



## Two sides of the same coin? A new instrument to assess body checking and avoidance behaviors in eating disorders



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### ABSTRACT

Body checking (BC) and avoidance behaviors (BA) are the dominant behavioral features of body image disturbances (BID) that characterize most individuals with eating disorders (EDs). Whereas BC can be reliably assessed, a valid assessment tool for BA is lacking, preventing an adequate assessment of BID differences across different EDs (anorexia nervosa, AN; bulimia nervosa, BN; binge eating disorder, BED). A total of 310 women with EDs and 112 nonclinical controls completed measures of BC-, BA- and ED-related symptoms. BA did not differentiate between EDs, whereas BC did: it was highest in AN and BN, and lowest in BED. Multivariate analyses also discriminated AN from BN based on BC. Given that results are of preliminary nature, evidence is promising that EDs can be discriminated from healthy controls and that differential BID profiles for the behavioral component among ED subgroups exist. However, replication of the factor structure remains open within ED subsamples.

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### 1. Introduction

Eating disorders (ED) are among the most common clinical problems encountered by adolescent girls and young women (Thompson, 2001). In particular, the classic EDs anorexia nervosa (AN) and bulimia nervosa (BN) are characterized by body image disturbances (BID) as core symptoms; but individuals with binge eating disorder (BED) or subclinical forms of EDs (e.g., eating disorders not otherwise specified, EDNOS) also present a negative body image (Vocks, Legenbauer, Rüdell, & Troje, 2007). BID symptoms can include perceptual deficits (e.g., inaccurate perception of one's own body shape and size), cognitive-affective/attitude distortion (e.g., negative self-evaluation of one's body, distress provoked by body evaluation) and dysfunctional body-related behaviors such as checking (BC) and avoidance behavior (BA; e.g., Cash & Deagle, 1997; Legenbauer, Thiemann, & Vocks, 2014; Vossbeck-Elsebusch et al., 2015). BC is defined in this regard as the practice of repeatedly inspecting aspects of one's body in a range of ways" (Engle, Cash, & Jarry, 2009), whereas BA refers to behaviors that help to

avoid situations in which the body may be exposed and as such reduce body-related anxiety (e.g., covering mirrors, refusing to be weighed, wearing clothes that disguise one's shape; e.g., Engle et al., 2009; Rosen, Srebnik, Saltzberg, & Wendt, 1991).

While perceptual and cognitive-affective BID have been studied intensively, body-related behaviors are poorly understood. This is unfortunate, because cognitive-behavioral models of body image and EDs propose that body-related behaviors such as BC and BA are not only a symptom of BID, but are also responsible for the maintenance thereof (Fairburn, Cooper, & Shafran, 2003; Shafran, Fairburn, Robinson, & Lask, 2004; Vossbeck-Elsebusch et al., 2015; Williamson, White, York-Crowe, & Stewart, 2004). For example, a negative appearance-related schema is triggered by an external event (negative comment about one's shape, reflection in a mirror, exposure to another woman who is thinner than oneself), resulting in negative body-related emotions and cognitions. To cope with this situation, various strategies may be applied, including avoidance by leaving the threatening situation or trying to alter one's appearance or seek reassurance (appearance fixing; Cash, Santos, & Williams, 2005). Hence, behavioral elements of BC such as weighing oneself, and touching or measuring certain body parts may serve as a reassurance or objective verification, triggering safety and control beliefs (Mountford, Haase, & Waller, 2007) and "countering" body-related anxiety. BA, on the other hand, seems to be established by negative reinforcement and as such prevents exposure to body-

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threatening situations. In sum, both behaviors play a crucial role in the development and maintenance of BID and should be addressed in treatment. However, the interplay between the two behavioral facets of BID is unclear, and focused, thoroughly defined assessment tools are still needed (e.g., Cash, 2011; Engle et al., 2009).

One of the most frequently used tools for the assessment of BID is the body image avoidance questionnaire (BIAQ, Rosen et al., 1991). However, this instrument is not without its limitations: originally published in 1991, failures to replicate the original factor structure have recently accumulated, thus calling the reliability of the measure into doubt (Brytek-Matera & Rogoza, 2015; Cash, 2011). One reason for this might be that the BIAQ includes behaviors that can be considered as eating, checking, control, grooming, or other behaviors (e.g., “I restrict the amount of food I eat”, “I get dressed up or made up”, “I am inactive”) and thus does not solely measure BA. This assumption is also supported by the fact that these items load on a subscale dealing with restraint eating style, which correlates highly with the restraint scale from the Eating Disorders Examination questionnaire (EDE-Q; see also Legenbauer, Vocks, & Schütt-Strömel, 2007). Moreover, the BIAQ asks about the frequency of behaviors such as wearing baggy or dark clothes or avoiding physical intimacy, which might not only reflect body-related concerns (Cash, 2011). Thus, an assessment of BA with the BIAQ is contaminated by restraint-related items and items that are not specific to body concerns, hindering an adequate assessment and hence understanding of BA. There is only one assessment tool that addresses the limitations pointed out above: the Body-Image Behaviors Inventory-3 by Engle et al. (2009). The BIBI-3 was developed to assess a broad spectrum of BC, including a range of compulsive actions relating to the behavior component of BID as well as body image avoidance. The validation study was conducted in a large sample of college women in the Northern US and Canada. For both BC and BA, results showed two subscales reflecting relevant areas of BC (fixing<sup>1</sup> and checking) and BA (contextual avoidance and camouflaging). Although the BIBI-3 thus emphasizes that different facets of BA and BC may be present, the results are limited to community-based samples. Accordingly, one aim of the present study is to present a short and comprehensive, as well as factorially “clean” scale measuring BA particularly in clinical samples to allow “profiling” of various EDs on BA and its “counterpart”, BC.

As a second aim of the present research, this new scale is used together with measures of BC and other ED symptoms to characterize the various ED subgroups, since few comprehensive studies have tackled this. Evidence from nonclinical populations suggests that BA is associated with eating and shape concern (Engel et al., 2006) as well as with general eating pathology and clinical impairment (White & Warren, 2013). Moreover, most women with clinical EDs avoid exposure to images of or contact with their body parts (Shafran et al., 2004). Furthermore, dynamic changes in BID occur: BA during one time period can turn into BC and vice versa (Shafran et al., 2004). BA and BC are also related to other, non-BID-related ED symptoms such as restraint eating and preoccupation with eating (e.g., Legenbauer et al., 2007; Reas, Whisenhunt, Netemeyer, & Williamson, 2002; Vocks, Moswald, & Legenbauer, 2008). In particular, in mixed samples of clinically diagnosed patients with EDs (AN, BN, BED and EDNOS; Mountford et al., 2007), an association between BC on the one hand, and checking-related cognitions, eating, shape and weight concern as well as restraint eating on the other hand was reported. Similarly, a comparison of diagnostic ED groups showed higher BC in BN compared to AN and BED. On the

other hand, recent evidence indicates no difference in BC between women with acute AN (underweight), weight-restored patients with AN and healthy controls (Bamford, Attoe, Mountford, Morgan, & Sly, 2014).

Whereas BA investigated among BN and EDNOS (Vossbeck-Elsebusch et al., 2015) showed a positive relation with BMI and with body size overestimation, Bamford et al. (2014) reported a negative relationship between BA and BMI, with lower weight being associated with more BA. Associations between behavioral BID and overvaluation of shape and weight have also been reported in obese individuals and binge eaters (Grilo et al., 2005; Latner, 2008; Reas, Grilo, Masheb, & Wilson, 2005).

In sum, BC and BA are strongly related to eating symptomatology in the various ED diagnostic categories; however, methodological issues impede the ability to draw conclusions from the described empirical evidence. Besides the need for a useful and short assessment tool, it is still unclear whether BA and BC differ between diagnostic categories or whether they are related to specific ED symptoms across ED subgroups. Most studies have focused either on single disorders (AN or BN; e.g., Bamford et al., 2014) or single behavioral symptoms (either checking or avoidance; e.g., Calugi, Grave, Ghisi, & Sanavio, 2006; Vossbeck-Elsebusch et al., 2015). Only a few studies have included several diagnostic categories (AN, BN, BED, subclinical forms) and reported comparisons between these groups (e.g., Mountford et al., 2007; Vossbeck-Elsebusch et al., 2015), controlled for body weight statistically (obese vs. normal weight; e.g., Legenbauer et al., 2011; Lewer, Nasrawi, Schroeder, & Vocks, 2016) or assessed both BC and BA (Bamford et al., 2014; Shafran et al., 2004). Finally, while there are distinct assumptions concerning BC, the relation between ED symptoms and BA remains unclear, giving rise to the question whether BC and BA serve different purposes. This seems especially important with regard to the maintenance and therapy of EDs and BID. To our knowledge, only two studies outlined above – the one by Bamford et al. (2014) and Engle et al. (2009) have addressed the differential functions of body-related behaviors, however results refer only to college women and patients with AN. The aim of the present study is therefore to (1) provide a sound and comprehensive measure to assess BA and BC in females with different diagnosed EDs, and (2) further explore associations of BA and BC depending on diagnostic group and symptom level.

## 2. Method

### 2.1. Participants

A total of 441 individuals took part in the present study. The participants were recruited in two different ways: 56 patients with the primary diagnosis of an ED according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) were recruited through the outpatient clinic of the University of Mainz, a specialist center for EDs where they were receiving psychotherapy (recruitment period December 2012 through April 2013). ED diagnosis was assessed with the Structured Clinical Interview for DSM-IV TR Axis I Disorders (SCID I; First, Spitzer, Gibbon, & Williams, 1996; German version: Wittchen, Zaudig, & Fydrich, 1997) by trained psychological or medical psychotherapists. The second part of the sample ( $n = 385$ ) was recruited through an online survey from February 2013 to April 2013.<sup>2</sup> The

<sup>1</sup> “...reflecting persons' elaborate efforts to manage, modify, or gain assurance about their looks (e.g., ‘I fixed and refixed certain aspects of my appearance before leaving the house’). . .” (Engle et al., 2009)

<sup>2</sup> The outpatient sample and the online sample did not differ significantly on Eating Disorder Examination questionnaire (EDE-Q) or Eating Disorder Inventory 2 (EDI-2) subscales, with the exception of EDE-Q “restraint eating”, where the online sample reported higher values than the outpatient sample as measured by an independent samples t-test,  $t(429) = 2.37$ ;  $p < .05$ .

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