Title: **A mindful approach to eating disorders**

Adhip Rawal, M.Sc., Rebecca J. Park, Ph.D., Jasmin Enayati and J. Mark G. Williams, D.Sc., University Department of Psychiatry, University of Oxford, UK.

This research was supported by the Wellcome Trust GR067797 and an MRC studentship to the first author. The focus group reported in this article is based on a doctoral dissertation of the first author, which explored modes of self-focus in eating disorders.

Word count: 2983

Healthcare Counselling & Psychotherapy Journal, 14750724, October 1, 2009, Vol. 9, Issue 4

This article is original, and has not been previously published or is currently under consideration elsewhere.

Eating disorders are a challenge to researchers and clinicians because of their clinical complexity. Their causes remain poorly understood and they are difficult to treat[1]. Eating disorders are divided into three diagnostic classifications - anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified - but it is thought that there is much overlap in the core psychopathology[2]. Cognitive behaviour therapy (CBT) is most often the treatment of choice for EDs and is primarily aimed at identifying and replacing maladaptive thoughts about the implications of eating, weight, and shape with more realistic cognitions[3]. While CBT has shown benefit for a wide range of patients with EDs[4], outcome data suggests that it has its limitations, particularly for those with anorexia nervosa such that for some their eating disorder becomes chronic and can even be fatal[5]. Anorexia nervosa has the highest mortality rate of all psychiatric disorders[1]. Even among patients who no longer meet diagnostic criteria, continued symptoms such as weight and shape concerns, and relapse after inpatient treatment is common[6-7]. Treatment is also complicated by the fact that patients derive satisfaction from successful weight control, particularly in the early stages[8]. There is a need for research to advance understanding of psychological mechanisms underpinning the eating psychopathology[4].

For individuals with EDs, the control of eating, weight and shape holds great personal significance[2]. Much theory and research has focused on the content of maladaptive cognitions. In contrast, surprisingly little attempt has been made to study the ways in which individuals with EDs relate to their concerns.

Research in other psychological disorders has suggested that individuals often relate to their thoughts and feelings in ways that intensify concerns, such as by dwelling on their content or attempting to avoid them[9]. Thoughts processes like rumination and avoidance are common across a range of disorders and have been associated with increased cognitive and emotional dysfunction[10-12]. Teasdale argues that ruminative/analytical self-focus is only one of two distinct ways of processing self-material, and that changing the way individuals relate to their cognitions can influence how they feel[13]. This analysis identifies the *way of focusing on self* as a potential target for interventions. Mindfulness-based approaches are aimed at disengaging from ruminative thoughts patterns and

encourage engagement with an alternative 'experiential' mode of self-focus, which is characterised by directly 'experiencing' thoughts, body and emotions on a moment-to-moment basis as mental events in contrast to judgemental or evaluative thinking that often elicits goal-directed behaviour[14]. A series of studies in depression have found that mindfulness is related to the ability to let go of unhelpful goals, reduces self-ideal discrepancies, depressed mood, dysfunctional attitudes, and the extent of rumination and avoidance[15-16].

While there have not been any investigations aimed at assessing the way individuals with EDs relate to self-experience, it is known that they are highly perfectionistic and self-critical[17]. Furthermore, interviews have revealed that attempts to control internal experiences and emotions are pervasive[18]. We suggest that individuals with EDs may be inclined to focus on self in an analytical/ruminative way and that this intensifies their concerns. Altering the response style to thoughts, feelings and bodily sensations may have beneficial effects. As a first step to study this, we carried out a focus group to explore phenomenological aspects of severe eating disorders and patients' perceptions of participating in a body-mindfulness group. We expected that patients' reports of their self-experience would show signs of ruminative/analytical self-focus, and that encouraging engagement with experiential forms of self-awareness, as cultivated in mindful movement practices, would enhance awareness and acceptance of self and body.

Method

The value of focus groups to gain insights into the perceptions, opinion and attitudes of individuals has been well-recognised[19]. Focus groups are often used for exploratory research when little is known about a phenomenon of interest to help gain insight into a particular topic. We obtained informed consent from patients for this study, as well as from carers and physicians at the unit. The focus group lasted approximately one hour.

Sample

The sample consisted of 10 in-patients from the tertiary eating disorder service for Oxfordshire and Buckinghamshire. All patients were suffering from severe AN. The age range of the group was 18-55, with a mean age of 24. All participants were female.

Body-mindfulness class

The body-mindfulness group consisted of mindful movement practice with an experiential emphasis on being in the present moment with the body (gently guiding patients to attend to present bodily states, using the breath as an anchor, in a non-judgemental way). Classes were taught by a qualified yoga teacher (JE) and performed weekly for an hour over an 8 week period , during which time patients were encouraged to continue practicing between sessions. No didactic or psychoeducative material was included in these sessions.

Discussion Guideline

The discussion guideline included a minimal set of general, open-ended questions: "What is your experience of having an ED?", "Could you tell me something about the thoughts and feelings that you experience?", and "Can you tell me something about your experience of the body-mindfulness group?". The purpose of this was to elicit discussion of patient-relevant experiences as naturally as possible in order to keep with the study's aim of gaining insight into phenomenology. At the end of the session participants were debriefed and thanked for their time and contributions.

Results

Four major themes were identified: ‘Anorexic voice’, ‘Control/emotional avoidance’, ‘Rumination/self-analysis’, and ‘Mindfulness’, which are illustrated below with examples from the interview transcript.

Anorexic Voice
Patients expressed that an ‘anorexic voice’ had become an intrinsic part of their minds and this influenced their subjective experience:

“It has becomes such a habit to listen to the voice telling you something different from what you know academically what is good for you. It’s quite difficult to stop that thought process.”

“*A lot of the time I feel like I am actually two people, like there is a perfectly rational, intelligent, logical side to me but there is also another side, which is my emotional side and it may as well still be 5 or 6 years old. You end of up having those ridiculous arguments within yourself that you can’t actually win, neither side can ever win*.”

Control/emotional avoidance
For patients food restriction commonly served the specific purpose to provide control:

“*My motivation for having an eating disorder is that when you are at a very low weight your emotions are suppressed, and for me it has always been about suppressing my feelings and emotions because I can’t handle them.*.”

“*I think I have often used it as a safety mechanism. We have a strong need for self-control and controlling our lives. I think that for me too one of the things that has drawn me back into an eating disorder is my lack of being able to cope with uncertainties of life and my emotions*.”

Rumination/self-analysis
Recurrent thinking about past events, mistakes and analysing self were common:

“*I tend to judge a situation that might have just seemed alright at the time but when I look back I think it wasn’t good enough, I should have done it differently. There is always a self-analysis, also with things you can’t actually make better because the time has past but it still burns you up because you do over-analyse. It’s difficult to move forward, you almost fester on those times*.”

“*I think for people like us who are very hard judges of ourselves, this can often lead to self-punishing behaviours or thoughts, whereas people who don’t have an eating disorder can maybe let things go*”

“*I find it is kind of automatic, it’s almost like I’m torturing myself with little things that I perceive I have done wrong, I mean I still sometimes think back at things that I did when I was 11 and think why did I do that? It happens all the time. Just having a chat with somebody in the corridor can be enough.”*

“*I think perfectionism combined with over-analysing is quite a deadly combination*.”

"*Yes, absolutely and it kind of spirals it off and you end up thinking about things that are totally, completely and utterly unrelated but somehow you got there and you can't get back*".

Mindfulness

Following this, the discussion spontaneously moved to exploring ways of dealing skilfully with this self-perpetuating thought process. This led to exploration of the body-mindfulness group:

"*That's where the mindfulness idea does come in because it helps you learn to stand back. I sometimes think of it as a rollercoaster ride. You've got to learn to stop the rollercoaster and think about whether I'm going to allow myself to go down the other side. It gives you a chance to just look at things from a distance*".

"*I think a lot of us would agree that spending time on ourselves in a healthy, positive way is often very difficult. It induces guilt and there is often such a conflict going on in your head. But I think the thing about mindfulness is that it actually focuses on your thought processes, your sense of well-being as well as becoming aware of your body.*"

"*It is not that you just escape into an academic environment where you are thinking about the reasons but you are actually also using your body instead of rejecting it. Particularly as you start to put a bit of weight on one can be extremely anxious, but I find coming out of those sessions, you know that nothing has changed by itself but you feel better with it, with the way you carry yourself as a whole, feeling content and even slightly OK with your shape and yourself*".

"I find it very helpful to have that calmness to be able to look at things a bit more logically, rational and I suppose kind of detached and say, well, it doesn't actually make any sense. Why am I doing that?"

"I think it makes you less preoccupied with the things we are often preoccupied with which obviously centre around food, our body image, feeling uncomfortable in our own skin. I found that it's a slow process and it simply needs practice but in terms of getting you back to back to feel at one with your body and comfortable in your skin, I think that is something new for me. I haven't had that in previous treatments."

"*It helps you re-train your mind. I mean not to override those automatic thoughts but to jump in when they come up. And it's a very, almost frustratingly, slow process because it is so natural and so automatic to have these thoughts but compared to other treatments that I have been in I think this has great positives*".

DISCUSSION

This qualitative study set out to examine ED patients' phenomenology and their experiences of participating in a body-mindfulness group. Four major themes were identified: 'Anorexic voice', 'control/emotional avoidance, 'rumination/self-analysis', and 'mindfulness'.

The first theme described how anorexic thoughts tend to become an intrinsic part of patients' minds and guide their perceptions, feelings and behaviours. The theme "control/emotional avoidance" highlighted patients' resistance to facing emotions and that food restriction often served the purpose of control. The theme 'rumination/self-analysis' expressed the tendency towards repeatedly thinking about the past, particularly in evaluative terms. Such meticulous analyses seemed to occur automatically without necessarily having been triggered by a specific stimulus in the present and commonly induced negative feelings.

If we take these descriptions of patients' subjective experience as reflections of the way they normally relate to self-experience, this supports our suggestion that these individuals are highly analytically minded. The first three themes provide evidence for verbal, evaluative and ruminative thinking (descriptions of analysing, judging, comparing, remembering, elaborating, goal-striving etc. were common), and that this is associated with intensification of concerns. 'Thinking *about*' self and body prevents their direct experience[14], and patients' reports indicated a reduced focus on emotions and sensations. Rumination may also become a strategy to minimise direct experience of bodily sensations and emotions, which may be crucial for continued dietary restraint in the face of symptoms of starvation (e.g., feeling of cold, hunger or pain)[20].

The theme 'mindfulness' explored patients' experience of the body-mindfulness group. Patients reported increased focus on present-moment experience, the ability to interrupt the tendency to automatically react to thoughts and become entangled in ruminative thinking. Furthermore, patients described developing greater awareness and becoming more accepting of self, body and even tolerant of weight gain. Patients' discussion also indicated less preoccupation following mindfulness classes. These findings support the view that attending to self and body in an 'experiential' way may improve emotional and self-regulation.

As only one focus group was conducted, these findings cannot be considered as conclusive of all ED patients' subjective experience and the effects of mindfulness. These preliminary findings await further empirical scrutiny. If further substantiated, our findings suggest two main implications: (1) Understanding the ways individuals with EDs *relate* to their thoughts, together with the content of concerns, may enable a more complete understanding of the maintenance of ED psychopathology and the development of more efficacious treatments, and (2) treatments that target the way individuals react to thoughts and which specifically encourage experiential forms of self-awareness may be effective at disengaging from destructive thoughts patterns, improving emotional regulation, and integration of the body into more adaptive self-concepts. This would suggest that it may not be necessary, in patients such as those with AN who fear change, to directly target changing thoughts or emotions as in classical forms of CBT. Indeed, patients with AN typically respond poorly to such strategies.
It is important to note that CBT and treatments fostering experiential processing are not mutually exclusively of each other. The application of Mindfulness-based Cognitive Therapy[21] to depression has shown that techniques from both approaches can be effectively combined with each other to improve treatment.

Potential problems with mindfulness
Although our findings support the use of mindfulness in EDs, there are potential problems that need to be addressed before this can be accepted with confidence. Attending fully to present moment experience can potentially be emotionally aversive

and overwhelming for underweight patients with severe EDs. As shown in this study, attention is often directed away from emotional material and awareness seems to be dominated by rumination and avoidance of emotive material. It will be a challenge to develop experiential methods that encourage attending to emotional material in a containing rather than overwhelming way. Otherwise, these could act to reinforce the tendency towards ruminative/analytical self-focus and may even intensify psychopathology. It is possible that body-mindfulness may be most fruitfully applied to individuals whose ED is less severe than this inpatient group with AN, or as a relapse prevention strategy.

Follow-up research

Extending the findings from this focus group, we recently carried out a series of experiments where we showed that sub-clinical and clinical samples of EDs are highly ruminative and experientially avoidant[22]. Furthermore, manipulating the way ED individuals focus on self and body had unique effects on cognitive, emotional and behavioural reactions following a stressful event (an imaginary meal task), where relative to analytical/ruminative self-focus, experiential self-focus reduced ED psychopathology[23]. This supports the view that the way individuals relate to self-experience may have distinct effects on symptoms, and that experiential training procedures may ameliorate psychopathology.

References

1. Fairburn CG, Harrison PJ. Eating disorders. Lancet. 2003;361:407-16.
2. Fairburn CG, Cooper, Z., & Shafran, R. Cognitive behaviour therapy for eating disorders: A transdiagnostic theory and treatment. Behaviour Research and Therapy. 2003;41:509-28
3. Cooper Z, Shafran R. Cognitive behaviour therapy for eating disorders. Behavioural and Cognitive Psychotherapy. 2008;36:713-22.
4. Fairburn CG, Cooper Z, Doll HA, O'Conner ME, Bohn K, Hawker D, et al. Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: A two-site trial with 60-week follow-up. American Journal of Psychiatry. 2009;166:311-9.
5. Wilson GT, Grilo CM, Vitousek KM. Psychological treatment of eating disorders. American Psychologist. 2007;62(3):199-216.
6. Sullivan PF, Bulik CM, Fear JL, Pickering A. Outcome of anorexia nervosa: a case-control study. American Journal of Psychiatry. 1998;155(7):939-46.
7. Berkman ND, Lohr KN, Bulik CM. Outcomes of eating disorders: a systematic review of the literature. International Journal of Eating Disorders. 2007;40(4):293-309.
8. Vanderlinden J. Many roads lead to Rome: Why does cognitive behavioural therapy remain unsuccessful for many eating disorder patients? European Eating Disorders Review. 2008;16(5):329-33.

9. Harvey A, Watkins E, Mansell W, Shafran R. Cognitive behavioural processes across psychological disorders: a transdiagnostic approach to research and treatment. Oxford: Oxford University Press; 2004.
10. Watkins E, Scott J, Wingrove J, Rimes K, Bathurst N, Steiner H, et al. Rumination-focused cognitive behaviour therapy for residual depression: a case series. Behaviour Research & Therapy. 2007;45(9):2144-54.
11. Watkins E, Teasdale JD. Rumination and Overgeneal Memory in Depression: Effects of Self-Focus and Analytical Thinking. Journal of Abnormal Psychology. 2001;110(2):353-7.
12. Spasojevic J, Alloy LB. Rumination as a common mechanism relating depressive risk factors to depression. Emotion. 2001;1(1):25-37.
13. Teasdale JD. Emotional processing, three modes of mind and the prevention of relapse in depression. Behaviour Research and Therapy. 1999;39:53-77.
14. Williams JMG. Mindfulness, depression and modes of mind. Cognitive Therapy and Research. 2008;32:721-33.
15. Crane C, Barnhofer T, Duggan DS, Hepburn S, Fennell MV, Williams JMG. Mindfulness-based cognitive therapy and self-discrepancy in recovered depressed patients with a history of depression and suicidality. Cognitive Therapy and Research. 2008;32:775-87.
16. Kumar S, Feldman G, Hayes A. Changes in mindfulness and emotion regulation in an exposure-based cognitive therapy for depression. Cognitive Therapy and Research. 2008;32:734-44.
17. Shafran R, Cooper Z, Fairburn CG. Clinical perfectionism: A cognitive-behavioural analysis. Behaviour Research and Therapy. 2002;40:773-91.
18. Schmidt U, Treasure J. Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. British Journal of Clinical Psychology. 2006;45:343-66.
19. Merton RK. The focused interview and focus groups: Continuities and discontinuities. Public Opinion Quarterly. 1987;51:550-6.
20. Park RJ, Dunn BD, Barnard PJ. Schematic models and modes of mind in anorexia nervosa: A novel process account with treatment implications. Manuscript submitted for publication. 2009.
21. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-Based Cognitive Therapy for Depression - A New Approach to Preventing Relapse. New York: Guilford Press; 2002.
22. Rawal A, Park RJ, Williams JMG. Rumination and experiential avoidance in anorexia nervosa. Manuscript submitted for publication.
23. Rawal A, Park RJ, Williams JMG. Effects of analytical and experiential self-focus on measures of emotion and cognition in eating disorder psychopathology. Manuscript submitted for publication.