST: Try to stop body checking for a couple of weeks and assess the effect on your concerns about weight and body shape. Once you have done this experiment, let's talk about this again.

PATIENT: Body checking helps me to control my weight.

THERAPIST: It is true, healthy body checking, like checking weight once a week, may help to maintain control over weight. On the other hand, other types of body checking—for example, weighing yourself several times a day, spending a lot of time looking at parts of your body you do not like, or measuring yourself with a tape measure—provide an inaccurate estimate of your size and increase concerns about shape and weight.

PATIENT: I feel good when I feel my bones stick out; it is a sign that I am thin.

THERAPIST: How long does this state of well-being last? Why do you need to touch your bones so frequently? Perhaps you feel reassured at not having lost control over your shape and weight? However, it seems that this state of well-being does not last long because after a while you still need to touch your bones again. Are you sure that this is an accurate method for estimating the shape and weight of your body? How much should your bones protrude? Do you think that checking your bones may increase your concerns about shape and weight?

PATIENT: I compare myself with fat people and I tell myself that I must continue to diet to avoid becoming like them.

THERAPIST: Are people who you compare yourself with really fat? Individuals with eating problems often judge people who are in a normal weight range as "fat." Maybe the people who you label as "fat" are happier than you. For example, they may feel good about themselves because they are fulfilled in their work and have satisfactory relationships with others. When you compare yourself with others, try to focus your attention on characteristics other than their body—for example, their hair or their style, and so on.

PATIENT: You say that addressing body checking will reduce my concerns about shape and weight, but being preoccupied with my body helps me to control my weight.

THERAPIST: That may be true, but your excessive concern prevents you from thinking about other important things in life, such as friends, school, and hobbies. Are you sure that you need to think about shape and weight all day

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in order to control them? Most people rarely think about their shape and weight but maintain their weight within a healthy range and are free to do other fulfilling activities.

4. *Categorizing the various forms of shape checking.* The therapist and patient should allocate the identified forms of shape checking to one of two groups:

- *Those best stopped altogether.*
  - Unusual, non-normative, forms of behavior (e.g., pinching parts of the body to assess "fatness"; repeatedly touching the abdomen, thighs, and arms; feeling bones; checking the tightness of rings and watchbands; and looking down when sitting to assess the extent to which one's abdomen bulges out over the waistband of one's pants or skirt or the degree to which one's thighs spread).
  - Those that are usually secretive, as they would be embarrassing if someone else found out (e.g., using a tape measure to check thigh circumference; checking whether there is a gap between the thighs when standing with the knees placed together; and, when lying down, placing a ruler across the hip bones to check that the surface of the abdomen does not touch it).
- *Those best modified.* These are more normative forms of behavior, whose frequency or extent may be an issue (e.g., mirror use, comparison checking).

5. *Helping patients stop non-normative forms of shape checking.* Patients are told that they need to become aware that they are shape checking in real time, as this helps to stop this behavior. Often patients succeed in stopping non-normative forms of shape checking without too much difficulty. In our experience, it is best that they go "cold turkey" rather than trying to phase these behaviors out. Such behavior tends to undermine self-respect and, after a few weeks, stopping it is experienced as a relief. As with reducing the frequency of weight checking in Step One, modifying habitual shape-checking behavior results in a short-lived increase in preoccupation with thoughts about shape. However, this is subsequently followed by a marked reduction in these thoughts and the associated concerns, although note that some patients may need to engage in alternative forms of behaviors for a while.

6. *Helping patients modify normative forms of shape checking.* Again, patients need to become aware of the behavior in real time, and then learn to question themselves before checking (i.e., "think first") with the goal that they gain control over their behavior and become better at interpreting what they see. Patients are encouraged to ask themselves the same questions that the therapist asked the patients when reviewing their adapted monitoring records (see point 3 above).

The procedure of addressing shape checking has the goal of reducing the frequency of such behaviors and enabling the patients to reinterpret what they see. The best example is mirror use (see "Addressing Mirror Use" below). Often the procedure needs to be blended with education about body shape and its assessment,

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referring the patients to the relevant part of the manual *Overcoming Binge Eating, Second Edition* (Fairburn, 2013). Usually, the procedure takes many weeks, and it is a recurring item on the session agenda. However, if done well, it can have a profound impact on the patients' quality of life.

VIGNETTE

The patient is a 17-year-old girl in the final phase of weight restoration who, despite having addressed some shape checking, continues to report extreme concerns about the shape of her body that are preventing her from achieving a healthy body weight. A review of her monitoring records reveals that she often has difficulty eating her evening meal or afternoon snack. The patient states that during the afternoon she has more concerns about her body shape, even if she does not understand the reason, and that this has caused her to deviate from the meal plan. The therapist suggests that she use the monitoring record to reassess her shape checking, explaining that some shape checking might still be acting to increase her body dissatisfaction, even if she is not aware that this is happening. The patient agrees to accurately monitor shape checking again, focusing in particular on what happens during the afternoon. At the next session, the patient arrives, saying that she was amazed by what she found, as self-monitoring had revealed that she was shape checking without being aware of it. Indeed, after reviewing her monitoring records, it becomes evident that the patient looks at her thighs reflected in the oven, which is at just the right height, every time she walks through the kitchen, and that this mostly happens in the afternoon, when she is not at school. The patient can now see that this behavior is frequent, and understands that it is greatly contributing to her increase in concern about the shape of her thighs, ultimately causing her to restrict her diet. The patient agrees to address this form of residual shape checking by taking notice of the behavior in real time. In a few weeks, this reduces the patient's concerns about the shape of her thighs, and helps her to reach a healthy body weight.

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Addressing Mirror Use

People tend to believe what they see in the mirror, so mirror use is a form of shape checking that has the potential to provide misleading information about appearance. Although patients may think that what they see should be believed, information obtained from mirror use is complex and prone to misinterpretation by those with shape concerns. Thus, problematic mirror use, especially scrutiny, is likely to play a major role in maintaining many adolescent patients' body dissatisfaction. Addressing mirror use is therefore of great importance, and the procedure for doing so includes three steps:

1. *Assessment.* As always, the first step is to find out exactly what patients are doing. The therapist should assess:
   - *Frequency of mirror use.* This can be done by looking at the shape-checking records, and asking about their mirror use at home and at school. Patients are also encouraged to monitor their mirror use starting now.

- *Manner of mirror use.* This can be assessed by asking the following questions:
  - "How long do you spend looking in the mirror on each occasion?"
  - "What exactly are you checking? Which part are you looking at and which are you ignoring or avoiding?"
  - "What exactly are you trying to find out?"

2. *Education.* Patients need to be educated about mirrors and how to interpret what they "see." To this end, there are four main pieces of information that the patients should know:

- *Information obtained from mirrors is complex.* Patients are invited to consider the size of their image when they look at themselves in a full-length mirror. Is it to scale? To get the answer to this question we suggest that patients ask a friend to mark the top and bottom of their reflection on the mirror when their whole body is reflected, and to measure how far they have to stand back to be able to see themselves entirely. Although they had not probably realized this, they will now see that their mirror image is half their actual size. Patients may be persuaded that they need to be careful about how they interpret what they see when they look in a mirror by the fact that they have not noticed this before.
- *What you see is influenced by how you look in the mirror.* For example, scrutiny magnifies the perceived defects ("If you look for bulges, you will find them").
- *Many patients use mirrors in ways that are liable to magnify their apparent size.* For example, they scrutinize their body for a long time without taking in reference points for scale.
- *Drawing a contrast with incidental reflections.* Ask patients whether they have ever accidentally caught sight of themselves in a store window, for example, and not immediately recognized themselves. Many will acknowledge that on these occasions their negative opinion only "kicked in" when they realized it was their own reflection that they were looking at, and their first glance showed them as they truly are.

3. *Modifying the behavior.* The therapist should ask patients the following questions:

- "When it is appropriate to use the mirror?" Appropriate use may include to check hair and clothing, to apply or remove make-up, and/or shave.
- "What forms of mirror use are inappropriate or unhelpful?" Examples of inappropriate mirror use include focusing on body parts that one dislikes, and scrutinizing them for long periods of time.
- "How can we avoid magnifying our apparent defects?" To avoid magnification we should avoid focusing on body parts that we dislike, and instead look at the whole body, including more neutral areas (e.g., hands, feet, knees, hair). In addition, we should take in the background environment, as this helps give us a sense of scale.

On this basis, the therapist should help patients modify their mirror use using two main strategies:

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1. Questioning themselves before looking in the mirror and doing real-time recording.
2. Changing the way they look at themselves in the mirror.

Addressing mirror use will usually take several sessions. The goal is for patients to adjust their behavior and become more skilled in interpreting what they see. It is not necessary to recommend avoiding mirrors entirely, but rather to restrict mirror use to the purposes listed above, at least for the meantime. It is also instructive to ask patients how much time they spend choosing what to wear before they go out, and whether they have any difficulty deciding on an outfit. Many admit that, in fact, they spend a long time in front of a mirror, being unable to decide among several outfits. They may also express that this makes them feel gradually more despondent and dissatisfied with their shape. With every outfit their self-esteem drops, and they may even give up on the idea of going out altogether because of this. It can be helpful to suggest to patients who report this behavior to commit to an outfit before they try it on, and not to get dressed in front of a mirror.

Addressing Comparison Making

A particular form of shape checking that actively maintains concerns about shape is repeated *comparison making*. Usually, there are two forms of comparison making: (1) comparison with other people and (2) comparison with media images. This behavior is common in adolescents, and is seen particularly 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 comparison is often biased in one, or both, of the following ways:

- *Subjective bias*. The comparison is with someone who is attractive (*selective attention*). When making these comparisons, patients tend to choose biased reference groups composed of thin, good-looking people of the same gender and age. They fail to notice others who are less thin and good-looking. Thus, there is an inherent unfavorable bias both in the way that shape is assessed, and in the objects of comparison.
- *Assessment bias*. The way the other person's body is evaluated is cursory. In marked contrast to their prolonged negative appraisal of their own bodies, patients' assessment of other people is often based on uncritical snap judgments.

Addressing comparison making involves two steps:

1. *Addressing subject bias*. Patients should be helped to appreciate the subject bias inherent in their comparison making and draw logical conclusions. To this end, the therapist should ask patients to conduct an experiment (Fairburn, Cooper, Shafran, Bohn, Hawker, et al., 2008). They should walk along a street and compare themselves with every third person their age and gender, and then reflect on what they discover. It is likely to emerge that people are far more varied in appearance than

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the patients had previously noticed, and that some people with body shapes that they consider "unattractive" actually look pretty good. It is also important to encourage patients to reflect on the notion of "attractiveness," which is not only related to thinness, and to broaden their comparison making to include aspects of people other than their shape (e.g., their hair, shoes, sense of humor).

2. *Addressing assessment bias.* In order to help patients to appreciate the assessment bias inherent to their comparison making and draw logical conclusions, the therapist should ask patients to engage in another experiment. This involves going into a shared changing room (e.g., at a swimming pool, in a store), quickly assessing those present, and identifying someone who they think looks "good"; they should then furtively scrutinize that person's body, focusing on what they dislike about their own body, and then reflect on what they find (Fairburn, Cooper, Shafran, Bohn, Hawker, et al., 2008). It is likely to emerge that bodies that appear attractive at first glance have "flaws" and imperfections if they are studied more carefully (in the way that the patients study their own body); what they "see" is influenced by the way that they assess their own body.

Addressing Comparison with Media Images

It is common for adolescents with an eating disorder to compare themselves with people portrayed in the media. For this reason, the therapist should always ask the patients to monitor this form of comparison making, which might include images from magazines and/or the Internet. In order to inoculate patients against the uncritical acceptance of media images, they should be educated (with examples) on the manipulation of images (airbrushing) and encouraged to do some research on the subject.

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ADDRESSING SHAPE AVOIDANCE

Some adolescents with eating disorders avoid looking at their bodies, and dislike other people looking at them. Often these adolescents have engaged in repeated body checking in the past but have switched over to body avoidance because body 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 loose clothing or a cushion when seated), and not looking at photographs of themselves. This kind of expression is problematic, as it allows concerns and fears about shape and appearance to persist in the absence of an awareness of what one actually looks like. Therefore, addressing shape avoidance is of great importance, and includes three steps:

1. *Explaining the rationale.* As with shape checking, the therapist should remind patients of (a) the two reasons for addressing overvaluation and (b) their extended formulation. Moreover, if applicable, it is worth informing patients that they have already addressed one form of body avoidance—namely, avoidance of knowledge of

body weight—in Step One during in-session weighing. Almost invariably, patients will have found in-session weighing helpful, as it will have assuaged their concerns about weight. They should be told that similar benefits will result from addressing shape avoidance, but that this may also likely result in a short-lived increase in concerns about shape.

Patients should also be informed that shape avoidance needs to be addressed directly because it causes profound impairment. It maintains dissatisfaction with shape by leaving assumptions unchallenged, and consequently encourages dietary restraint and the adoption of other extreme weight-control behaviors. Moreover, it may prevent patients from socializing, being physically intimate with their partner, swimming, using public changing rooms, or buying new clothes.

2. *Identifying the various forms of body avoidance.* The assessment of body avoidance is relatively straightforward, as generally it is something patients are aware of. Usually it exists on a spectrum ranging from minor sensitivity to seeing one's body or others seeing it to total shape avoidance.

3. *Addressing shape avoidance.* The strategy involves progressive "exposure" in its technical and literal sense. The therapist should help patients to recognize their shape avoidance and then plan specific body exposure "experiments," beginning with situations that will create the least discomfort. Patients need to get used to the sight and feel of their own bodies. They need to get used to others seeing their body, too. Patients need to stop dressing and undressing in the dark, and wearing shapeless, baggy clothes. They also need to get used to using mirrors (bearing in mind the information in "Addressing Mirror Use" above) and participating in activities that involve body exposure, such as swimming or going to the beach. Some aspects of body avoidance and how to gradually address shape avoidance are as follows:

- *Avoiding others seeing the body* (e.g., patients avoid wearing tight or revealing clothes).
  - Start by wearing less baggy, shapeless clothes.
  - Work toward being able to wear more form-fitting clothes, including bathing suits.
- *Avoiding being touched.*
  - Start by getting hugged by a friend.
  - Work toward being able to be touched by friends and a romantic partner.

And in extreme situations:

- *Avoiding the sight of the body* (e.g., patients can only get dressed and undressed in the dark).
  - Start by putting candles in the bedroom.
  - Work toward having the light on and the curtains open.
- *Avoiding touching the body* (e.g., patients wash without touching themselves).
  - Wash in a self-aware way, using bare hands and starting with neutral body parts (e.g., feet, forearms, or hands). Apply body lotion to the same areas.
  - Work toward being able to wash the whole body with the hands and being able to apply body lotion all over.

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A typical objection of patients to the suggestion that they should not hide their bodies by wearing baggy clothes is saying that it is merely their chosen style of dress. In this case, the therapist should ask something like this:

> "Did you also avoid wearing better-fitting clothes before the onset of your eating disorder? If not, why did you change your style?"

The therapist may also ask the patient if she or he would be able to wear tighter clothes than usual to go to a party. The goal is to help the patients understand that wearing loose clothing, as well as other forms of body avoidance, is not a free choice, but is instead dictated by their eating disorder.

Body avoidance may take a considerable number of sessions to address if it is particularly severe. Patients need help establishing normative levels and forms of body checking, and the therapist must take care to ensure that patients do not merely exchange body avoidance for repeated body checking, which is always a risk.

VIGNETTE

The patient has reached a normal weight and is addressing body avoidance. With the help of the therapist, she identifies several avoidance situations, including going to bars or dancing, where other people can see her body. The few times she has been to such places she has worn loose-fitting clothing that covers her from head to toe. The patient states that it is too difficult for her to address this kind of avoidance, because she gets extremely anxious even thinking about it. However, she is also sad because she likes to socialize with her peers at the bar, and she loves to dance. When analyzing the patient's fears, it emerges that she was teased about her body shape (wide hips) in the past, and she is afraid that this will happen again. The patient, however, also reports that the young bullies who teased her also harassed other girls, and that she does not see them anymore because she has changed schools. The therapist, using the patient's extended formulation, explains that body avoidance maintains her concerns about body shape, not allowing her to see whether what she fears will materialize, and preventing her from having a fulfilling social life. The patient agrees on the importance of addressing body avoidance, and between subsequent sessions she starts to go to bars and dancing wearing progressively better-fitting clothes. To her surprise, she notes that no one criticizes her body shape, and this helps her to continue wearing form-fitting clothes and spend enjoyable time with her friends.

ADDRESSING "FEELING FAT"

"Feeling fat" is an experience reported by many adolescents, but the intensity and frequency of this feeling appears to be far greater among those with an eating disorder. There has been very little research on feeling fat in adolescents; indeed, remarkably little has been written about it. Feeling fat may not be a major problem for underweight adolescent patients during the first stages of weight restoration,

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as other experiences, such as feeling full and feeling bloated, are usually dominant. However, some patients do equate these feelings with feeling fat, and this may become more significant when they are near to achieving their target weight range. "Feeling fat" tends to be equated with "being fat" by both underweight and not-underweight patients. Patients who are not initially underweight, on the other hand, may feel fat from the beginning of treatment. It is worth noting that people with obesity may have this experience, too, although many are simply dissatisfied with their shape. It is an expression of excessive concern about shape and weight, but it also maintains it, reinforcing shape dissatisfaction and prompting dieting, and so needs to be addressed.

Patients should be helped to understand that feeling fat fluctuates from day to day and throughout the day, while body shape barely changes within such a short time frame. Therefore, something else is likely to be responsible for the fluctuations in feelings of fatness. In fact, feeling fat appears to result from a mislabeling of certain other experiences:

- Body awareness (in those who are dissatisfied with their appearance).
- Adverse physical states.
- Adverse emotional states.

In general, addressing feeling fat is best left until inroads have been made into body checking and body avoidance, because these behaviors may be a trigger for feeling fat. However, this is not always the right strategy—with patients in whom feeling fat is particularly prominent or distressing, the therapist should reverse the order and address it first. The strategy is to help patients identify the experiences that trigger feeling fat and to address them directly. Over time, this results in patients no longer equating feeling fat with being fat, and it ceases to be a maintenance mechanism. The strategy includes three steps:

1. Identifying "peak" times for feeling fat.
2. Identifying their triggers.
3. Addressing the triggers directly.

The therapist should put the topic on the agenda in the first week and discuss it in outline form, asking patients to identify the "peak times" they feel fat in real time using the "Context and Comments" column of the monitoring record. The following week, the therapist should put the topic on the agenda and discuss any "peaks" identified, and what might be triggering them, encouraging patients to conclude that it would be best to explore the trigger in detail in real time. As homework, patients should undertake to ask themselves, immediately after each peak, the following two questions:

"Has anything happened in the last hour that might have triggered my feeling fat?"
"What else am I feeling just now (in addition to feeling fat)?"

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The therapist should again put the topic on the agenda and review the patients' records, labeling the apparent trigger for each "peak" as one of those listed below. The therapist should then consider with the patients how best to address these triggers directly and immediately; here are some examples of how to do so:

- *Heightened body awareness triggers* (e.g., comments on appearance, body checking, physical contact, being sweaty, body shaking, tight clothing). These require reappraisal with or without behavior change (e.g., looser clothes) and a continued focus on addressing body image.
- *Adverse physical states triggers* (e.g., feeling bloated, premenstrual, full, hungover, or sleepy). Require reappraisal with or without behavior change (e.g., having a nap).
- *Adverse emotional states triggers* (e.g., feeling depressed, lonely, bored, unloved). Require reappraisal and application of the problem-solving procedure (see "Problem Solving: Steps One–Four" in Chapter 14).

Once addressing feeling fat has begun, it needs to be a recurring item on the session agenda. Using the above procedures, it may take 4–8 weeks. Over this time, the frequency and intensity of feeling fat generally gradually wanes, and patients become able to stop equating it with being fat. Once this happens, feeling fat loses its potency to maintain the patients' shape concerns.

VIGNETTE

The patient has been implementing the Body Image module for several sessions, and has markedly reduced her episodes of shape checking. Despite this, she still reports intense feelings of being "fat," which she copes with by reducing the portions of food she eats. The therapist first educates the patient about feeling fat, and then asks her to monitor when she has particularly intense feelings of fatness. In the next session, it emerges that the patient feels fat around 1:30 P.M., after coming back from school and having stood for half an hour on the bus because there were no free seats. The therapist encourages the patient to try to identify any potentially masked feelings and sensations associated with these episodes. In the next session, the patient reports that her feeling fat is triggered either by feeling tired or sleepy (adverse physical states). Finally, the therapist encourages the patient when she feels fat to ask herself the question "What am I really feeling right now and why?" and address the triggers using the problem-solving procedure.

INVOLVING PARENTS

If the patient and therapist decide to involve the parents, they should be informed about the overvaluation of shape and weight and their control, and how it is maintained (with the aid of the patient's extended formulation), as well as the main strategies used to address it. Here are some examples of ways parents may help:

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- Helping and supporting the patient to remove unhelpful mirrors from the home.
- Removing any triggers of shape and weight concerns in the home (e.g., diet magazines).
- Refraining from making comments about the body weight and shape of the patient or others.
- Helping the patient overcome practical obstacles to expanding marginalized domains of self-evaluation (e.g., taking the patient to join a choir).
- Helping the patient (in a manner agreed upon with both the therapist and the patient) to become aware of shape checking and reminding her or him how to stop it.
- Helping the patient to throw away fashion magazines that glorify thinness.
- Avoiding giving the patient repeated reassurance about body shape and weight.
- Refraining from taking the initiative to buy new clothes for the patient until the patient and therapist have agreed upon a plan to do so.
- Not interfering in or commenting on the patient's choice of clothes.
- Helping the patient tackle an agreed-upon "exposure" task (e.g., going with her or him to the beach).
- Helping the patient to store clothes that are too small in an inaccessible place, or better still, help her or him to give the clothes away.
- Encouraging the patient to use her or his monitoring record in real time to understand the triggers of feeling fat.

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VIGNETTE

The patient, a 15-year-old girl who has just reached her 25th BMI-for-age percentile threshold in Step Two of CBT-E, reports experiencing a marked increase in concerns about her shape and weight over the preceding week. A collaborative review of her monitoring records shows the presence of frequent shape-checking comparisons with her 10-year-old sister, triggering a recurrence of caloric restriction. The patient affirms that these shape-checking comparisons began when her mother gave her younger sister the clothes that the patient was no longer able to wear because they had become too tight. In the joint session, the therapist explains to her parents that when she sees her "emaciated-state" clothes worn by her younger sister, this reactivates her eating-disorder mindset and reasserts her concerns about shape and weight, which she attempts to manage by restricting her diet. The mother reports that it would be a waste to throw away all of those clothes, but understanding the difficulties her daughter has in seeing them worn by her sister, agrees with the therapist and her daughter that the clothes should be donated to charity.

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