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Experiential avoidance and dysfunctional beliefs in the prediction of body image disturbance in a nonclinical sample of women

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ABSTRACT

Body image disturbance (BID) refers to persistent dissatisfaction, distress, and dysfunction related to some aspect(s) of one's physical appearance. Cognitive models of BID highlight the importance of dysfunctional beliefs in maintaining BID. Relational Frame Theory (RFT), in contrast, posits that psychological distress is sustained by the unwillingness to experience aversive internal experiences (i.e., experiential avoidance [EA]). The present study tested the hypothesis that both dysfunctional beliefs and EA uniquely predict BID even after accounting for general distress. A nonclinical female sample ($N = 100$) completed measures of general distress, dysfunctional beliefs about appearance, EA, and BID in addition to providing in vivo anxiety ratings after looking at their most dissatisfactory facial feature in a vanity mirror. Linear regression analyses showed that dysfunctional beliefs, but not EA, accounted for significant unique variance in BID outcomes. Implications for understanding, assessing, and treating clinically significant BID are discussed.

1. Introduction

Body image disturbance (BID) is a construct that refers to persistent dissatisfaction, distress, and dysfunction related to an aspect of physical appearance (e.g., the shape of one's nose; Cash, Phillips, Santos, & Hrabosky, 2004; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). BID has been associated with adverse psychosocial consequences including disordered eating, depression, anxiety, and impaired social and sexual functioning (Cash & Pruzinsky, 2002), as well as with compromised physical health and overall quality of life (Fiske, Fallon, Blissmer & Redding, 2014; Mond, Owen, Hay, Rodgers, & Beaumont, 2005; Phillips, 2007). BID differs from the more broadly defined *body dissatisfaction* by the severity of psychosocial impairment associated with negative body evaluation. Current models (e.g., Cash & Pruzinsky, 2002) conceptualize BID as a multidimensional construct that exists on a continuum that includes "everyday" BID on one extreme and psychiatric conditions such as eating disorders or body dysmorphic disorder (BDD) at the other (e.g., Hrabosky et al., 2009).

Several theoretical models have been proposed to better understand the development and maintenance of BID (e.g., Fairburn, 2008; Veale, 2004; Williamson, White, York-Crowe, & Stewart, 2004). Cognitive (and cognitive-behavioral) models are derived from Beck's (1976) cognitive specificity theory, which posits that psychological distress does not result from distressing stimuli (e.g., perceived flaws) per se, but rather from *maladaptive interpretations* of these stimuli (i.e., dysfunctional beliefs; "No one will like me because of the shape of my nose"). These interpretations derive from core beliefs about the self, world, and future (e.g., "One's appearance is very important to their success"). Applying this framework to body image, Cash and Pruzinsky (2002) conceptualized BID as related to investment (i.e., the importance individuals place on their appearance) and evaluation (i.e., appraisals of one's appearance). Empirical work suggests that these beliefs are shaped by social comparison, appearance-related teasing, and the internalization of sociocultural ideals (Stormer & Thompson, 1996). Within a cognitive framework of BID, environmental triggers (e.g., viewing one's reflection in a mirror) are thought to induce maladaptive cognitions, which are associated with negative emotions and prompt self-regulatory activities (i.e., coping strategies) aimed at reducing distress (Cash, Santos, & Williams, 2005). Such behaviors include avoidance, distraction, appearance fixing (e.g., camouflaging a blemish), and eating disturbance. Although these coping strategies can effectively reduce distress in the moment, they serve to maintain appearance-related beliefs and distress in the long term (Blakey & Abramowitz, 2016).

Although empirical evidence underscores the importance of dysfunctional beliefs in the development and maintenance of BID (see Thompson et al., 1999), these cognitions do not fully account

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for the variability in appearance-related psychosocial impairment. Consequently, researchers have sought to identify additional psychological constructs associated with BID that may add explanatory power to existing models. One such construct is experiential avoidance (EA), which refers to the unwillingness to tolerate unpleasant emotions, thoughts, or memories (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). EA plays a critical role in Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001), from which Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) was derived.

Pearson, Follette, and Hayes (2012) adopted an RFT/ACT-based conceptualization of BID. In contrast to the cognitive model, the RFT/ACT framework asserts that body image concerns are driven by the avoidance of more distressing and uncontrollable emotions, rather than dysfunctional beliefs about appearance. That is, whereas the cognitive model maintains that maladaptive cognitions underlie appearance-related distress (as well as urges to perform distress-neutralizing behaviors), the RFT/ACT perspective posits that BID emerges from an individual's attempts to avoid, resist, or suppress unpleasant emotions, thoughts, and other private experiences (e.g., those encountered when considering one's own physical appearance). The primary distinction between these theoretical approaches, therefore, is that in RFT/ACT, the problem is thought to lie in the *avoidance* of emotional discomfort over appearance, whereas in cognitive theory, it is the cognitions *themselves* that are viewed as problematic.

Despite the theoretical foundation for an EA conceptualization of BID—and RFT/ACT research has certainly improved conceptual understanding of several anxiety- and mood-related conditions (e.g., A-Tjak et al., 2015)—little research has empirically examined the specific relation of EA to BID. Nevertheless, available research with individuals with BDD suggests that EA adds explanatory power to theoretical models of BID. Wilson, Wilhelm, and Hartmann (2014), for example, found that compared to healthy controls, individuals with BDD demonstrated greater EA, even after accounting for depressive symptoms. In another study, Callaghan et al. (2012) found that EA was a significant unique predictor of BDD diagnostic status in a logistic regression model as well as dimensional BID severity in a linear regression model. Yet given that neither of these studies examined the predictive power of EA after accounting for established BDD-related distorted cognitions (e.g., beliefs about appearance), the degree to which EA *improves* our understanding of the maintenance of BID over and above traditional cognitive conceptualizations remains unclear.

Understanding the relative explanatory power of dysfunctional beliefs and EA in the prediction of BID would carry important implications for clinical practice. First, some individuals who participate in BID-related prevention programs nevertheless go on to develop clinically significant BID (e.g., Stice & Shaw, 2004). Therefore, enhancing our understanding of which psychological factors predict BID could help to inform and improve available prevention programs. Second, although several treatment programs have been developed to ameliorate clinically significant BID, some individuals who receive these interventions fail to obtain clinically significant improvement or maintain their treatment gains over time (e.g., Brownley, Berkman, Sedway, Lohr, & Bulik, 2007; Shapiro et al., 2007; Williams, Hadjistavropoulos, & Sharpe, 2006). Elucidating the relative importance of dysfunctional beliefs and EA—empirically supported psychological maintenance factors of appearance-related distress—to BID may help clinicians or clinical researchers prioritize psychological risk factors when designing, delivering, and evaluating BID treatments. Finally, given the prevalence of, and distress associated with, body image concerns among individuals who do not meet criteria for a BDD diagnosis—as well as Cash et al. (2004) conceptualization of BID on a continuum of severity—further research is needed to understand the relative contributions of cognitive and RFT/ACT constructs across levels of BID severity.

The aim of the present study was to elucidate the relative explanatory power of key constructs from RFT/ACT (i.e., EA) and the more traditional cognitive model (i.e., dysfunctional beliefs) in predicting BID. On the basis of previous empirical and theoretical work, we hypothesized that dysfunctional beliefs and EA would be associated with each other as well as with (a) self-reported BID and (b) in vivo appearance-related anxiety ratings. We also predicted that dysfunctional beliefs and EA would both emerge as significant unique predictors of self-reported BID and in vivo appearance anxiety ratings after accounting for each other and for general distress. We elected to test these hypotheses in a non-clinical sample in order to maximize the variability in BID (which would be restricted in a clinical sample) and in light of the fact that BID, beliefs about appearance, and EA are all conceptualized as dimensional constructs (Cash et al., 2004; Chawla & Ostafin, 2007; Thompson et al., 2005). Moreover, we restricted our sample to include women only because women are more likely than men to report appearance concerns related to facial features (Phillips, Menard, & Fay, 2006); accordingly, testing our hypothesis in a sample of women would maximize the variability in—and ecological validity of—vanity mirror-related anxiety.

2. Method

2.1. Participants

One hundred female undergraduates enrolled in introductory psychology courses at a large university in the southeastern United States provided informed consent to participate in this study, as part of a larger experiment, in exchange for course credit. Participants were able to enroll in this study if they identified as female, were at least 17 years old, were fluent in English, and could identify at least one facial feature with which they were at least somewhat dissatisfied. Three steps were taken to ensure that participants were eligible to participate. First, the study advertisement stated that participants must (a) identify as female, (b) be at least 17 years old, and (c) be able to identify at least one facial feature with which they are somewhat dissatisfied in order to participate. Second, participants were asked prior to providing informed consent to verbally confirm their gender, age, and whether or not they were at least somewhat dissatisfied with at least one out of 21 facial features on a study checklist (e.g., nose, eyebrows, hairline). Finally, participants had to provide a dissatisfaction rating of at least a "4" on a 0 (*not at all dissatisfied*) to 10 (*completely satisfied*) scale before beginning the mirror task described below to be included. Participants had a mean age of 18.8 years ($SD = 2.34$; range 17–40) and a mean dissatisfaction rating of 6.88 ($SD = 1.39$). The majority (67%; $n = 67$) of the sample identified as white, with 17% ($n = 17$) identifying as Asian, 11% ($n = 11$) identifying as Black, and 5% ($n = 5$) identifying with another race/ethnicity.

2.2. Measures

2.2.1. Body Image Disturbance Questionnaire (BIDQ; Cash et al., 2004)

The BIDQ is a widely used 7-item self-report BID screening measure derived from the validated Body Dysmorphic Disorder Questionnaire (BDDQ; for descriptions of the BDDQ, see Dufresne, Phillips, Vittorio, & Wilkel, 2001; Phillips, 1996). Participants rate the strength of their concerns and preoccupations with physical appearance, appearance-related distress, the effects of body image concerns on multiple aspects of functioning, and appearance-related avoidance behavior on a 1 (*not at all*) to 5 (*extremely*) scale.