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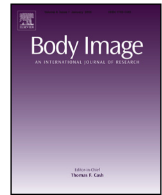

Brief research report

# Experiential avoidance in body dysmorphic disorder

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ABSTRACT

Experiential avoidance (i.e., the attempt to avoid certain internal experiences including bodily sensations, thoughts, emotions, memories, and urges) has been studied in various psychological disorders. However, research examining experiential avoidance in individuals with body dysmorphic disorder (BDD) is limited and inconsistent. The present study compared experiential avoidance in individuals with primary BDD ($n = 23$) to healthy controls ($n = 22$). Standardized measures were used to assess baseline clinical characteristics as well as experiential avoidance. Compared to healthy controls, individuals with BDD presented with significantly greater experiential avoidance ($p < .001$, $d = -2.51$). In BDD, experiential avoidance was positively correlated with depressive symptoms ($p < .01$) and avoidant coping strategies ($p < .01$). Clinician sensitivity to experiential avoidance may serve to improve the course of treatment for BDD.

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## Introduction

The cognitive-behavioral model of body dysmorphic disorder (BDD) posits that BDD-related beliefs and behaviors persist because they are negatively reinforced through the use of maladaptive coping strategies, including avoidance and appearance fixing (Neziroglu, Khemlani-Patel, & Veale, 2008). In contrast to behavioral avoidance in which certain situations or stimuli are avoided due to their association with negative or feared outcomes, experiential avoidance refers to the unwillingness to endure certain psychological experiences including bodily sensations, thoughts, emotions, memories, and urges (Hayes, Strosahl, & Wilson, 1999). Extant research suggests experiential avoidance is generally maladaptive (Zvolensky & Forsyth, 2002), and is associated with symptoms of psychopathology (for a review, see Chawla & Ostafin, 2007).

However, research exploring the role of experiential avoidance in body image disorders is limited and inconsistent. For example, results of a study examining cognitive-affective processing in individuals with anorexia nervosa found significantly greater experiential avoidance compared to a healthy control group (Rawal, Park, & Williams, 2010). However, another study found that levels of experiential avoidance did not differ significantly between individuals with anorexia nervosa, bulimia nervosa, and clinical controls (Hrabosky et al., 2009). Therefore, the role of experiential avoidance in the etiology and maintenance of body image disorders needs to be explored further.

Furthermore, research on the role of experiential avoidance in individuals with BDD is limited. In a recent study, researchers compared body image coping strategies (including the use of appearance fixing, experiential avoidance, coping by eating, and positive rational acceptance) in individuals with BDD versus individuals diagnosed with other Axis I disorders (e.g., obsessive–compulsive disorder, panic disorder, major depressive disorder; Hrabosky et al., 2009). Results indicated a significant difference between the two groups in the use of appearance fixing, but did not find significant group differences in the use of the other strategies (including experiential avoidance). However, because the questionnaire measured experiential avoidance specifically in response to body image threats, it remains unclear whether individuals with BDD tend to engage in experiential avoidance more generally.

In another study, Callaghan, Duenas, Nadeau, Darrow, Van der Merwe, and Misko (2012) examined the relationship between body image disturbance, experiential avoidance, and interpersonal expression of affect in individuals with BDD. Results indicated that experiential avoidance was a significant predictor of diagnosis of BDD, but not of BDD severity. Aside from measures of symptom severity, the researchers did not examine other correlates of experiential avoidance.

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Therefore, the aim of the present study was to compare experiential avoidance and coping with body image stressors in individuals with primary BDD ($n = 23$) to healthy controls ($n = 22$). Furthermore, we sought to examine the relationship between experiential avoidance and clinical characteristics in BDD. We hypothesized that individuals with BDD would have greater experiential avoidance compared to the control group. In addition, we predicted that individuals with BDD would engage in greater use of maladaptive coping strategies in response to body image threats, including appearance fixing and avoidance. Furthermore, we predicted that experiential avoidance in BDD would be significantly correlated with clinical characteristics, such as symptom severity and depression. In addition, we assessed the relationship between experiential avoidance and coping strategies and predicted that experiential avoidance would be significantly associated with greater use of avoidant coping strategies.

## Method

### Participants

We recruited a total of 45 participants with BDD ($n = 23$) and healthy controls ($n = 22$). Both BDD and healthy control participants were recruited through advertisements and flyers posted at local businesses (e.g., coffee shops, hair salons, libraries) throughout Boston and surrounding communities. In addition, BDD participants were recruited by asking prospective patients at the Obsessive–Compulsive and Related Disorders Clinic at Massachusetts General Hospital (MGH) if they were interested in participating. Individuals 18 and older were eligible to participate. For the BDD group, additional inclusion criteria were a diagnosis of BDD according to DSM-IV-TR (APA, 2000) and a score ≥20 on the Yale-Brown Obsessive Compulsive Scale modified for BDD (Deckersbach, Wilhelm, Otto, Savage, & Buhlmann, 1998; Phillips, Hollander, Rasmussen, Aronowitz, DeCaria, & Goodman, 1997). Participants were excluded if they met criteria for a comorbid eating disorder, substance abuse or dependence, psychotic or bipolar disorder in the past 3 months, presented with homicidality or current clinically significant suicidality, or if they had previously received an adequate trial of cognitive behavioral therapy (CBT; >10 sessions in the last 10 years). This exclusion criterion was applicable to another study conducted with the current participants. Participants with self-identified English language difficulties were also excluded.

### Procedures

Participants in the present study were part of a larger study comparing psychological mechanisms in body dysmorphic disorder and anorexia nervosa. Analyses from the larger study focusing on delusionality of body image beliefs in anorexia nervosa and BDD have been published elsewhere (Hartmann, Thomas, Wilson, & Wilhelm, 2013). The former publication does not include the main variables of the present study including the Acceptance and Action Questionnaire (AAQ-II), Beck Depression Inventory (BDI-II), and Body Image Coping Strategies Inventory (BICSI). After providing informed consent, participants completed a diagnostic clinical interview with a trained clinical psychologist and completed a series of self-report questionnaires on REDCap, an electronic data capturing system (Harris, Taylor, Thielke, Payne, Gonzalez, & Conde, 2009). The Partners Human Research Committee at Massachusetts General Hospital (MGH) approved the study protocol.

### Measures

**Structured Clinical Interview for DSM-IV (SCID).** The SCID (First, Spitzer, Gibbon, & Williams, 2002) is a semi-structured clinical interview for the diagnosis of Axis I disorders, which we used to confirm participants' BDD diagnosis and assess comorbidity. In previous studies, the inter-rater reliability for the SCID has been satisfactory to good across disorders ($.61 \leq r_{icc} \leq .83$; Lobbestael, Leurgans, & Arntz, 2011).

**Yale Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS).** The BDD-YBOCS (Phillips et al., 1997) is a 12-item semi-structured clinical interview designed to rate the severity of BDD. The BDD-YBOCS has shown excellent inter-rater reliability in previous studies ($r_{icc} = .99$; Phillips et al., 1997). In the present study, internal consistency for the BDD-YBOCS was acceptable for both the BDD group (Cronbach's $\alpha = .65$) and the control group (Cronbach's $\alpha = .63$).

**Brown Assessment of Beliefs Scale (BABS).** The BABS (Eisen, Phillips, Baer, Beer, Atala, & Rasmussen, 1998) is a 7-item semi-structured clinical interview that assesses insight and delusionality of body image beliefs. The clinician elicits the individual's core appearance belief, and then assesses the individuals' degree of insight into this belief. In the present study, internal consistency for the BABS in the BDD group was excellent (Cronbach's $\alpha = .97$). In addition, inter-rater reliability in a related sample rated by the same raters was good (ICC = .85; Hartmann et al., 2013).

**Body Image Coping Strategies Inventory (BICSI).** The BICSI (Cash, Santos, & Williams, 2005) is a 29-item self-report measure that assesses cognitive and behavioral strategies that one uses to cope with body image threats or challenges. The BICSI contains three subscales scores with acceptable to good internal consistency: Appearance Fixing (BDD group: Cronbach's $\alpha = .89$; Control group: Cronbach's $\alpha = .76$), Avoidance (BDD group: Cronbach's $\alpha = .63$; Control group: Cronbach's $\alpha = .74$), and Positive Rational Acceptance (BDD group: Cronbach's $\alpha = .76$; Control group: Cronbach's $\alpha = .85$).

**Beck Depression Inventory (BDI-II).** The BDI-II (Beck, Steer, & Brown, 1996) is a 21-item self-report measure of depressive symptom severity. In the present study, internal consistency for the BDI-II total score was good for the control group (Cronbach's $\alpha = .81$) and excellent for the BDD group (Cronbach's $\alpha = .91$).

**Body Image Disturbance Questionnaire (BIDQ).** The BIDQ (Cash, Phillips, Santos, & Hrabosky, 2004) is a 7-item self-report measure assessing appearance-related concerns and preoccupation. In the present study, internal consistency for the BIDQ total score was good for both the control group (Cronbach's $\alpha = .88$) and BDD group (Cronbach's $\alpha = .74$).

**Acceptance and Action Questionnaire (AAQ-II).** The AAQ-II (Hayes et al., 2004) is a 10-item self-report measure of experiential avoidance, conceptualized as the tendency to avoid internal experiences, such as emotions and thoughts. Lower AAQ-II scores indicate greater experiential avoidance. In the present study, internal consistency for the AAQ-II total score was acceptable for the control group (Cronbach's $\alpha = .67$) and good for the BDD group (Cronbach's $\alpha = .85$).

### Data Analysis

To test the primary hypothesis, we conducted a Student's *t*-test with group (BDD vs. control) as the independent variable and experiential avoidance as the dependent variable. In addition, we conducted a Student's *t*-test with group as the independent variable and coping strategies as the dependent variables. Then, we computed correlations between experiential avoidance and clinical characteristics, as well as symptoms of psychopathology, in the BDD group. If a variable was significantly correlated with

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