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Can the impact of body dissatisfaction on disordered eating be weakened by one's decentering abilities?

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ABSTRACT

Decentering has been defined as the ability to deal with thoughts and emotions as subjective and ephemeral inner events. Since it implies a non-judging and present focused attitude towards thoughts and emotions, decentering has been considered as an important protective process against psychopathology, as it has been empirically shown to decrease depressive relapse rates. Nevertheless, its role in eating disordered attitudes and behaviours has not been fully uncovered.

Therefore, the aim of the present study is to explore the moderator effect of decentering on the relationship between eating psychopathology and one of its main risk factors, body image dissatisfaction.

The sample comprised 279 female students, aged between 14 and 21 years-old. Results revealed that decentering abilities were negatively linked to body image dissatisfaction and to the global score of eating psychopathology. Through a path analysis, the buffer effect of decentering was confirmed.

The findings suggest that the ability to take a non-judgmental and accepting stance towards internal experiences diminishes the impact of one's body dissatisfaction on disordered eating attitudes and behaviours. This study seems especially pertinent since it uncovers a mechanism to lessen the pervasive impact of body image dissatisfaction, which is highly prevalent in women from Western societies.

1. Introduction

Decentering has been pointed as an important protective mechanism in regard of psychopathological conditions and a core change process in therapy (Hayes, Strosahl, & Wilson, 1999; Sauer & Baer, 2010; Segal, Williams, & Teasdale, 2002; Teasdale et al., 2002). This process is defined as the ability to deal with one's inner experiences (thoughts and emotions) as subjective and ephemeral inner events. That is, being contrary to a self-focused form of attention, decentering allows the detached observation of one's thoughts and feelings, recognising them as products of the mind (versus reflections of the self or reality) that do not require particular responses (Fresco et al., 2007).

The construct of decentering, first introduced by Safran and Segal (1990), has been the focus of particular interest from the classical cognitive–behavioural therapy to the more recent third wave models (e.g., Mindfulness and Acceptance and Commitment Therapy; Fresco, Moore, et al., 2007) due to its capacity to produce long-term treatment effects (Ingram & Hollon, 1986). Throughout history, crucial to the conceptualisation of decentering is the ability to take a present-focused, nonjudging and accepting attitude towards thoughts and feelings (Fresco, Segal, Buis, & Kennedy, 2007). In fact, decentering seems to imply a mindful stance, since it translates the capacity to observe the temporal stream of internal experiences as they occur in the mind (Bishop et al., 2004; Safran & Segal, 1990).

Furthermore, decentering describes a fundamental shift in perspective that allows one to be less attached to unwanted thoughts and feelings (e.g., Teasdale, Segal, & Williams, 1995; Teasdale et al., 2002; Wells, 2002). As it reduces automatic cognitive patterns, including rumination and obsession, this shift may have multiple psychological and behavioural advantages (Teasdale et al., 2002). Moreover, it may potentiate a non-reaction to negative experiences and the ability to be self-compassionate (Segal et al., 2006). In this sense, decentering may be conceptualised as a functional emotion regulation process to cope with unwanted internal events, allowing the adoption of adaptive choices before aversive events. In fact, theoretical and empirical evidence have revealed that the ability to take a decentered perspective on internal experiences holds positive correlations to well-being and mental health (Fresco, Moore, et al., 2007). More specifically, it has been linked with protection against depressive symptoms and relapse (Ingram & Hollon, 1986; Teasdale et al., 2002).

To date, however, there has been little work that clarifies the importance of decentering in eating psychopathology. Nonetheless, recent research has recognised that emotion regulation difficulties assume a crucial role to the development of disordered eating attitudes and

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behaviours (Ferreira, Trindade, Duarte, & Pinto-Gouveia, submitted for publication; Lavender, Jardin, & Anderson, 2009; Merwin et al., 2011; Trindade & Ferreira, 2014; Whiteside et al., 2007). These difficulties include experiential avoidance, the incapability of being in the present moment and the tendency to take a judgmental stance about thoughts and feelings (Lavender et al., 2009). Indeed, disordered eating behaviours (such as binge eating, purging and excessive exercise) may be seen as strategies to avoid or control unwanted internal experiences related to one's body image (e.g., body image dissatisfaction; Merwin et al., 2011; Trindade & Ferreira, 2014).

Body image dissatisfaction is, indeed, an acknowledged risk factor for eating psychopathology (Stice, Marti.,, & Durant, 2011) and has also gathered attention of several studies within the third wave of cognitive–behavioural therapy. In fact, the negative evaluation of one's body weight and shape has been considered as a source of pervasive psychological distress and is associated with disordered eating attitudes and behaviours even amongst women without eating psychopathology (e.g., Lewis & Cachelin, 2001; Niemeir, 2004). Furthermore, recent data suggests that the prevalence of body image dissatisfaction and associated disordered eating behaviours may be reduced via an increase in psychological flexibility when dealing with unwanted weight-related thoughts and feelings (Lillis, Hayes, Bunting, & Masuda, 2009).

Several therapies have therefore included acceptance- and awareness-based modules in the treatment of the body image and eating disorders' field (e.g., Acceptance and Commitment Therapy, Hayes et al., 1999; Mindfulness-based eating awareness training, Kristeller & Hallett, 1999). These forms of therapy encourage a non-judgemental and nonresponsive observation of body-related thoughts, images and fears, instead of responding to those events with maladaptive behaviours (Heffner, Sperry, Eifert, & Detweiler, 2002; Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2000). However, although these therapies are definitely promising in eating psychopathology (e.g., Baer, Fischer, & Huss, 2006; Merwin & Wilson, 2009), little research has been performed concerning the association between decentering and such disorders. Before this lack in literature, the current study aims to clarify whether the ability to take a decentered perspective regarding unwanted inner experiences has a buffer effect on the impact of dissatisfaction with body weight and shape on disordered eating difficulties.

2. Methods

2.1. Participants

Two hundred seventy nine female students, ranging from 14 to 21 years old, were enrolled in the study. The participants presented an average age of 17.88 years old ($SD = 1.95$) and a mean of 11.63 years of education ($SD = 1.86$).

2.2. Measures

2.2.1. Demographic data

Participants were asked to report their age, completed educational level, and current height and weight. BMI (Wt / Ht^2) was then calculated.

2.2.2. Experiences Questionnaire (EQ; Fresco, Moore, et al., 2007; Pinto-Gouveia, Gregório, Duarte, & Simões, 2012)

The EQ comprises 11 items designed to assess decentering in daily experiences (e.g., "I notice all sorts of little things and details in the world around me"; "I think over and over again about what others have said to me"). Items are scored on a 5-point Likert scale (1 — never; 5 — always), according to their frequency. Higher scores imply greater ability to view one's thoughts and feelings as temporary and separated from the self. The EQ revealed good internal consistency values, having Cronbach's alpha values of .83 in the original version and .81 in the Portuguese validation study.

2.2.3. Figure Rating Scale (FRS; Thompson & Altabe, 1991; Ferreira, 2003)

The FRS is a well-known measure that presents nine silhouettes, ranging from very thin (1) to very large (9). The participant is asked to choose two figures: one that best translates her current body size and one that reflects her ideal body shape; the divergence between these two silhouettes indicates the level of body dissatisfaction (BD). According to Thompson and Altabe (1991), the scale holds good temporal, convergent and divergent validities.

2.2.4. Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994; Machado, 2007)

The EDE-Q is a 36 item self-report questionnaire that was adapted from the Eating Disorder Examination interview. This scale evaluates the participants' psychopathological eating attitudes and behaviours over a 28 day period in a scoring system of 0–6 (0 — no days; 6 — everyday). The EDE-Q includes 4 subscales (restraint, eating concern, shape concern and weight concern) and also a global score of eating psychopathology. In the present study only the global score from the EDE-Q was used as we were interested in measuring the severity of eating psychopathological symptoms. In accordance with Fairburn (2008), the EDE-Q holds good reliability values and may be used to discriminate eating psychopathology cases.

The study variables' Cronbach's alphas are presented in Table 1.

2.3. Procedures

The study was granted ethical approval by the ethics committees of the educational institutions enrolled in the research. Participants were female students recruited from several middle and high schools and also from the University of Coimbra. All the female students from the schools enrolled in the study were invited to participate. Participants (and their parents, if they were minor) were fully informed about the aim of the study and the confidential nature of the data before completing several self-report measures. The majority of the invited students accepted to participate in the study and signed the consent form. Students who did not participate were given a task by the teacher. The questionnaires were completed during class (in approximately 30 min), in the presence of the teacher and one of the researchers that provided further explanations when needed, in order to ensure the correct fulfilment of the measures.

2.3.1. Data analysis

Data analyses were performed using IBM SPSS Statistics 20 (IBM Corp, 2011) and path analyses were examined using the software AMOS.

Descriptive statistics (means and standard deviations) were used to explore the sample's characteristics in the study variables.

Pearson correlation coefficients were conducted to explore the association between decentering (EQ), body dissatisfaction (BD),

Table 1
Mean (*M*), standard deviation (*SD*), Cronbach's alphas and intercorrelation scores on self-report measures (N = 345).

Measures	*M*	*SD*	α	EQ	BMI	BD	EDE-Q
EQ	33.68	6.07	.85	–			
BMI	21.16	2.72	–	−.15*	–		
BD	.60	.92	–	−.34***	.54***	–	
EDE-Q	1.51	1.36	.96	−.51***	.38***	.59***	–

Note. $^{*}p < .050$. $^{**}p < .010$. $^{***}p < .001$. EQ = Experiences Questionnaire; BMI = Body Mass Index; BD = body dissatisfaction; EDE-Q = Eating Disorder Examination Questionnaire.