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Mirror Exposure Therapy, Body Image Disturbances and Eating Disorders

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Body image disturbances arise when a discrepancy between a person's idealized body image and perceived body image leads to clinically significant impairment or distress. One's idealized body image is influenced by a variety of sociocultural factors, and idealized body images can take many forms and are not limited only to shape and weight but can include functional ideals (i.e. ideals of strength, speed, and dexterity). Whether a mismatch between body image ideal and perceived body image leads to impairment may be influenced by factors including how strongly the individual regards body image as a component of self-value, the degree of disparity between ideal and perceived body image, and the degree of disparity between one's own perception of their body image and their perception by others. Having a negative view of one's own body is a risk factor for and a core component of several eating disorders, including anorexia nervosa and bulimia nervosa (Stice & Shaw, 2002).

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Individuals with poor body image suffer independently of whether they have a comorbid eating disorder and often body image disturbances remain after an individual with an eating disorder normalizes their eating. Unfortunately, there are a limited number of interventions designed specifically to target body image dissatisfaction occurring outside of the context of body dysmorphic disorder and their effects are often small (Alleva et al., 2015). Poor body image may be addressed specifically as a component of enhanced cognitive behavioural therapy (CBT-E) for eating disorders (Fairburn, 2008) or with cognitive behavioural therapy (CBT) strategies outside of the context of eating disorder treatment (Alleva et al., 2015).

Mirror exposure therapy is a form of exposure therapy designed to specifically target body image disturbances. The therapeutic process involves the patient standing in front of a full-length mirror, ideally with wings to maximize viewing area, and describing their appearance to a therapist over the course of a therapy session. Mirror exposure therapy is sometimes used as a component of specialized CBT for body dysmorphic disorder (Harrison et al., 2016), and it has been studied as an adjunctive treatment for individuals with eating disorders and as a standalone treatment for individuals with body image disturbances who do not necessarily meet criteria for a psychiatric diagnosis (Griffen et al., 2018). There have been four randomized controlled trials evaluating the efficacy of mirror exposure therapy as an isolated intervention. Three of these studies tested its efficacy in women with body image dissatisfaction (Delinsky & Wilson, 2006; Glashouwer et al., 2016; Moreno-Domínguez et al., 2012) and one examined efficacy in individuals (mostly women) with body image dissatisfaction *and* an eating disorder (Hildebrandt et al., 2012). Together, these studies found that mirror exposure therapy leads to a moderate improvement in body image (effect size: $d = 0.67$; Griffen et al., 2018). In the studies with follow-up after the treatment period, beneficial effects of mirror exposure therapy continued to be evident at the end of the follow-up periods, which were as long as one month.

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Several variations of mirror exposure therapy exist, and the protocols vary in the randomized, controlled clinical trials that have been published. Unlike for some evidence-based psychotherapies, there is not a published treatment manual nor a clear consensus on which approach is most effective. Therefore, clinicians wishing to use mirror exposure therapy in their practice should seek supervision from an experienced therapist. Two basic approaches to mirror exposure therapy are "pure" mirror exposure and "guided, non-judgmental" mirror exposure (see Griffen et al., 2018 for further review). For both approaches, the patient is asked to stand in front of a full-length mirror and describe what they see to the therapist, who typically sits with their back to the patient during the exposure. The patient is instructed to avoid using judgmental or subjective language in describing their appearance, and the therapist provides reminders and redirection them as needed. The initial exposure begins with the therapist briefly modeling the intended self-description style. In pure mirror exposure therapy, the patient is instructed to look at their body and describe their emotions as they arise. Thus, a patient might state that they feel "disgusted" when looking at a particular body part; however, if they refer to a body part as "disgusting" or "nice" they should be redirected. In guided, non-judgmental mirror exposure therapy, the patient is instructed to use objective language and describe their body starting with their head and progressing down to their feet. Using this approach, the patient is guided to describe their body such that the therapist would be able to draw an accurate picture of them even if they had never met. Other variations in technique have also been proposed including guiding the patient to look preferentially at the body parts with which they are either most or least satisfied (Jansen et al., 2016).

There is no clear consensus on which approach to take with a particular patient and an experienced therapist may combine elements of these approaches to treat the individual in the room. For example, there is some evidence to suggest that approaches that focus more heavily on negatively perceived body parts are more difficult to tolerate and may be too challenging for a severely impaired patient; however, approaches associated with higher subjective distress early in treatment appear to lead to slightly more improvement by the end of treatment (Griffen et al., 2018). Clinicians working with patients with eating disorders, however, should be aware that only the guided, non-judgmental approach has been studied (and was found to be effective) in an eating disordered population (Hildebrandt et al., 2018). Clinicians may also incorporate psychoeducational components into their sessions. These may include a discussion of the basic principles of exposure therapy and acknowledgement of the external influences that may have contributed to the patient's body dissatisfaction. Clinicians can model distancing from harmful social and systemic messages by acknowledging them without engaging in extensive discussion or debate. Consistent with acceptance-based strategies, the goal of mirror exposure therapy is to reduce distress from and struggles with external influences outside of the patient's direct control in favour of more meaningful life pursuits.

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Mirror exposure treatment sessions typically last about an hour each, including a post-session debriefing with the therapist. A typical course of treatment is four to eight weekly or twice weekly sessions, although an optimal duration of treatment has not been studied. Patients are usually asked to increase the difficulty of the exposure across the treatment, often by wearing clothes that will be progressively more challenging for them. Body image exposure homework should be assigned between sessions to facilitate generalization of learning outside of the session.

Mirror exposure therapy can be considered a first-line treatment for body image dissatisfaction whether or not an individual has an eating disorder and it is generally well tolerated and efficacious (Griffen et al., 2018). However, it is not the ideal treatment for everyone, and clinicians should be aware of potential barriers to successful treatment. In my clinical experience, the population that

seeks treatment for body dissatisfaction, if it is offered in an accessible manner, is extraordinarily diverse, comprising individuals of most ethnic, cultural, age, socioeconomic and gender groups. The treatment-seeking population includes individuals who would not qualify for any psychiatric diagnosis and those with eating disorders, body dysmorphic disorder, and other acute psychiatric illnesses including psychotic disorders such as schizophrenia. Clinicians offering body image treatment should be thorough and comprehensive in their evaluations to ensure that comorbidities are promptly identified and addressed. Clinical worsening has been reported for individuals with recent non-suicidal self-injurious behaviours (e.g. cutting) and major depression, and mirror exposure therapy has not been studied and is widely proscribed for individuals with low-weight eating disorders (i.e. underweight individuals with anorexia nervosa). Therefore, mirror exposure therapy should only be used by a mental health clinician with extensive expertise in mirror exposure therapy and body image pathology, or their direct supervisee, to treat individuals with a history of suicidality or recent non-suicidal self-injurious behaviour, who are underweight (e.g. with anorexia nervosa), or who are in a current major mood or psychotic episode (Griffen et al., 2018). Importantly, for individuals with either an eating disorder or body dysmorphic disorder, mirror exposure therapy should only be one component of a comprehensive care plan implemented by a specialist treatment provider.

In addition to comorbid illnesses, the clinician may anticipate other barriers to efficacious treatment. Patients often find the first session to be extremely distressing. Clinicians can help patients using standard CBT exposure psychoeducation about anticipating distress and by providing encouragement to continue the exposure in spite of moderate distress. The average patient experiences a significant reduction in distress across the course of treatment; some patients may require modification of the intensity of the initial exposure as described above in order to allow completion. Clinicians should also be mindful to maintain neutrality during treatment and to be aware of their own reactions to both the therapy and the patients. Given the diversity of the treatment-seeking population, clinicians will likely encounter patients with whom they identify in some way or whose body dissatisfaction induces an emotional response, and should therefore be aware of reactions and work to avoid letting them influence the treatment. Additionally, mirror exposure therapy can be taxing to the therapist: just as a patient with high levels of distress may require the expenditure of emotional energy on the part of a therapist, listening to a patient highly compliant with the treatment protocol describe the size, shape, and skin tone of their nose, including the number, shape, and size of each freckle for the fifth time, may be less exciting than the content of other psychotherapy modalities. Conversely, the rewards of successfully helping someone to improve their body image can be tremendous.

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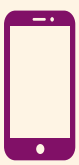
Mirror exposure therapy is an important tool in the treatment of body dissatisfaction and may be a very helpful adjunct for the treatment body image disturbances associated with eating disorders. Given the pervasive nature of body image disturbances, mirror exposure therapy could likely benefit a very large number of individuals.



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