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Impact of DBT Treatment on the Relationship Between Women's Overall Self-Concept and Body-image

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Abstract

Given the connection between self-concept and body-image for women recovering from eating disorders, this study researched the impact of twelve women's participation in a body-image group in a Dialectical Behavior Therapy Center. The dialectical behavior therapy approach is of particular interest given its emphasis on mindfulness and acceptance, which may aid in decreasing the tension between how women with eating disorders view their ideal versus perceived selves. Quantitatively, this study investigated change in scores on the Total Self-concept Score (TOT) and Conflict Score (CON) of the Tennessee Self-concept Scale – 2. As hypothesized, data analysis revealed a large effect size of .89 for positive change in TOT following group participation; however, there was no change in CON. Qualitatively, this study evaluated thematic differences regarding the interaction between body-image treatment, gender identity, and ideal versus actual perceived self before and after group participation. Themes revealed through grounded theory analysis of the qualitative data addressed participants' core

conflict between longing for perfection and valuing acceptance of imperfection. These quantitative and qualitative results indicate the potential of DBT based body-image treatment for improving the overall sense of self in women in the recovery phase of eating disorders. Implications for future research are discussed.

Table of Contents

List of Tables

List of Figures

Chapter 1

Introduction

The social pressure to maintain a thin figure for women is undeniable. As Roberta Seid (1989) explains in her book *Never too Thin,* these cultural messages and images have been promoted by a variety of sources: the political dynamics of the public health field, fashion industry, and common prejudices. Seid argues that the public health field helped fuel the latter half of the twentieth century's campaign against body fat by misrepresenting insufficient scientific evidence that weight gain is controlled by a person's behaviors, regardless of the natural effects of age and life circumstances. Despite later contradictory evidence, this assurance of "hard scientific evidence" furthered prejudices against overweight and obese people, thereby establishing weight and body-image as a reflection of moral upstanding. Culturally, body-image came to be understood as an important reflection of a personality. However, as Seid states, these prejudices have now also extended to those that are of normal weight, and the ideal weight has continued to decrease, approaching and often surpassing what some medical research suggests to be healthy.

These stringent standards have become so pervasive and influential that according to a 1986 University of California study, 50% of fourth grade girls and 80% of ten and eleven year old girls had been on diets to lose weight (Seid, 1989). Equally frightening has been the increase of eating disorders. Body-image disturbance that unduly influences self-evaluation is a core

feature of eating disorders (American Psychiatric Association [APA], 2000). There are a variety of clinical perspectives on the development of body-image disturbance and its relationship to self-concept. For example, one cognitive behavioral explanation for the development of body-image salience in eating disorders states that body-image disturbance involves perceptual distortion, cognitive distortion, and avoidant behaviors (Rosen,1997). Psychodynamic explanations suggest that body-image disturbance results from "internalization" of external messages and experiences of the body, or "projection" of disturbances in the self onto the body (Kearney-Cooke & Striegel-Moore, 1997). The purpose of the present study is to understand this link between self-concept and body-image in women recovering from eating disorders and to evaluate the impact of body-image treatment in a DBT center upon their overall self-concepts.

Eating Disorders: Postmodern Feminist Perspective

In her book *Unbearable Weight*, Bordo (1993) likens the rapid onset of anorexia in the 1980s to the Freudian phenomenon of hysteria at the turn of the century. According to her conception, both represent feminine protest to repression as a response to power in a male dominated society. The author further suggests that for young women, the initial stages of an eating disorder can be an expression of fear of anything female, represented by the developing female physique, since traditional femininity comes with limitations in society. Starvation stops the course of the developing female body and can also be a way of expressing self-discipline and control, freedom from one's most basic biological needs. In Bordo's conceptualization, both body fat and uncontrollable hunger are to be feared. Ironically however, the anorexic assertion of power and control backfires by consuming energy that could otherwise be devoted to arguably more satisfying and attainable aims. In the most extreme cases of eating disorders, the pursuit of

the “perfect” body culminates in death, the most literal manifestation of powerlessness through consumption of life and energy (Bordo, 1993).

This pursuit of power through self-starvation begs the question of, “why?” In partial answer to this paradox, Bordo calls anorexia a “battle between male and female sides of self;” (1993, p. 174) the male side referring to self discipline, while being checked by the female side warning the anorexic to avoid filling too much space. The author observed that as women have gained increasing places of power in the work place, assuming positions previously allowed only to men, the ideal physical size of a woman has shrunk. It is as if she must compensate for the position of power she now fills by filling less space with her body. Of course, as Bordo noted, this ideal does not come naturally to the overwhelming majority of women. Rather, anorexic women waste productive, creative, and physical energy consuming their minds and very bodies in the pursuit of thinness. By obsessive diet and exercise, they practice obedience to cultural demands, but paradoxically, experience this slavery as control and power (Bordo, 1993).

The implications of this battle for a woman’s self-concept are considerable. As Bordo (1993) wrote, in the anorexic mindset, the body is seen as the enemy of self-control and power, a thing to be starved and despised. The body becomes an alien enemy, representing limitations of biological need and traditional feminine roles. Bordo traced this view of the body as the weak, undisciplined enemy to a historical, cultural association of women with the fulfillment of the basic biological drives of sexual desire and early childhood needs. This cultural association is relevant to the female body and self in that, as Foucault would urge, the body is not separate from culture (Bordo, 1993). If one assumes an inherent connection of culture and the body, the body being the place in which the individual and culture meet, it follows that the body would be

a ground of power struggle, influencing and influenced by culture. Body appearance then, is no superficial matter, but as Bordo phrases, comprises the "politics of appearance" (p. 27). This representation of gendered cultural messages through expectations for bodily appearance is a concept that Bordo and other postmodernists term "body as text" (p. 180).

Bordo's (1993) discourse applies not only to pure anorexics, but describes a general cultural phenomenon affecting a wide range of women at different levels of intensity. Bordo proposes that Western Society experiences an imbalance in the tension between consumer and producer extremes. The producer extreme is encapsulated by the anorexic struggle for control, discipline, and defiance of the limitations of nature and society. The consumer extreme, on the other hand, is represented in the bulimic struggle. This strain between consumer and producer extremes is exemplified by the phenomenon of simultaneous increases in pressure for thinness and availability and constant advertising to consume in general, and consume indulgent foods in particular. As the clinical research will suggest, bulimics in particular are pulled from one extreme to the other between consumption and restriction. The imbalance of excessive dietary restraint often backfires in the form of a binge, followed by shame and compensation and more restriction, triggering another binge. As Bordo hypothesizes, eating disorders are not simply individual pathology, but rather are the "crystallization" (Bordo, 1993, p. 139) of cultural pathology.

Bordo (1993) argues a case for the centrality of body-image to self-concept. She defines self- concept not only as an individual concept, but also as a social reality. The body, being the obvious point of interaction between the individual and culture, is the political battleground for one's power struggles with society and with one's self. For woman, this struggle is particularly

pronounced, especially in her interactions with cultural ideals for physical attractiveness. The present research will aim to qualitatively understand the struggles of women recovering from eating disorders in terms of discrepancies between their ideal an actual perceptions of self and body as women. Interpretations will be partly informed by postmodern understanding of body as described by Bordo.

Relevance of Body-image Treatment for Clients Recovering from Eating Disorders

Relationship of body-image and eating disorders. As suggested by the 10% mortality rate for anorexia nervosa (APA, 2000), eating disorders require crisis oriented treatment. After the initial stages of crisis have subsided, however, abnormal, intense worry and preoccupation with body weight and shape remains. Rosen (1997) cites studies by Deter and Herzog (1994), Goldbloom and Olmsted (1993), Ratsriya et al. (1991) and Windauer (1993) that suggest that 1/3-2/3 of recovered anorexics and bulimics still struggle with this acute, time consuming distress in body-image to an extent that interferes in daily life. Moreover, distortion in body-image and dependence on body-image for self-evaluation are core diagnostic criteria of eating disorders in the DSM-IV. The diagnostic criteria, combined with the research, imply that body-image disturbance is thoroughly intertwined with eating disorders, and specifically, for those recovering from eating disorders.

Research thus far on body-image treatment. A small minority of the literature does not support the efficacy of body-image treatment for body-image improvement (Farrell, Shafran, & Lee, 2006; Ramirez & Rosen, 2001). The overwhelming majority of research suggests the efficacy of certain treatments for body-image disturbances. Jarry and Ip (2005) conducted a meta-analysis of the literature on the efficacy of specific body-image treatment components.

Their analysis related that treatments that have attitudinal, behavioral, and perceptual components are most effective. Participants undergoing treatments with these three variables showed significant changes at follow up, both in terms of body-image and other psychological variables. Results of studies testing the efficacy of mirror exposure on body-image treatment is mixed but promising (Farrell et al., 2006; Hilbert, Tuschen-Caffer, & Vogele, 2002). Although *body-image investment* improves as a result of body-image treatment, as suggested by Jarry and Ip's (2005) meta-analysis, it is a symptom that is particularly chronic, despite other improvement. Attention to developing and testing body-image approaches which would be effective for this particular factor could be helpful.

The majority of the literature champions a Cognitive Behavioral Approach to body-image treatment. Jarry and Berardi's (2004) meta-analysis suggested that most effective body-image treatments were CBT, normally adaptations of Cash's or Rosen's treatment manuals. Farrell et al. (2006) confirmed these two treatment manuals as the most commonly used and possessing the most empirical evidence. Cash and colleagues conducted series of studies testing the efficacy of Cash's manualized body-image treatment approach and specific components of Cash's treatment in both controlled and uncontrolled studies (Butters & Cash, 1987; Cash & Hrabosky, 2003; Grant & Cash, 1995; Nye & Cash, 2006; Strachan & Cash, 2002). Although these studies unanimously support the efficacy of Cash's treatment, they have been unable to establish the superiority of Cash's treatment to other approaches, or to determine which components of Cash's approach contribute to its success. The success of CBT, then, could be due to the inclusion of the three components distinguished by Jarry and Ip's (2005) meta-analysis: attitudinal, behavioral, and perceptual. Jarry and Ip's meta-analysis, as well as Cash's and colleagues' research, imply

that other treatment approaches that incorporated these components could be equally effective to CBT approaches.

Towards the development of a dialectical behavior therapy-based treatment approach to body-image. Although *dialectical behavior therapy (DBT)* was originally designed for clients with borderline personality disorder, it has since been applied to a variety of other clinical disorders, including eating disorders. Distinctions between CBT and DBT approaches lie in DBT's emphases on affect regulation and mindfulness-based acceptance. While CBT emphasizes systematic desensitization by slowly increasing small amounts of feared foods, DBT emphasizes the toleration of negative affect that arises as one consumes these foods (Stewart, 2004). In their meta-analysis Jarry and Berardi (2004) suggested that although the studies thus far suggest that affect focused therapy may be helpful for eating disorders, more research needs to be done on this specific variable as relates to body-image disorder approaches.

Telch, Agras, and Linehan (2000) conducted a preliminary, uncontrolled trial on group dialectical behavior therapy for binge eating disorder, conceptualizing binges as a maladaptive affective regulation strategy. The understanding was that negative affect led to binge eating, which led to a temporary decrease in negative arousal. Part of the intention of this DBT treatment was to learn more adaptive affective regulation strategies through DBT skills training. At the end of treatment, 82% of women were binge free, and at follow up, 50% were binge free, consistent with the results of DBT treatment. Following this pilot study, Telch, Agras, and Linehan (2001) proceeded with a randomized waitlist control replication of this study, demonstrating not only significant effects for decrease in binges, but also significant decrease in

weight concerns, shape concerns, and eating concerns. Telch, Safer and Agras confirmed these results for bulimics (as cited in Chen, Matthews, Allen, Kuo, & Linehan, 2008).

Chen et al. (2008) substantiated the efficacy of a Stanford adaptation of DBT skills training for eating disorder behaviors and body-image concerns. Skills included behavioral chain analyses, mindfulness practice, emotion regulation skills, and distress tolerance skills tailored for eating disordered concerns. Participants were encouraged to view their binges within a dialectic framework, meaning combining acceptance of present eating behaviors with a commitment to change. Effect sizes at end of treatment for binges and EDE measure of weight and shape concerns and eating disordered behaviors were large, and remained at six month follow up.

This study by Chen et al. (2008) tested a range of skills that are central to DBT. Affective regulation strategies are key in the conceptualization of DBT studies thus far, as is the notion of acceptance. Mindfulness practices are key to the DBT approach to increasing acceptance. Practicing mindfulness skills trains one to simply notice and be aware of one's experience, without making reactive judgments of that experience or engaging in a need to fix or change the experience. In her overview of present mindfulness-based approaches to eating disorders, Kristeller, Baer, and Quillan-Wolever (2006) described the purpose of mindfulness practices as allowing a person to be in a state in which he or she can make more adaptive choices in response to their emotions. Theoretically, the mindfulness attitude incorporated in the act of eating moves one away from a mood of shame and fear which precipitate and follow poor food choices, to a psychological, physical state in which one is able to make better choices (Kristeller et al., 2006; Stewart, 2004).

Although there have been studies conducted on DBT approaches to eating disorders, thus far, there have been no studies conducted on DBT approaches to body-image disturbance. Although CBT approaches, including Cash's body treatment manual, have incorporated mindfulness approaches in mirror exposure techniques and the cognitive re-modification processes, the difference between CBT and DBT lies in emphases. Cognitive modification is pivotal to CBT, and mindfulness techniques are used to aid in this process. In DBT, however, mindfulness-based acceptance is the foundation of change. As Stewart (2004) suggested, the approach of CBT is to challenge cognitive distortions, whereas the approach of DBT is to increase awareness of alternative perspectives through mindfulness-based acceptance. A dialectical approach to mirror exposure therapy would encourage one to mindfully experience his or her entire body as a whole, and as part of their self as a whole, rather than a collection of parts (Stewart, 2004). Moreover, given DBT's emphasis on affective regulation skills, a DBT body-image treatment would emphasize affective regulation strategies during exposure techniques and would draw on behavioral chain analyses. Given that the literature suggests that a strong emotional investment in body-image remains after other eating disorder and body-image symptoms have subsided, a body-image approach, founded on mindfulness-based acceptance and affective regulation, deserves research and is the subject of the present study.

Relationship of Self-Concept and Body-Image Treatment

Self-concept operationally defined. The present study investigates whether body-image group treatment in a DBT center will impact overall self-concept of women recovering from eating disorders. Before proceeding, it is important to operationally define the term *self-concept* for the purposes of this study. According to Roid and Fitts (1994, as cited in Stowers & Durm,

1996), self-concept, as operationally defined by the *Tennessee Self-Concept Scale-2* (TSCS-2), refers to overall self esteem, when considering both descriptive ways in which one understands the self, as well as evaluative elements of self-concept. In the test manual, Fitts and Warren (1996) presented two overall scores for the TSCS-2: Total Self-concept Score (TOT), and Conflict Score (CON). Levin, Karnie,& Frankel (1978, as cited by Fitts & Warren, 1996), conceptualized the Total Self-concept Score (TOT) as being a measure of one's appraisal of the physical, moral, personal, family, and social dimensions of self-concept according to the three internal organizing principles of identity, self satisfaction, and behavior. The Conflict Score (CON) measures the balance of people's conceptualization of themselves in terms of who they are not versus who they are (Fitts & Warren, 1996).

Relationship between self-concept and body-image. The research tends to support a connection between self-concept and body-image as well. Jourard (1953, as cited in Rosen & Ross, 1968) suggested a moderate correlation between body-image and self-concept. Rosen and Ross' (1968) research suggested that the importance of a particular body part to a person impacted the strength of the connection between body-image and self-concept. The relevance of body-image importance is consistent with the chronic salience of body-image investment for individuals recovering from eating disorders. Lipowski (1977, as cited in Champion, Austin, & Tzeng, 1982) added to this body of evidence, finding that emotional and psychological states are a function of body perceptions . Stowers and Durm (1996) reported a correlation of .70, $p < .01$ between the Total Self-Concept Score (TOT) of the TSCS-2 and the Physical Self Subscale for men and a correlation of .75, $p < .01$ for women.

Stein and Corte (2006) conceptualized over-identification with body-image as a core component of identity for women with anorexia and bulimia and suggested that as a result, women with eating disorders had less range of identity and more negative self-schemas. Participants of their study who scored high on the Eating Disorder Inventory and Eating Disorder Behavior Questionnaire had significantly fewer positive self schemas and more interrelatedness in self-concept, consistent with their hypothesis. Jacobi, Paul, Zwaan, Nutzinger, and Dahme (2004) found lower self-concepts on a scale adapted from the Rosenberg Self-Esteem Scale for participants with eating disorders compared to a control group without eating disorders. Low self- efficacy scores of eating disordered clients were similar to those of participants with depression. Girodo (2003) compared the self-concept scores of participants with bulimia to those without and found that bulimic participants had significantly lower self-concepts. In summary, the research uniformly suggests that the majority of eating disordered clients have lower, limited self-concepts oriented around body-image as the primary component.

Intervention research on self-concept. Given the connection between self-concept and body-image for clients experiencing or recovering from an eating disorder, it may be worthwhile to review the intervention research impacting both self-concept and body-image. Cash and Hrabosky (2003) conducted an outcome study of Cash's body-image treatment, which indicated significant changes not only in body-image, but also in self-esteem. Moreover, Stewart and Williamson's (2003) four case studies of body-image treatment indicated not only improvement in body-image, but also improvement on other psychological variables, including, anxiety and depression. Jarry and Ip's (2005) meta-analysis of efficacy of body-image treatment approaches

also indicated significant changes at follow up on psychological variables technically unrelated to body-image.

Champion et al.'s (1982) conceptualization of the discrepancy between present and ideal self being correlated with discrepancy between present and ideal body is particularly intriguing to the present research, and speaks to the Conflict Score of the TSCS-2. DBT dialectics focus on "radical acceptance" of self, for the sake of acceptance itself, regardless of change, and at the same time balances this acceptance with commitment to change (Linehan, 1993). Mindfulness skills engage the client in practice of radical acceptance without needing to change the present, "what is" into the ideal "what should be." Given the importance of body-image investment to clients recovering from eating disorders, based on the centrality of body-image to self-concept, a DBT acceptance approach could potentially be well suited both to body-image and overall self-concept improvement.

Present Study

Quantitative. The above overview of the literature on body-image treatment indicates that after treatment progress occurs in terms of cognitive, emotional, and behavioral symptoms of body-image disorders, what remains is body-image investment. In other words, an unusually strong investment of self-concept in body appearance is one of the most chronic symptoms, and arguably a core cause of eating disorders and body-image disturbance. Research also supports that when body-image and eating disorders are treated, other psychological variables improve as well. The present research operates on the premise that the DBT dialectical strategies promoting radical acceptance and simultaneous change may address the inherent tension between how women think they should be (ideal self) versus how they perceive themselves (actual self). This

approach to the tension characteristic of body-image disturbance would promote a more positive overall self-concept (TOT) and decrease conflict reported in self-concept (CON). The present study tested two hypotheses.

Hypothesis 1. Specific treatment of body-image would positively and significantly impact women's overall view of themselves, as reflected by increase in Total Self-Concept Summary Score (TOT) and decrease in the Conflict Score (CON) of the TSCS-2.

Hypothesis 2. Increase in Total Self-concept Summary Score (TOT) and decrease in the Conflict Score (CON) of the TSCS-2 between pre and post treatment would positively co-vary with change in body-image variables, as measured by the *Appearance Schemas Inventory Revised* (ASI-R) and *Multidimensional Body-Self Relations Questionnaire* (MBSRQ).

Qualitative. The qualitative component of this research flowed from Bordo's (1993) postmodern feminist perspective on eating disorders surveyed above. The researcher of the present study suspected that the tension women experience in self-concept is related to the existence of a significant gap between how women conceive the ideal woman and how they see themselves. Exploring this tension with women recovering from eating disorders is of particular interest in that some arguably unrealistic standards for what women "should be" is culturally projected in the form of stringent physical appearance standards. However, the approach for the qualitative portion of this dissertation was more open-ended and allows the participants an opportunity to share the similarities and differences between how they see themselves and their personal concept of the ideal woman. The interaction between individual self-concept, gender identity, ideals, and body-image in women struggling with eating disorders has not been studied by qualitative means and is likely to be a highly individual experience. Given the scarcity of

research and the individual specific nature of this topic, an open-ended qualitative approach adds depth of meaning to the quantitative results of participants' TOT and CON scores of the TSCS-2.

Chapter 2

Method

Participants

Participants consisted of three groups lasting for ten sessions, with each group consisting of approximately three to six female clients recovering from eating disorders in a Dialectical Behavior Therapy Center (DBT). Women were recruited by the main facilitators of the "Resolving Negative Body-image Group" tested in the present study, a staff psychologist and licensed counselor at the DBT center. Women in the eating disorder treatment program at the DBT center who had completed Phase I of DBT skills training group were recruited both from the main facilitators' caseloads, and also by word of mouth to therapists on the eating disorder treatment team at DBT. Participants' therapists recommended clients to the present study. Participation in the group was recommended as a new addition to the Mindful Eating Program currently in practice at the DBT center.

Regarding demographics, average age was 39 and all participants were female. 16.7% of the women had previously met criteria for bulimia, 16.7% for anorexia, 16.7% for bulimia, and 66% for eating disorder NOS. All of the women currently met criteria for eating disorder NOS. 58.3% of the participants were restrictive in their eating disordered behaviors, and 41.7 % were impulsive. All but one Latina woman was European-American. 25% of the women did not meet criteria for any disorders other than eating disorder KNOWS. 33.3% of participants met criteria for major depressive disorder, 25% for depressive disorder NOS, 16.7% for dysthymia, 16.7%

for substance abuse in remission, 8.3% for alcohol dependence, in remission, 16.7% for GAD, 8.3% for ADHD, 8.3% for borderline personality disorder, and 8.3% for PTSD. The researchers decided that participants would be excluded from the data if they missed more than two sessions of the group treatment. On the basis of this criterion, none were excluded. However, one woman from the third group failed to complete the assessments, and three women total chose to cease participation. Group 1 consisted of five members, Group 2 of four members, and Group 3 of three members. The total study consisted of 12 participants due to time related practical reasons and the pilot nature of this study. No other research to this date has tested the impact of body-image treatment in a DBT center.

Materials

Intervention materials. Intervention materials included Cash's (2008) Body-image Treatment Manual, *The Body-image Workbook: An Eight-Step Program for Learning to Like Your Looks*, and a manual specifically designed by the facilitators and co-facilitators (researchers) as an adaptation of Cash's manual for use in a DBT center. See Appendix A for a copy of this manual. The Group Facilitators, a permanent staff psychologist at the DBT center, staff licensed counselor at the DBT center, and the co-facilitators, two doctoral clinical psychology students, summarized and adapted each of the eight sessions of Cash's 8 Step Body-image Treatment Manual according to DBT treatment principles. Relevant changes include alteration of session format according to standard DBT group format. This format consists of two parts, the first part being Mindfulness Meditation Exercise followed by a format check in. Mindfulness exercise is often accompanied by self disclosure from one of the group facilitators. There was a break after the first part of the group. During the second part of the group, new

material is introduced (Linehan, 1993). This standard DBT format will be applied to all sessions of the current "Resolving Negative Body-image" Group tested in this study. DBT based changes to the content of the sessions included application of dialectical principles, application of dialectical behavior therapy skills to problem solving in session, and use of behavioral chain analysis. Some of Cash's homework assignments were eliminated, and new assignments added. Researchers also included mindfulness exercises from the *Mindful way through anxiety workbook* (Forsyth & Eifert, 2007). An additional session was added for the purposes of post-test assessment and processing of the therapy in relation to progress and future goals, as well as a session on nutrition delivered by a registered nutritionist on staff at the DBT center. This 10-week treatment is the intervention being evaluated by the present study.

Tennessee Self-Concept Scale (TSCS-2). In the test manual, Fitts and Warren (1996) present two overall scores for the Tennessee Self-Concept Scale: Total Self-concept Score (TOT), and Conflict Score (CON). Levin, Karnie, and Frankel (1978, as cited by Fitts & Warren, 1996) conducted a factor analysis on the TSCS-2. Their results supported a conceptualization of Total Self-Concept Score (TOT) as being a measure of one's appraisal of the physical, moral, personal, family, and social dimensions of self-concept according to the three internal organizing principles of identity, self satisfaction, and behavior. Several studies cited .80 alpha coefficients for the internal reliability of the TOT (Roid & Fitts, 1994 and Tzeng et al., 1995, as cited in Stowers & Durm, 1996). Stowers and Durm posited that the TSCS-2's correlation with various other measures, such as the Coopersmith Self-Esteem Inventory (Van Tuinen & Ramanaiah, 1979, as cited in Fitts & Warren, 1996), supports the concept validity of the TSCS-2. Fitts, 1965, as cited in Garner & Garfinkel, 1997) cited test retest reliability of .87 for both the Total Self-

concept and Physical Self Subscale. The other comprehensive score of the TSCS-2 is the Conflict Score, which measure the balance of people's conceptualization of themselves in terms of who they are not versus who they are (Fitts & Warren, 1996). Changes on these measures between pre and post test were be assessed quantitatively.

Cash's body-image assessments. Cash's body-image assessments also demonstrate robust psychometric properties. The *Appearance Schemas Inventory Revised* (ASI-R; Cash, 2003, unpublished as cited in Cash, 2003) Manual claims internal consistency of .90 for men and .88 for women. The *Multidimensional Body-Self Relations Questionnaire* (MBSRQ), as posited by the Manual (Cash, 2000b), boasts high test retest reliability above .70 for all factors of the scale, as well as high internal reliability, as expressed in Cronbach's alpha, ranging from .77 to .90 for all factor subscales. Changes on these measures between pre and post test were assessed quantitatively.

Qualitative approach. The following qualitative questions were given at pre and post test: *What is your image of an ideal woman? Where have these messages come from? What does she look like? Act like? Believe? What do you think about this? How is this woman similar to you and how is she different?* Grounded theory analysis and N-Vivo software were used to detect shift in themes from pre to post test. The depth of understanding and meaning facilitated by this qualitative inquiry helped counteract the limitations of the small sample size of this study. Specifically, this approach illuminated the quality and nature of the relationship between participants' self-perceptions as compared to their ideal self-concepts, particularly in relation to their understanding of their body-images. It also furthered investigation of the origins of these scripts, cultural or otherwise.

Procedures

For the first group, the group facilitator recruited participants nearing completion of Phase I of DBT skills training group via direct contact of clients in her caseload and contact with therapists on eating disorder team of the DBT center. During the first session of the first group of 6 people, participants signed an informed consent (Appendix B). They completed all of the assessments noted above. For the qualitative question, women were given 15 minutes to write a response. Sessions 2-8 followed the format of the sessions as described in Appendix A. Participants completed the same assessments in Session 10.

Participants for the second and third trials of the group were recruited in the same manner described above. The first and second groups will were facilitated by the same doctoral level psychologist and two graduate students, and the third group was led by a licensed counselor on staff of the eating disorder team at the DBT center. Procedure for second and third group followed approximately the same procedure as described for the first group. However, the staff facilitators altered the procedure for the second and third group in order to adapt to client needs that arose as treatment progressed.

Data Analysis

Quantitative analysis. The assessment methods of this study were quantitative and qualitative in nature. Quantitative analysis consisted of two parts. The first part of the analysis will employed a paired samples t-test to measure the entire treatment group's change in self-concept at pre and post test, as measured by Tennessee Self-Concept Scale Summary Score (TOT) and Conflict Score (CON). Repeated measures effect sizes (Gibbons et al., 1993) were calculated for changes in TOT and CON scores. The second portion of the quantitative design

assessed the extent to which change in body-image and change in self-concept varied together. A change correlation was applied to the first part of the analysis in order to determine the amount of covariance between change in the TOT and CON scores with change in body-image variables assessed by Cash.

Qualitative analysis. N-Vivo Software was used to compare the qualitative themes imbedded in the data at pre and post test of the "Resolving Negative Body-image Group" intervention. The core of the qualitative portion of this study entailed the application of grounded theory analysis to the data yielded in written narratives as a response to the prompting question. This approach was originally developed and presented by Glaser and Strauss (1967). According to Creswell (2003), there are six steps to grounded theory analysis. First, the researcher transcribes the data, and then reads in order to develop a general sense of the data. In the third step, called coding, the researcher divides the data into smaller pieces based on meaning. Next, the researcher brings meaning to these pieces, organizing them according to categories based on themes arising from the data. In Step 5, the researcher organizes the presentation of these themes in narrative form. Finally, Step 6 calls for an interpretation of these themes according to a theory that arises from the data. This theory is the holistic understanding of the themes interpreted in the data (Creswell, 2003).

In the case of the present research, the themes that emerge from the data were informed by clinical and feminist perspectives of what body-image means for the discrepancy between participants' concept of the ideal woman and participants' self perception of their actual self as a woman. However, although feminist and clinical perspectives on body-image and self-concept likely influenced and provided context for the data interpretation process, the data yielded by

participants was primary. The priority of allowing theory based on meaning to stem from the data, rather than from an outside theory, is fundamental to the practice of grounded theory (Strauss & Corbin, 1998). Furthermore, as Strauss and Corbin explain, data interpretation results from an interplay between researcher and data. This relational emergence of meaning between participants and the researcher distinguishes qualitative methodology, and particularly grounded theory, as a method well suited for the study of clinical work. As the present study is a form of treatment evaluation in a clinical setting, grounded theory serves as an excellent approach to understanding the experiences of the women engaged in the present study.

Chapter 3

Results

Quantitative Results

Hypothesis 1. Hypothesis one stated that specific treatment of body-image would positively and significantly impact participants' overall view of themselves, as reflected by increase in Total Self-Concept Summary Score (TOT) and decrease in the Conflict Score (CON) of the TSCS-2. The researchers conducted a paired samples t-test to assess for the differences in overall self-concept between pre and post test, as measured by the TOT and CON scores of the TSCS-2. TOT scores were in the low range (M = 30.25, SD = 7.96) prior to participation in the group, and remained in the low range (M = 36.33, SD = 9.25) at post-test. Although overall self-concept remained in the low range following treatment, change in TOT score was statistically significant and positive. Statistically significant differences were found between pre and post-test for the TOT score, $t = -3.09$ ($df = 11$), $p < .01$, SD = 6.83. Repeated measures effect sizes (Gibbons et al., 1993) were calculated at .89, considered a large effect size by Cohen (1992). These results serve to reject the null hypothesis that there are no significant differences in overall self-concept between pre and post-test as a result of the women's participation in the mindfulness based body-image group. Quite the contrary; there was a large effect of the intervention on total self-concept scores.

Analysis did not indicate rejection of the null hypothesis of Hypothesis 1b, namely, that the Conflict score (CON) would decrease between pre and post-test, $t = .03$ ($df = 11$), $p < .98$. In

other words, there was no change in the degree to which the participants understood themselves, positively, in terms of who they understood themselves to be, as opposed to, negatively, how they saw themselves to not be. The mean conflict scores both at pre and post-test fell in the high average range (M = 55, SD = 9.3 at pre-test and M = 54.92, SD = 10.1 and post-test) and remained virtually the same.

Hypothesis 2. Hypothesis two stated that increase in Total Self-concept Summary Score (TOT) and decrease in the Conflict Score (CON) of the TSCS-2 between pre and post treatment would positively correlate with change indicative of improvement in body-image variables, as measured by *Appearance Schemas Inventory Revised* (ASI-R) and *Multidimensional Body-Self Relations Questionnaire* (MBSRQ). Correlations of change variables primarily supported this hypothesis, particularly for the TOT score. See Table 1 to view these correlations. Correlations of change between MBSRQ variables and TOT score change were medium (Cohen, 1992); .43, .48, -.38, -.34, .54 for MBSRQ Appearance Evaluation Change, MBSRQ Appearance Orientation Change, MBSRQ Overpreoccupation change, MBSRQ Self-Classified Weight Change, and Body Areas Satisfaction Change, respectively. These results indicate that as TOT increased, participants' satisfaction with looks, and interestingly, investment in looks, increased. Negative correlations supported the hypothesis as well, as they indicated decrease in over-preoccupation with appearance and inflation of body weight as overall self concept increased. Change in TOT scores was negatively correlated with ASI Total change at -.43 and with ASI Self-Evaluation Change at -.50, suggesting that as overall self-concept increased, overall body-image investment and relevance of body-image investment to one's self-evaluation decreased.

No relationship was found between increase in TOT and motivation to engage in grooming behavior and rituals; .04.

Table 1

Hypothesis 2: Change in TOT and CON Will Co-vary with Improvement in ASI-R and MBSRQ Scores.

Variable	Tenntotal Change	Tennconflict Change
Tenntotal Change	1.000	
Tennconflict Change	-.265	1.000
OQ45total Change	-.300	-.359
OQ45IR Change	.152	-.410
OQ45SD Change	-.430	-.316
OQ45SR Change	-.192	-.216
MBSApp.Eval.Change	.425	-.134
MBSApp.Or.Change	.479	.054
MBSOverPreoc.Change	-.376	.046
MBSSelfClWt.Change	-.315	.326
MBS.BAS.Change	.541	-.316
ASI.Total.Change	-.432	.414
ASI.SelfEval.Change	-.498	.276
ASI.Motiv.Change	.042	.559
EDEQ.Global.Change	-.740	.183
EDEQ.Rstrnt.Change	.060	.479
EDEQ.EatingConc.Chnge	-.806	.115
EDEQ.WtConc.Change	-.816	.234
EDEQ.ShpConc.Change	-.381	-.028

Results also indicated support for covariance of change between Conflict Scores (CON) and body-image variables. Change in CON scores was negatively correlated with change in MBSRQ Appearance Evaluation Change at -.13 and positively with MBSRQ Self-Classified Weight Change at .33, and negatively with MBSRQ Body Areas Satisfaction change at -.32. Therefore, it seems that as participants' CON scores decreased, satisfaction with one's looks and contentment with most areas of one's body increased, and participants' estimation of their weight decreased. Change in CON scores was positively correlated with ASI scores. There was a medium, positive correlation of .41 between ASI Total change and CON change, and a small positive correlation of .28 between ASI Self Evaluation change and CON change, thereby indicating that as CON scores decreased, overall body-image investment and importance of body-image to one's self-evaluation decreased. A large, positive correlation of .56 between ASI motivation and CON scores suggests that as CON decreased, motivation to engage in grooming rituals and behaviors also decreased. No relationships were found between change in CON scores and change in degree of investment in one's looks; .05, or preoccupation with one's looks; .05.

Although not part of the original hypotheses or scope of this project, the largest correlations were found between increase in Overall Self-Concept and decrease in eating disordered beliefs and behaviors, as measured by the EDE-Q. Increase in TOT scores was correlated with decrease in EDEQ overall scores at -.74, with Eating Concerns at -.81, with Weight Concerns at -.82, and to a lesser extent with Shape Concerns at -.38. In summary, results primarily support covariance of change in overall self-concept, as measured by TOT scores, and

decrease in conflict, as measured by CON scores, with improvement in body-image, as well as eating disorder variables. Therefore, the null hypothesis of Hypothesis 2 is rejected.

Qualitative Results

At both pre and post-test, women were asked to answer the following prompt with a written description: *What is your image of an ideal woman? Where have these messages come from? What does she look like? Act like? Believe? What do you think about this? How is this woman similar to you and how is she different?* What follows is a narrative analysis of the thematic results arising through the method of grounded theory.

Thematic findings. The women were asked to describe a multifaceted view of an ideal woman, addressing physical, personality, action, and belief domains. Additionally, they were asked to compare themselves to this ideal, addressing those ways in which they are similar and those ways in which they are different from this ideal. Women also related their thoughts and feelings about their ideal and the process of comparing themselves to that ideal. What follows addresses each of these categories of themes, as well as a discussion of trends in thematic changes between pre and post test.

Physical attributes. The participants presented a variety of physical characteristics, the most common being thinness, prettiness, and health or strength. One of the more interesting and common themes arising was the effortless or natural quality of this woman's physique. Although the ideal described was one which was "perfect" or objectively difficult to obtain, the women commonly stressed the effortlessness of this physique. As one woman stated, "This woman would be so ideal that her natural beauty would make her appearance effortlessly flawless and pleasing to all." Oftentimes, the participants referred to the way in which the ideal woman was

non obsessive and carefree about maintaining this difficult physique. “She likes to jump on the trampoline with her kids and eat chocolate and doesn't have a scale,” wrote, ED, one of the participants. Another participant, SH, stated the following:

> The ideal woman would be able to eat whatever she wanted and when she wanted and not worry about her weight. She would not feel judged by others by her looks. She would not care what the number on the scale said. She would be free of the standards and the labels that society has forced upon all women today.

Personality characteristics. With regard to the character of this woman, the overwhelming majority of participants described a woman who is both confident in herself and supportive of, loving, and kind towards other people. Acceptance of self and others, and interestingly, acceptance of imperfection, were characteristics woven throughout several of the narratives. “She would be accepting of her own and others' imperfections and flaws. She would be aware of the world around her and work to improve it.” Still another woman, TS, commented, “She believes everyone has a best self - that there is no one way to look, act or be - that we can appreciate the strengths and flaws in everyone.” Several of the women echoed the following phrase from one participant, “Not obsessive - confident, very self-confident but not stuck-up or closed to views of others. Knows her limits, willing to try new things. Willing to fail. Usually succeeds.” As suggested by these examples, this woman’s personality, like her physique, is carefree, effortless, and natural. It seems as though this woman, though sometimes described as perfect, is unattached to her perfection, and able to accept what flaws she does have.

Whether explicitly or implicitly stated, the ideal woman’s interactions were predominantly characterized by interdependence. “My image of an ideal woman would be

competent, compassionate, independent, actively engaged in her own life as well as the lives of those around her," wrote one participant. Another woman, SH, described her ideal as "interdependent" and "committed to service while true to self." As still another woman, BC stated, "She doesn't need others to be fulfilled but she doesn't close people out. She cares about what she cares about and doesn't waste a lot of time on what other people think." Essentially, the ideal woman described is able to balance her own needs and the needs of others. In other words, she is both independent and relational.

Moreover, the woman described often embodies paradox, combining capability and success with the ability to be carefree, or being virtually perfect herself, yet accepting of her imperfection. For example, one woman, JS, described her as, "Laid back while being devoted and determined." Commenting on her paradoxical personality, one woman writes:

> She is complex and mysterious - both intelligent and well-educated, open minded and non-judgmental. She is a mass of paradoxes existing in perfect balance that she maintains with the ease and security of one who has faith and hope that all is as it should be and who knows everything will be okay.

Participants noted a wide variety of other characteristics, including fun, charismatic, feminine, capable, generous, intelligent, strong, and emotionally regulated. For example, KEH, described her ideal as, "… competent, compassionate, independent, actively engaged in her own life as well as the lives of those around her, very intelligent and witty, fun to spend time with, loving, and yes, thin and beautiful." BC, highlighting the emotional regulation of her ideal, stated, "She sits in her emotions and works them through. She loves herself intrinsically no matter how she was raised. She's self-accepting and thinks in gray, not black and white."

While most traits noted were positive, one woman did note that she believed that the ideal woman appears perfect on the outside, but is actually as flawed and insecure as anyone else. This woman, CK, asserted:

> I believe on the outside these women appear to be self-confident, yet I believe that as individuals also have their own personal demons. This woman may be feeling the same way about themselves on the inside, yet having fit bodies helps them push through these with the appearance of self-confidence.

Her perspective was unique relative to the other participants' descriptions of the ideal woman.

Actions. The women tended to ignore the action component of this woman, prompted by the question, "What does this woman act like?" Most of participants' descriptions of this woman's behavior focused on her balanced exercise and eating habits. For example, one woman (ED) stated, "She exercises regularly, eats mindfully, gets an adequate amount of sleep - all with balance and flexibility." Other behaviors mentioned were specifically related to personality characteristics, as described.

Beliefs. No common theme emerged regarding participants' descriptions of their ideal woman's beliefs. However, some participants noted a basic trust in life and self as a belief of the ideal woman. As one participant, TS, wrote, "She believes she's worthy of love and acceptance - that she can have a good life and go for what she wants." Another echoed this theme, stating that an ideal woman believes that, "Life is good, there is enough to go around (abundance), is supported by life." A few of the women designated some kind of faith as important to the ideal woman. Others designated valuing moderation as an important belief for their ideal, stating that, "She believes in herself. In having a healthy lifestyle in general. In moderation not excess

(food/exercise and life in general).” Several, highlighted the importance of open convictions. For example, as one woman, JM, wrote, “An ideal woman believes whatever she believes. She has conviction in her belief system, but is open to new ideas and doesn't force her beliefs onto others.” It seemed more important that this woman be open in her convictions, whatever they were, than that she have specific convictions.

Understanding of source of ideal. Women varied in their understanding of the source of their ideal. The media and culture, however, were the most commonly cited sources. Regarding the role of culture, one woman stated, “Being thin and beautiful is an overblown cultural value, and although I know it's not true, I feel like reflecting beauty on the outside is the only way others can believe there is beauty within a person.” Some mentioned men and significant relationships (such as mothers) as the source of their personal ideals. As one woman vehemently wrote, “Men have double standards. They tell you that you are pretty then look at *Play Boy*. I will never look like that. I am invisible.” Several participants also made mention of their own role in creating this ideal. In the words of one woman, JM, “These messages come from my sociocultural environment and from my own personal thought processes and experiences.”

Comparison between self and one’s ideal. In terms of their understanding of how they differed or were similar to this woman, the majority of the women were more likely to acknowledge personality rather than physical similarities. Acknowledgement of physical similarities was minor and rare. In the words of KEH, “I am not at all like the physical ideal.” One of the largest discrepancies mentioned, as expected, was weight. One woman, for example, wrote, “I have always had such high standards for myself and feel that in the matter of my weight I have failed.” Some women were unable to mention any similarities between themselves

and their ideal. Perhaps one of the most extreme examples of this perceived discrepancy was stated by MR as follows, “I don't think we have any similarities. I think we are polar opposites. She is who I want to become.”

Most recognition of similarities was connected to morals, spiritual values, and kind, compassionate, loving ways of interacting with others. KEH stated:

> I think I am friendly and accepting of others, but I don't know if that is apparent. I am confident in some situations. I am conscientious and try to improve the lives of others when I can. I am not strong. I have a long way to go to reach the ideal.

In a more confident tone, this same woman wrote, “I am competent, loving, compassionate, and somewhat independent. I am told that I am intelligent, witty, and fun to spend time with. I am working towards being actively engaged in life and am sometimes succeeding.”

Perhaps one of the most interesting acknowledgements of difference between themselves and their ideal woman was the distinction between the carefree, non-obsessive effortlessness of the ideal woman, and the participants’ awareness of their own obsession with perfection, both in terms of their personality and physique. Moreover, while often experiencing an intense longing to be like this woman, the participants commonly felt a keen sense of always falling short of this expectation. As BC commented:

> I've never had an opinion of an ideal woman; I've always been more preoccupied with how I would be ideal. So, if I were able to describe an ideal woman, I would probably describe what I would like to see in myself. I am a recovering alcoholic of 27.5 years, a non-smoker for almost 22 years, so I have made great strides but it's never enough.

To varying extents, they recognized the impossibility of achieving this ideal. TS captured this

recognition, stating that the ideal woman, "…is way more accepting of who she is and how she looks - she isn't always striving for something more - trying to reach some elusive target."

A few admitted experiencing dissonance in finding that they both valued acceptance of imperfection, while at the same time continued to long for the impossible perfection of their ideal. As TS noted:

> Intellectually I realize that no person is perfect- everyone has insecurities, but emotionally it is difficult not to keep striving for that perfection in hopes of being more loved or a better wife, mother, daughter, boss, etc.-just wanting to limit the "bad feelings."

At times, the participants were ironically self-punitive in recognizing this dissonance and their own lack of self-acceptance. Recall NW's statement that:

> I worry about everything even the things I have no control over. I criticize myself too much and think too much of what other people think of me. I put too much emphasis on the number on the scale. The ideal woman wouldn't care about anyof those things. She would be free to be the person she wants to be.

An ideal woman, after all, would not struggle with self-acceptance, and while nearly perfect, would not be attached to being perfect. Moreover, she would not need to strive to achieve or maintain perfection, but would naturally reach perfection. This accepting relationship with oneself was very different from the one that the participants endorsed experiencing.

Trends in thematic changes following participation in group therapy. Following participation in the group, there did seem to be an increase in women's self-described confidence

and acceptance of their own imperfection. For example, MS, celebrated the “non-perfect ideal” as she termed it, declaring:

> I love the idea of idolizing a healthy, normal, flawed woman. It seems so much more meaningful and attainable. I may not be like this but I would like to be and it seems a lot more "real" to me to try to strive for perfectly average.

The women often recognized that they were far from their goals of confidence and self-acceptance, but had in fact made progress. As one woman, TS, declared:

> This woman has more confidence in who she is than I do. I still feel judged and feel like I come up short with the unrealistic expectations I've set for myself. Like her though, I'm open to learning more about myself and determined to keep working on areas of my life - to improve them.

Some women were able to state their hopes for continued growth in self-acceptance in a non-punitive tone. One such woman, ED, wrote:

> I am a lot like this ideal woman, but I am hard on myself. The ideal woman just says, "Oops!" I cringe and shrink out of the room when I make a mistake. I want to be able to just say "oops!" and do it with a smile.

In a similar tone, another woman, TS, wrote:

> This woman has more confidence in who she is than I do. I still feel judged and feel like I come up short with the unrealistic expectations I've set for myself. Like her though, I'm open to learning more about myself and determined to keep working on areas of my life - to improve them.

These excerpts exemplify the ways in which some women seemed to be more able to acknowledge their imperfection, including their lack of self-acceptance, with a commitment to continue to work towards change.

A second potential thematic shift at post-test was women's increased acknowledgement of their own role in creating this ideal at post-test than at pre-test. One woman in particular (KC) captured the glimmer of empowerment that some women were beginning to experience in shaping their own ideal. She wrote:

> I choose what I want to be and that fits. Everyone's ideal of the perfect woman isdifferent. I choose to be the best I can be (within reason). I have grown past looks only and see myself as a whole person/I feel pretty lucky. I wish more women would give themselves that gift. I am unique and my physical appearance is only one part of who I am. I will be around and enjoy the company and make friends with likeminded people. I cannot control what others are like, but I can decide or choose how much and what kind of influence they have on me. What freedom I now have. Yay!

Narrative summary of findings. Participants' descriptions of the ideal woman, and their understanding of how they compare to that ideal varies according to the data. In spite of thematic variety, a chorus of tension between longing for perfection and yet valuing acceptance of imperfection seems to run throughout the narratives, in reference to both physical and character-related attributes. The longing to be free of the sense of always striving, yet always falling short, pervades the whole of the narrative yielded through grounded theory analysis. The ideal woman described does not share this struggle with the participants. She does not experience this gap between ideal and actual self, but would be accepting of any such gap if it actually were present

in herself. The data tell a story of the participants' journey of wrestling to make peace with the discrepancy between ideal and actual self, and their ambivalence about whether and how to accept this gap. For some women, the response to this gap is further self-punishment for struggling with self-acceptance. For others it is an acknowledgment of progress made in terms of self-acceptance, while committing to the need to move towards further self-acceptance, for another it is a decision to embrace a "flawed ideal," and for others a continued longing to achieve the elusively perfect ideal.

Chapter 4

Discussion

Findings

Quantitative findings.

Hypothesis 1. The primary research focus of the present study was the question of whether participation in the present group would lead to improvement in overall self-concept. Hypothesis 1a was based upon the literature cited indicating the body-image salience in terms self-evaluation for women experiencing or recovering from eating disorders (APA, 2000; Deter & Herzog, 1994, Goldbloom & Olmsted, 1993, Rastriya et al., 1991, Windaeur, 1993, in Garner & Garfinkel, 1997; Jarry & Ip, 2005; Rosen, 1997; Stein & Corte, 2007). As hypothesized, overall self-concept for women in the present study did in fact improve following the treatment, as measured by improvement in TOT scores of the TSCS-2. This improvement in overall self-concept following participation in targeted group treatment of body-image supported the literature's indication of the salience of body-image to overall self-evaluation.

It should be noted that Cash and Hrabosky (2003) found improvement in self-esteem, as measured by the Rosenberg self-esteem scale, following participation in his CBT body-image treatment. Self-esteem is conceptualized as part of self-concept as measured by the TSCS-2, and overall self-concept is considered a broader concept encompassing both descriptive and evaluative components (Fitts & Warren, 1996; Roid & Fitts, 1994, as cited in Stowers & Durm, 1996). The present study is the only one to date thus far examining the post-test changes in the

broader construct of overall self-concept following body-image treatment, and specifically DBT based body-image treatment.

These results are theoretically consistent with DBT's focus upon nonjudgmental awareness, radical acceptance, and change. Nonjudgmental awareness, particularly through the skill of mindfulness, focuses on training oneself to notice, or describe one's experience in the moment, rather than becoming reactive or tangled in affects or evaluative judgments about one's experience. The aim of these exercises is to simultaneously become more objective about one's experience, while becoming more engaged in that immediate, present moment experience (Linehan, 1993). In the present study, women engaged in these exercises in relation to their body-image concepts and bodily experience. Following treatment, women's self concepts, as measured by the TOT, improved, which reflects improvement in terms of self-evaluation or esteem, development of a more broad and multifaceted self-concept, and improved descriptive ability. DBT exercises aimed towards nonjudgmental awareness skills target improved ability to describe oneself in an objective and broad way.

These quantitative results are also theoretically consistent with psychodynamic conceptualizations of the self for individuals with eating disorders. According to the TSCS-2 testing manual (Fitts & Warren, 1996), individuals with higher TOT scores generally have a broader, more multifaceted concept of self. According to psychodynamic theory, eating disordered women's narrow focus upon body-image distortion serves to mitigate the existential anxiety surrounding the responsibility for multiple aspects of one's internal and external world. This myopia acts as a defense of externalization, by which one projects this anxiety onto the self, specifically, one aspect of the self, namely the body, on which one acts out one's anxieties

(Kearney Cooke & Striegel-Moore, in Garner & Garfinkel, 1997). Bordo (1993) likewise addresses women with eating disorder's treatment of the body as a scapegoat. From a dynamic standpoint, as one recovers from an eating disorder, one's identity becomes less narrowly focused as one learns to manage previously overwhelming anxiety and can then face attending to other aspects of one's internal and external world. Women in the present study learned skills to manage the anxieties surrounding their bodily judgments and experiences, and following the group had more broad concepts of self, as measured by the TSCS-2.

Hypothesis 1b, that the conflict component of self-concept, as measured by the CON score of the TSCS-2, would improve following group participation, was not supported by the quantitative findings of the present study. This hypothesis was based upon DBT's focus upon training in tolerance of ambiguity. The construct measured by the CON score reflects the extent to which a person evaluates herself in light of who she is not, rather than who she is. It is possible that although women continued to view themselves in negative rather than positive terms to the same extent as before treatment, their ability to tolerate acceptance of this gap did improve. The CON score does not assess this capacity. However, the qualitative narratives suggest that the participants' ability to tolerate imperfection, and their commitment to working towards change while accepting their present state, did increase.

Hypothesis 2. The results confirmed the core link between eating disorders and the salience of body-image investment to overall self-evaluation, as set forth by the literature. Consistent with Hypothesis 2, improvement in body-image variables and overall self-concept, as measured by TOT scores, were positively correlated. These results confirm the literature's link between self-concept and body-image (Girodo, 2003; Jacobi et al., 2004; Lipowski, 1977, as

cited in Champion et al., 1982; Jourard, 1953, as cited in Rosen &Ross, 1968; Stowers & Durm, 1996) and provide preliminary evidence that body-image interventions may also serve as interventions for self-concept. Moreover, women in the present study's improvement in overall self-concept, as measured by increase in total self-concept scores (TOT) and decrease in conflict scores (CON), was correlated with decrease in eating disordered symptoms, as measured by the EDE-Q. This covariation suggests a link between body-image salience and eating disorders.

According to the research thus far investigating the efficacy of DBT for eating disorders and the theory of the efficacy of DBT for body-image, body-image treatment for women recovering from eating disorders should focus upon toleration of negative affect that arises as one systematically approaches feared normal and healthy eating, exercise, and body-image habits. Body-image rituals and eating disordered behaviors are conceptualized as maladaptive affective regulation strategies (Chen et al., 2008; Kristeller et al., 2006; Stewart, 2004; Telch et al., 2000; Telch et al., 2001). The purpose of the group treatment in the present study was to learn radical acceptance and affective tolerance skills, particularly mindfulness. Participants then applied these skills while systematically engaging in situations normally triggering to their body-image anxieties. They avoided maladaptive rituals, such as binging, which normally served to regulate their anxieties, replacing these maladaptive regulation strategies with radical acceptance, mindfulness, and other DBT skills. Participants used these skills as they examined and challenged their body-image beliefs. Preliminary research into the efficacy of such an approach to eating disorders has been promising thus far, and the present study provided pilot study evidence indicating a similar trend for body-image treatment. Women in the present study's

body-image, as measured by ASI-R and MBSRQ, did in fact improve following body-image treatment.

Qualitative findings.

DBT theory. Themes arising from the qualitative data also indicate that the fundamental values and objectives of DBT may have influenced the ways in which participants envisioned and responded to their conceptualization of the ideal woman. A core value of DBT is an assertiveness that allows one to balance the needs of self and others (Linehan, 1993). Participants described their ideal woman as strong and interdependent, confident in self and supportive of others. Acceptance of flaws, also a common characteristic of participants' "ideal woman," is also part of radical acceptance and flexible, "grey thinking," taught as part of DBT skills training. Flexibility was another common characteristic valued by the participants, as well as emotional regulation to a lesser extent, also reflective of DBT's emphasis on regulating the tension inherent in holding seeming opposite, paradoxical realities (Linehan, 1993). The fact that a number of the participants criticized themselves for not embodying these DBT values demonstrates the deep roots their vicious cycle of self-rejection. Their perceived lack of self-acceptance and obsession with rigid standards is only another way in which they fall short of their ideal.

Postmodern feminist theory. The preliminary theory arising from the participants' written narratives fits partially, though not explicitly, with all of the components of Bordo's (1993) postmodern feminist perspective on the body. Data did not reflect Bordo's interpretation that fear of fat is related to fear of cultural limitations on feminine roles, or her understanding that eating disorders are reflective of consumer and producer extremes prevalent in Western Culture.

The data did, however, mirror Bordo's (1993) commentary on the body and power dynamics playing out between the individual and culture. Bordo refers to the way in which women are trapped and controlled by their elaborate attempts to manage their bodies. Although women are seeking power by engaging in these rituals, the irony is the way in which they become trapped by the very rituals promising power. Likewise, in their narratives, the participants described an ideal woman as being powerful, free, and not rigid in terms of her exercise and eating habits or any other aspects of her life. The woman presented in the narratives also has complete control, however, but without being ruled by this control. The participants of this study demonstrated insight into their own obsession about their appearance, and the ways in which their high standards trapped them. Although they recognized the elusive, nature of their ideal, several seemed to struggle with a continued longing to reach this ideal, and a keen sense of always falling short of this ideal. Ironically, some participants felt shame about being unable to let go of this self- judgment, and inflexible standards, as an ideal woman would not only meet these standards, but would not be inflexible and judgmental towards herself. Unlike Bordo's theory, none of the women seemed to experience their regimens as empowering, although it does seem that the regimens were intended to induce control over their bodies.

Most, though not all of the participants described a woman who fits the thin, fat free, cultural ideal Bordo (1993) critiques. This ideal woman, according to the qualitative data, also frequently embodies capability and success, a cultural ideal that Bordo highlights. Several of the women acknowledged reluctantly that they were similar to the ideal woman in terms of being capable and intelligent, but differed according to physical standards. Bordo comments on the way in which as women's power in society has increased, the pressure for women to decrease in

size has increased. She speaks of how maintaining this unnatural physique robs women of the energy which they could otherwise direct towards more fulfilling endeavors, and shortchanges them of reaching their full potential. The participants did not acknowledge this dynamic in the narrative descriptions.

In presenting a theory of the centrality of the female body to cultural demands, Bordo references the postmodern construct of the *body as text* (1993, p.180) and *the politics of appearance* (p. 27). She cites Foucault's insight that the body is not separate from culture, the body being the meeting place of the individual and culture. The narratives demonstrated a sharp awareness of these cultural messages. Participants commonly designated media, culture, and men as sources of these messages. At times, women cited their own role in creating their "ideal." Trends in the qualitative data suggest that the body is not only text in the sense of being a medium on which culture inscribes its demands, but that the body is a medium through which women write their own text. Further data collection, and more in-depth inquiry, would be needed to confirm this interesting insight, however. Such a trend would be consistent with DBT's dialectical perspective on the individual's relationship to his or her environment.

Limitations

The present study is a pilot study investigating the efficacy of DBT body-image treatment for overall self-concept, from both qualitative and quantitative perspectives. The large and significant effect sizes representing posttest change in TOT scores following group participation provide evidence suggesting that DBT may be a promising approach to improving the self-concepts of women recovering from eating disorders. These results suggest that future research would be a worthwhile investment of resources.

Future research would address a number of factors that limit the ability to apply and generalize present results. These limitations include lack of consistency in procedure, failure or inability to control treatment and other variables, absence of a control group, sample size and characteristics, and the fact that the sample was not randomized.

Regarding the first limitation, lack of consistency of procedure, the experimental group consisted of three separate trials of the group. The first group consisted of five participants, the second of four and the third of three participants. A different therapist co-facilitated the second and third trials of the group. The curriculum was altered for these trials as well, thereby compromising consistency of approach and emphasis. Although failing to follow standardized procedures unfortunately compromised the integrity of the research, this choice was based on therapist perception of client needs. The choice to alter the curriculum allowed the therapist to learn from previous trials in order to maximize client benefit. While not ideal, this decision is reflective of a perennial ethical dilemma inherent in clinical research. At times it is debatable whether maintaining a standardized procedure, rather than tailoring to clients needs, is in the best interest of the client. However, the decision to prioritize client needs by altering the procedure in the case of the present study is a confound in the procedure which limit ability to generalize results of this study.

In addition to changing therapists and curriculum, other variables were not controlled, such as client variables and specific treatment components. It is not possible to determine whether change in overall self-concept was due to individual therapy or other groups in which participants engaged at the DBT Center. Moreover, even if change resulted from participation in the group, it is also impossible to determine whether change resulted from the radical acceptance,

mindfulness skills, nonjudgmental values, and behavioral chain analyses that are the bedrock of DBT, or the cognitive components and exposure therapy of Cash's CBT treatment. Because the curriculum was originally altered from Cash's manual, it is difficult to determine the extent to which the treatment differs substantially from Cash's manualized treatment. As posited in the Jarry and Berardi's (2004) metanalysis, normally adaptations of Cash and Rosen's manualized CBT treatments are the most effective. According to Jarry and Ip's (2005) metanalysis, as well as research by Butters and Cash (1987), Cash and Hrabosky (2003), Grant and Cash (1995), Nye and Cash (2006), and Strachan and Cash (2007), it is also yet to be determined whether Cash and Rosen's treatments are more effective than other treatments that also incorporate attitudinal, behavioral and perceptual components.

Although the researchers originally planned a waitlist control group, this did not materialize, again in the interest of prioritizing client interest over research integrity. Therapists at the DBT center made the decision to initiate the second and third trials of the group rather than delay in order to gather wait-list data. Moreover, there were not sufficient numbers of clients whose symptom severity was sufficiently reduced to participate in the body-image group.

Small sample size of 12 people also limits the generalizability of results. Two women dropped out of the first trial of the group, two out of the second, and one out of the third. One participant from the third group failed to complete her assessments, thus limiting the sample pool to three for the third group. Effect sizes, however, indicated that the post-test change in the TOT score of overall self-concept was not simply due to chance, in spite of the small sample size.

Increased sample size would also strengthen integrity and depth of qualitative results. According to grounded theory analysis, researchers continue to collect data until reaching

theoretical saturation, the point at which the data seems to cease revealing new themes. The data of the present study indicated trends of the dominance of certain themes, but further data collection could strengthen these trends or indicate new themes and trends. Moreover, further data would provide insight into differences between pre and post-test in participants' ideas about the ideal woman, as well as ways of reacting to the perceived gap between themselves and the ideal. At present, the theory arising from the data is preliminary, but promising. More data would need to be gathered in order to confirm and deepen this theory.

Not only the size, but also the characteristics of the research sample is noteworthy. The population at DBT Centers is oftentimes more resistant to treatment and demonstrates more severe symptom levels and a higher rate of dual diagnoses than other populations. DBT Centers specialize in therapy that is long term and provides wrap around services. All clients at DBT Centers must participate in both skills training groups and individual therapy. Finally, all of the clients in the present study were women and all were Caucasian, with the exception of one Latina woman. All of these client characteristics and treatment factors may have impacted the results of the present study. Expanding the diversity of client characteristics would increase potential to generalize results.

Recommendations for Future Research

Quantitative. As a pilot study, the present study's robust effect sizes for change in overall self-concept encourage future research with careful standardization of procedures. Increased sample size would increase validity of quantitative results of this pilot study. Diversity of ethnicity and gender would further enhance the relevance of the study. A wait-list control group would add significantly to the validity and ability to generalize results and would help

distinguish change from the body-image group specifically from change simply due to time or other components of DBT treatment. Using a randomly selected sample would also promote validity of results.

Finally, delineating and controlling for specific treatment components, such as attitudinal, perceptual, behavioral, radical acceptance, mindfulness skills training, emotion regulation skills, and behavioral chain analysis, and testing these components specifically and separately, would help distinguish which particular components actually lead to change in self-concept, body-image, and other variables for eating disordered women. Separating mindfulness and other skills intended to help clients refocus on their immediate experience, rather than their cognitions about their experience, would be particularly interesting given that this difference in emphasis is one of the core features distinguishing DBT from CBT.

The characteristics of the clientele referred to DBT centers complicate results. DBT based treatment may be more effective for eating disordered women referred to DBT Centers than for other clients. Other individuals with eating disorders may show similar, less, or more improvement in response to DBT based body-image treatment, due to differences in kind or severity of symptoms. Future research may seek to investigate the impact of a DBT based body-image treatment for clients with eating disorders who have not been referred to a DBT center specifically.

Qualitative. As discussed, on their written narratives, the women endorsed values fundamental to DBT, such as radical acceptance, as characteristics of the ideal woman. Following group participation, participants' entertainment of a "non-perfect ideal," as well as validation of progress while committing to work towards further change, is likely reflective of

the values explicitly taught by DBT. The emphasis on self-acceptance and acceptance of imperfection might not be present to the same extent in narratives produced by women not in DBT treatment. Future research into women's perception of the discrepancy between perceived ideal and perceived actual selves could also investigate the experience of eating disordered women not engaged in DBT. Interviews could clarify whether the struggle for self-acceptance and flexibility, and the perhaps rigid shame that participants in the present study experienced for struggling with self-acceptance and flexibility, would also be present in women not engaged in DBT.

In addition to expanding the kinds of women interviewed, as well as the number, future researchers could also deepen their approach to exploring the themes arising from the present data. In-person interviews with follow-up inquiries, rather than written narratives, would provide more in-depth and extensive information for a number of additional themes stemming from the present qualitative data. Such interviews could confirm present themes, clarify and deepen understanding of these themes, dismiss themes, or lead to the discovery of new themes regarding eating disordered women's understanding of their ideal woman and how they compare to that woman.

The presently emerging theory yields as many questions as it answers. For example, in addition to increased ability to balance self-acceptance and change, as well as accept one's lack of self-acceptance, another preliminary thematic shift indicated in the written narratives was the increased prominence of women's recognition of the co-constitution of the physical ideal by both the individual and culture. This theme is interesting from both a DBT perspective of the dialectics between self and environment and Bordo's postmodern understanding of the politics of

appearance and the body as text. Given that the body is the meeting place between the individual and interpersonal worlds, co-constitution of bodily prescriptions and the importance of the body as text in the dialogue between culture and individual seem particularly salient. The present data alludes to this theme, but does not delve into this loaded issue. Perhaps further interviews could deepen insight into this dynamic between societal and individual responsibility, and the active and passive roles women assume in this conversation.

Further interviews would also help clarify the relationships between the present literature and the themes arising from the narratives, specifically psychodynamic and post-modern theory, or suggest other theories in the literature. While the qualitative results did not contradict psychodynamic theory of eating disorders as a projective identification, they were not explicitly supportive, either. Although participants acknowledged differing from their ideal woman in terms of a global lack of self-confidence not limited to body-image, nowhere did they state that controlling their personal appearance was a way to manage anxiety about life as a whole. Physical appearance is simply one of many areas where they reported feeling that they fall short. It is possible that further inquiry into the function of body-image rituals would reveal such information, consistent with psychodynamic conceptualization of body-image as a projective identification.

Recall that the qualitative data did not match Bordo's commentary regarding the way in which occupation of energy and attention necessary to meet cultural prescriptions of bodily appearance serve as society's way of limiting women's overall power. However, the fact that eating disordered symptoms, as measured by the EDE-Q, and engagement in body-image rituals, as measured by the ASI-R, decreased as TOT scores increased, suggests that the women were

successfully making steps towards resisting the cultural norm. This correlation supports the possibility that participants were devoting less energy and resources to achieving the elusive physical ideal that culture demands, according to Bordo. It would be fascinating to explore what further qualitative inquiry would reveal about women's sense of whether and how cultural appearance prescriptions limit or control their potential in other areas of life. In fact, specifically exploring eating disordered women's experience of power in an in-person interview would be intriguing.

Implications for Practice

As a pilot study, the present study warrants further research to investigate whether DBT would be promising as a treatment for body-image. The present findings indicate the following for clinical practice:

- Struggle with radical self-acceptance, and self-punishment for one's struggle to self-accept, may be fundamental to eating disordered women's struggle with overall self-concept, body-image, and eating disorders. Therefore, therapy focusing on nonjudgmental awareness, mindfulness skills, and radical self-acceptance may be of benefit to these clients.
- Women recovering from eating disorders may benefit from therapy addressing the dynamic interplay between cultural messages regarding body-image and women's own agency in responding to and influencing these messages.
- Treatment targeting body-image with DBT based interventions may likely also impact women's overall self-concept.

- It is possible that not only the self-evaluative component of self-concept, but also women's ability to understand themselves in broader, more multi-faceted ways, improves following body-image treatment.

DBT and other interventions focusing upon regulating the affect surrounding body-image may help women manage the anxiety surrounding their experience of self as a whole. The ultimate goal of DBT skills training is to learn to refocus upon experiential, rather than conceptual, sense of self and body arising in one's immediate experience, and to be able navigate the affect that arises within that present moment, first hand encounter. Ironically, accomplishing this goal would make body-image and self-concept secondary and irrelevant. Perhaps women can come to experience their bodies as a lived text, through which they write their own stories and become active participators in, rather than spectators of an image or idea about their own lives.

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Appendix A

Treatment Manual

Session 1

Assessments Administration and Informed Consent

Homework, week one:

As we discussed in group this week, there are two dimensions of "body image" that are generally important. Please consider, on a subjective scale, how high or low you think you rate on these two dimensions.

Body Image Evaluation: The extent to which you tend to view your overall appearance with satisfaction or dissatisfaction

Very dissatisfied	Somewhat dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied

Body Image Investment: The extent to which your overall perception of your appearance seems to inform how you feel about yourself in a fundamental way, at the level of your identity or core self-esteem

"*My perception of how I look is a key determining factor in how I feel about myself overall*"

Not true at all	Not very true	Neither true nor false	Somewhat true	Very true

When you look at your answers above, does the level of investment in your body image seem to fit your core values? If not, how do you wish it could change?

_____

_____

_____

_____

If this group were to be really successful for you, what specific changes would you see in the following areas over the next couple months?

Thinking:

Behavior:

Emotions:

Relationships:

Other:
The process of changing beliefs and deep emotions about one's self is generally a difficult and painful process. Many of the assignments in this group will be ask you to think about things in new ways that may feel uncomfortable or unnatural, or to engage in activities that create some degree of anxiety or discomfort. Take some time to think about how willing you feel to engage in some discomfort in order to make some changes in your overall negative body image:

Is there anything else that has been left out that you want to express?

Session 2

Understanding Your Body Image Story

Factors that Influence Body Image:

1. Historical influences from the past are the forces that shaped how you came to view your appearance in the ways that you do. This is what we will focus on in this session.

2. The current influences are the events and experiences in everyday life that determine how you think, feel, and react to your looks.

Four Historical Factors That Feed Your Body Image:

1. Cultural Socialization
    - We learn early on that society places a high value on appearance. Society seems to say that you are probably not good enough the way you are. As a result, women do many things to their bodies to make them "acceptable."
    - However, **societal standards can't harm you if you don't buy into them.**
    - Other people don't judge you as harshly as you do yourself.

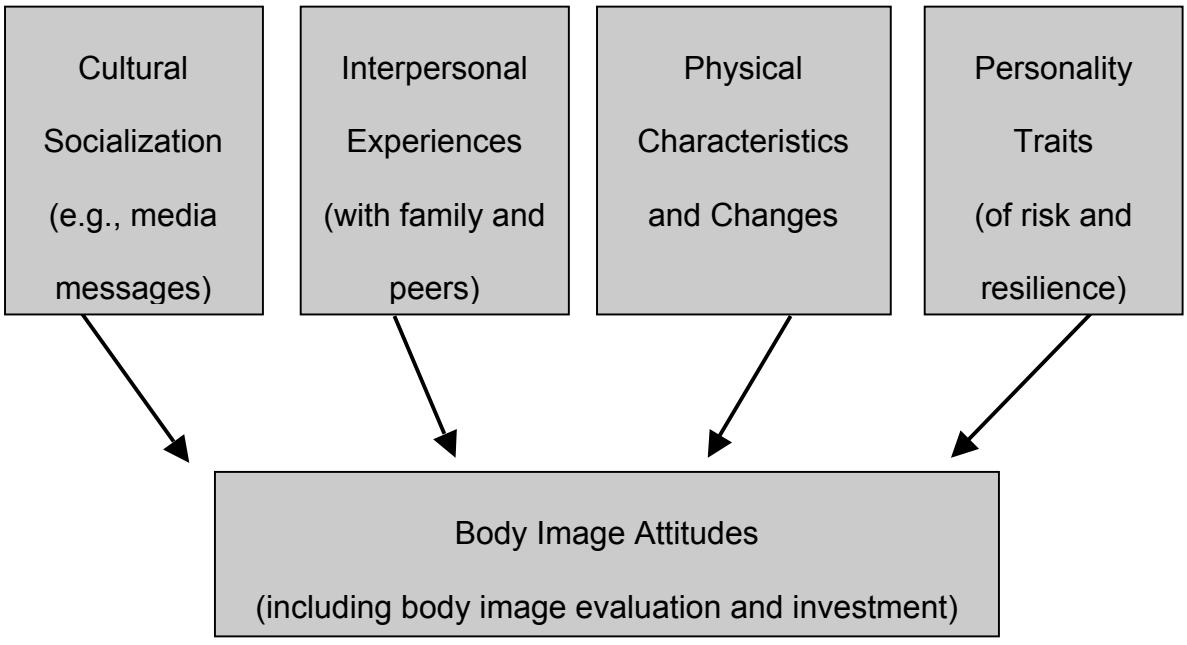

Figure A1. Four historical factors that feed your body-image.

2. Interpersonal Experiences
    - **Modeling-**If important people in your life worried about appearance, you may have learned to criticize your appearance as well.
    - **Teasing** by peers or family may have increased your focus on your body.
    - **Adolescence** may have brought insecurity about your body.
    - **Romantic** relationships can affect our body image, especially if a partner is harsh or critical.

3. Physical Characteristics and Changes
    - **Developmental** changes may cause insecurity.
    - Bodies are always changing; we cannot control all the changes our bodies go through, especially those related to heredity and/or life events.
    - How your body appears on the outside does not have to determine how you feel on the inside.
        - Think: Some people whose appearance you envy are just as unhappy with their looks as you are.
        - A fulfilling life is not dependent on how you look or how you think you look.

4. Personality Traits (for risk and resilience)

- **Low self-esteem** leaves us vulnerable to poor body image. A secure sense of self (as in feeling competent, lovable, and invested in hope and in living) we will have greater strength in resisting societal pressure and interpersonal wounds to our body image.

- The way we approach others also may affect our predisposition to a negative body image. For instance, if a person worries about being rejected, that worry may translate into a fear that one's physical self will be rejected.

- **Perfectionism** also affects body image, especially when a person feels a need to present herself to other people as exemplary and flawless in actions and appearance (called self-presentational perfectionism).

- People who are most resilient to threats and challenges to body image:
    - are not overly invested in their physical appearance for their identity and self-worth.
    - They keep their looks in perspective and are invested in many other things for self-fulfillment (such as family, friends, achievements, work, leisure interests, etc.)

Session 3

Mindfully Accepting Your Body Image Experiences

TRUTH: Negative body image may begin in our history, but it continues to exist and grow in the presence of your mind. It is our pattern of relating and interacting with ourselves that maintains a negative body image.

TRUTH: The most influential dictators of body image emotions are your own ways of judging your looks. They may be triggered by events, but once they start, they begin a cycle of self-criticism and distressing feelings.

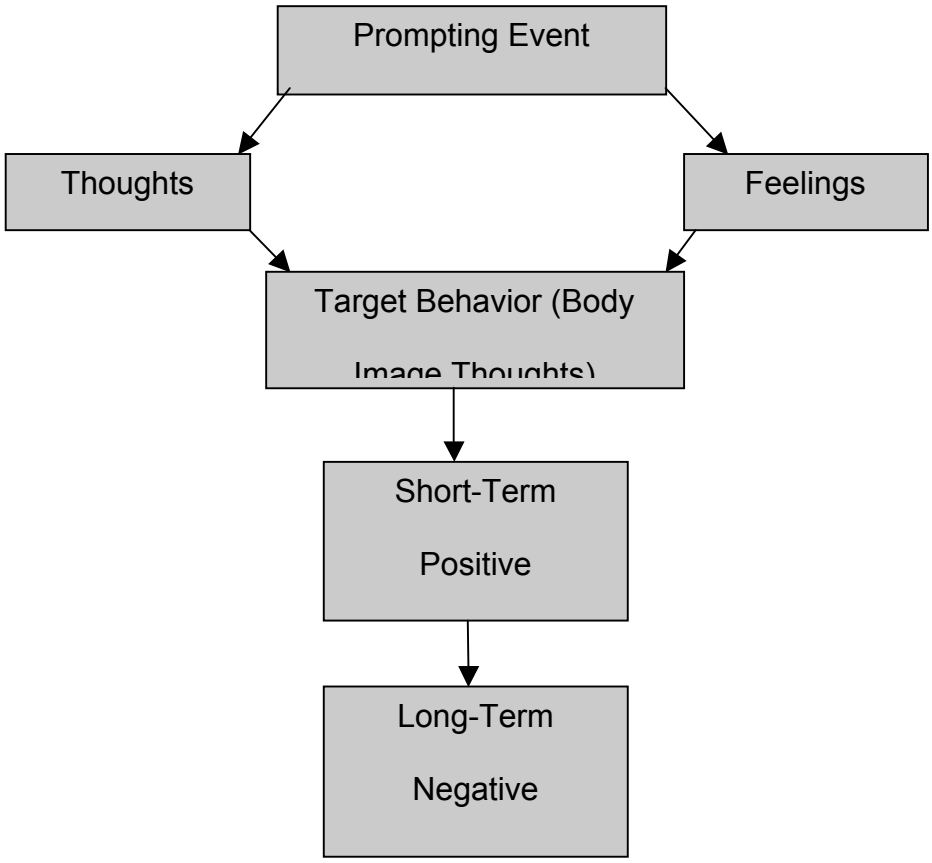

Figure A2. Mindfully accepting your body-image experiences.

ACCEPTANCE means seeing things as they really are and seeing them in the present moment. Feelings are just feelings. Pain is just pain. Not liking your body is simply what it is, nothing more, nothing less. The goal is to use your WISE MIND when you interact with your body and body image.

ACCEPTANCE means that you don't buy into the idea that you must DO something about the discomfort. Mindful acceptance means you are aware of your desire to avoid or fix but you just observe that desire. You don't follow the commands of your inner voice.

How to Mindfully Accept Your Body Image Experiences:

- **OBSERVE** Rather than judging inner experiences as intolerable, you learn to be mindfully aware of your discomfort and allow it to just be discomfort.

- **DESCRIBE** Put words on your experience, or put your experience into words. Tell yourself what is happening, but don't get caught in the content.

- **PARTICIPATE** Ask yourself "What is really needed in this situation?" Use your WISE MIND to discover what you truly need.

- **NON-JUDGEMENT** Don't evaluate. Usually you come to the verdict that something is wrong with you for having your experiences. You can't accept the experience or yourself if you have them. Your self-judgment is not truth; it is only another inner voice.

- **ONE-MINDFULLY** Rather than following your body image thoughts, focus on the activity at hand. Give the activity with your full attention.

- **EFFECTIVELY** Give yourself time to figure out how to interact with your body image experiences. Over time, focus on what works.

- **Mindful Self-Monitoring** will teach you to step back and ask, "What am I feeling? What just happened to make me feel this way? What am I saying to myself in this situation? How am I reacting or wanting to react behaviorally to this experience? You will learn to "eavesdrop" on yourself.

- You will learn to notice and describe **Body Image Episodes:** times when negative body image experiences crowd your consciousness.

Learning to Mindfully Self-Monitor: Body Image ABC's

A **Activators.** What happened?

B **Beliefs-**What is going through your mind?

C **Consequences** of your thoughts and beliefs**.** How did you react emotionally and behaviorally?

The acronym **TIDE** explains consequences:

T **Type** of emotion you felt in the situation.

I **Intensity** of your emotions. Rate on a scale from 1-10.

D **Duration**. How long did the distress last?

E **Effect**. How did the episode affect your behavior?

Homework: Option to Do ABC or Mirror Exposure.

Session 4

Facing Your Body Image Avoidance

Why would you want to face your Body Image feelings and thoughts without engaging in your escape and avoidance behaviors?

- It is understandable to want avoid the uncomfortable body image thoughts and feelings that happen when faced with a practice, person, place, or pose that triggers these thoughts and feelings.
- ***Evasive Actions*** are ***Escape Behaviors*** or ***Grooming to Hide Behaviors*** . ***Escape Behaviors*** refer your actions by which you seek to avoid persons, places, practices, or poses that trigger negative thoughts and feelings about your body. ***Grooming to Hide Behaviors*** are rituals through which you aim to hide what you do not like about your appearance. What are your ***Escape Behaviors*** and ***Grooming to Hide Behaviors***? *Take a moment to fill out pg.139 and 142 to uncover your Escape and Grooming to Hide Behaviors.*
- When you avoid these uncomfortable experiences by engaging in ***Evasive Actions*** or ***Grooming to Hide Behaviors***, you may feel better temporarily, but your negative feelings about your body actually become stronger as a result of engaging in these behaviors. No *counterconditioning* happens, and your poor self esteem remains and is *reinforced*. (See the chart on the third page)
- Research suggests that these negative emotional experiences, such as anxiety, have a rise and fall in intensity over time, like the curve drawn below. How strong does your anxiety or other negative emotion feel when you decide to engage in the ***Escape or Grooming to Hide Behavior*** that makes the anxiety temporarily go away? Draw an x at that place on the curve.

- Although these ***Escape and Grooming Behaviors*** are adaptive in the sense that they bring relief, in the long term, they are not. Your original thoughts and feelings about your appearance remain and often grow stronger as a result.
- According to research, without engaging in your typical escape and grooming behaviors, the uncomfortable experience will decrease on its own. This is hard to believe when you are actually having the experience. Our purpose in this session will be to learn to ride this intensity wave by experiencing negative feelings about yourself and body without engaging in your normal ***Evasive Action***. We will refer to these ***Evasive Actions*** as ***Target Behaviors***, since our aim is to learn a new response to the feelings and thoughts that arise when we encounter a certain person, place, practice, or pose, or desire to hide

what we do not like about ourselves. You may be familiar with this approach as *exposure therapy*, or *counterconditioning*. We will replace your ***Target Behaviors (Evasive Actions)*** by teaching you skills and strengthening your Wise Mind/New Inner Inner Voice.

Chain of Events

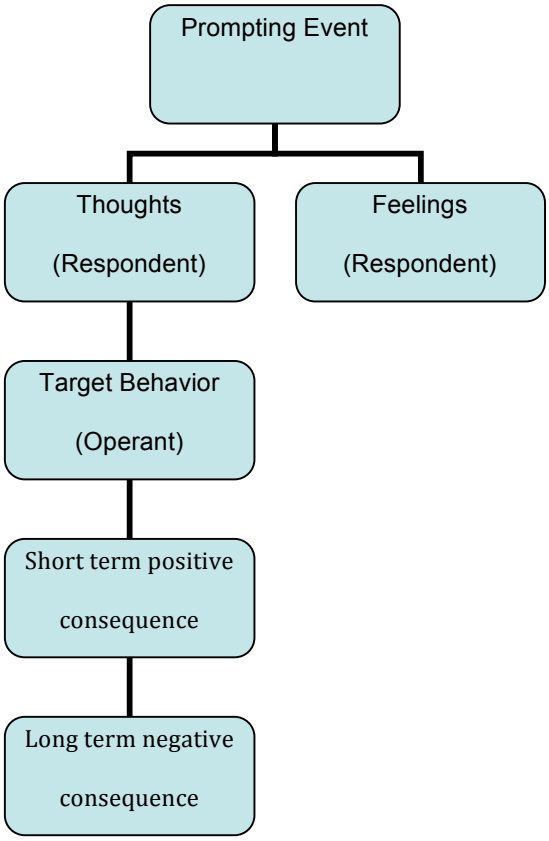

Figure A3. Chain of events.

Body Image Example

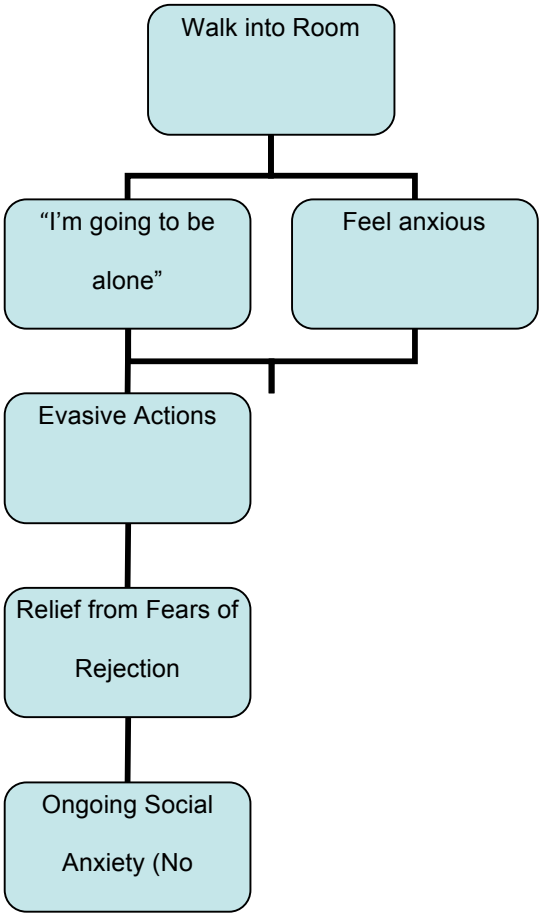

Figure A4. Body-image example.

Goal 1: Replace Escape Behaviors with the Wise Mind/New Inner Voice

Helpsheet for Change: My Ladder of Success for Facing It (p. 146)

How: PACE

Prepare: Exactly what will I do?
Act: When? Where? For how long?
Cope: What uncomfortable thoughts and feelings do I expect? How will I accept and cope with them?

- Suggestions:
    - Acceptance of Anxiety (p. 196 ***The Mindfulness & Acceptance Workbook for Anxiety*** **by Forsyth, J, & Eifert, G. Copyright New Harbinger Publications, Inc., 2007.**
    - Letting Go of Tension (p. 143)
    - Diaphragmatic Breathing (p. 144)
    - Mental Imagery (p. 144)

Enjoy: How will I reward my efforts?
Helpsheet for Change: My Plan for Facing It (p. 149)

Goal 2: Replace Grooming to Hide Behaviors with the Wise Mind/New Inner Voice

Helpsheet for Change: My Ladder of Success for Facing It (p. 151)

How: PACE

Helpsheet for Change: My Plan for Facing It (p. 153)

Homework for Remainder of Group: Do a Helpsheet for Change: My Plan for Facing It, for a rung of the Ladder of Success Each Week (For an Escape Behavior and a Grooming to Hide Behavior).

Session 5

Seeing Beneath the Surface of Your Private Body Talk

Private Body Talk – the conversation you have with yourself about your body

Appearance Assumptions - Appearance Assumptions are what drive your Private Body Talk. Appearance Assumptions are those beliefs about your physical appearance and the importance of your physical appearance in all areas of your life. They happen automatically, and you often take them for granted and do not even consider their accuracy. The assumptions can trigger and fuel negative, sometimes powerful painful emotions.

Getting in touch with Appearance Assumptions

1. What kinds of things do I say to myself about my appearance?
2. Why do I do this to myself?
3. To what extent do I define myself and my self-worth on the basis of what I look like?
4. To what extent do I ignore and reject any evidence that these appearance assumptions might not be on target?
5. Your particular "appearance assumptions" can be identified by referring back to your responses to the "Appearance Importance Test" on page 19 that you took at the beginning of this group.

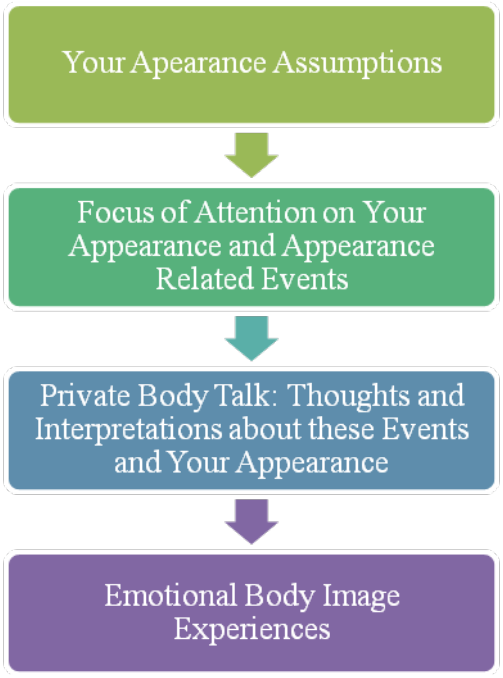

Figure A5. Assumptions underlying private body talk: from assumptions to emotions.

Ten Appearance Assumptions Underlying Private Body Talk

1. Physically Attractive People Have It All
2. My Worth as a Person Depends on How I Look
3. I Should Always Do Whatever I Can to Look My Best
4. The First Thing That People Will Notice About Me Is What's Wrong With My Appearance
5. If People Knew How I Really Look, They Would Probably Like Me Less
6. By Managing My Physical Appearance, I Can Control My Social and Emotional Life
7. My Appearance Is Responsible for Much of What Has Happened to Me in My Life
8. If I Could Look Just As I Wish, My Life Would Be Much Happier
9. My Culture's Messages Make It Impossible for Me to Be Satisfied with My Appearance
10. The Only Way I Could Ever Accept My Looks Would Be to Change My Looks

Loosening the Grip of Assumptions

Challenging Assumptions: Arguments against the 10 Appearance Assumptions

Use these arguments as a counter to the assumptions that presently dominate your Private Body Talk

- ***Assumption 1:*** *Physically Attractive People Have It All*. Physical Attractiveness is a poor and unreliable guarantee of happiness. There are ways in which being physically attractive can lead to sadness for a person.

- **Assumption 2:** *My Worth as a Person Depends on How I Look*. What aspects of myself, other than my appearance, suggest that I have self worth? What else do I like about myself? In your private body talk, begin talking about these aspects apart from your looks that define your value as a person.

- **Assumption 3:** *I Should Always Do Whatever I Can to Look My Best.* Why do I feel that I must, should, always have a responsibility to look perfect? Do I have the same expectations for others, or am I more likely to accept others regardless of their imperfections?

- **Assumption 4:** *The First Thing that People Will Notice About Me is What's Wrong with My Appearance.* Most of the time, this statement is not true. In the case of obesity or physical disfigurement, people will notice, but you have other aspects of yourself which are more relevant in determining whether or not they will like you.

- **Assumption 5:** *If People Knew How I Really Look, They Would Probably Like Me Less.* It is likely more difficult for you to accept your perceived physical flaws than it is for others to accept these perceived flaws. When you discover physical flaws in others, does your opinion of them change?

- **Assumption 6:** *By Managing My Physical Appearance, I Can Control My Social and Emotional Life.* In order to improve your social and emotional life, it is more effective to change body image rather than change your appearance.

- **Assumption 7:** *My Appearance is Responsible for Much of What Has Happened to Me in My Life.* Appearance does play a role, but other factors, such as choices, personality, and intelligence, play a much bigger role in what has happened in your life. Consider those people you admire or have been significant in your life. Ask yourself how much of their importance is related to their attractiveness.

- **Assumption 8:** *If I Could Look Just as I Wish, My Life Would Be Much Happier.* Research suggests that physically attractive people are not necessarily happier, or even happier with their bodies. Accepting your body and appearance, rather than wishing for a different body, will increase your happiness.

- **Assumption 9:** *My Culture's Messages Make It Impossible for Me to Be Satisfied with My Appearance.* Although the media makes it difficult to accept your appearance, it is not impossible. Intelligent examination of cultural messages reveals that these messages are clearly distorted and unrealistic. You are free to make choices to reject these distortions and accept your body.

- **Assumption 10:** *The Only Way I Could Ever Accept My Looks Would Be to Change My Looks.* Ask yourself if your past efforts to change your looks and appearance have actually changed how you feel about your body. If not, consider the possibility that changing body image is more effective than changing your actual body.

- *Helpsheets for Change: Arguing with My Appearance Assumptions (pages 94-103 - homework)*
- Each day, read aloud the arguments you recorded on your *Helpsheet for Change: Arguing with My Appearance Assumptions.*
- Tell others who know about the body image work you are doing. Be specific about the ways in which you are challenging and changing your assumptions.

Strengthening Your Wise Mind: Answering Assumptions with Acceptance

- Acceptance of Thoughts and Feelings (p. 157) (Forsyth, J, Eifert, G. (2007). *The Mindfulness & Acceptance Workbook for Anxiety.* Oakland, CA: New Harbinger Publications, Inc.*)*

Session 6- Mindfully Modifying Mental Mistakes

"What disturbs peoples' minds is not events but their judgments of events." Epicetetus, 1st century AD

Cognitive Distortions: Specific mental mistakes that steer inner self talk along crooked paths that send you in the wrong direction and down dead ends where it's difficult to turn around.

The key to turning cognitive distortions around is recognizing them as such.

Take the "**Self Discovery Helpsheet: Thinking about your Thinking"** on pgs. 106-109 and score.

Distortion 1 - Beauty or Beast: Viewing one's appearance in terms of extremes, and discounting the middle ground. For example, gaining one pound and thinking you are "huge".

Distortion 2 - Unfair to Compare: Pitting your appearance against some extreme or unrealistic standard. The "unfair" aspect of this distortion is that we tend to choose people to compare ourselves with who inevitably make us look worse. We choose to compare ourselves to someone tall if we are short, short if we are tall, with big breasts if we have small ones, with a shapely butt if we have a flat one, etc. The comparisons are never objective.

Distortion3 – The Magnifying Glass: This is based on the concept of "selective attention", meaning that we focus on specific bodily areas, and magnify their importance in terms of our overall looks. Not only do we magnify apparent "defects", it downplays all positive or neutral aspects of our appearance. A fear of being vain can also drive this distortion.

Distortion 4 – The Blame Game: This happens when you incorrectly conclude the some disliked physical attribute is directly responsible for certain disappointments you may experience. This is not to say that appearance does not affect outcomes in certain situations. However, the distortion occurs when the disappointing situation is automatically attributed to appearance, without consideration of other factors.

Distortion 5 – Mind Misreading: This is the distortion which leads people to think "If I think I look bad, others must think so as well." This faulty mental process is called "projection", in that we tend to project onto others what we ourselves are feeling.

Distortion 6 – Misfortune Telling: This distortion focuses on how you make negative predictions about the future based on your appearance.

Distortion 7 – Beauty Bound: This is reflected in body self talk that says you cannot do certain things because of your looks.

Distortion 8 – Moody Mirror: This distortion reflects what is known as "emotional reasoning", or mood-dependent reasoning. If you are having a strong emotion, you then try to make some kind of cognitive meaning out of the emotion, and end up with a conclusion that strengthens the emotion.

Talking Back with Corrective ways of Thinking:

Beauty or Beast distortion:

- Force yourself to see things on a continuum; to "see the dialectical nature" of your appearance
- Consider if you judge the looks of others in the same harsh good/bad manner that you use with yourself
- Eliminate judgmental language and use more descriptive language in your self talk.
- Consider what the evidence is to the contrary of the idea that you are bad-looking.

Unfair to Compare Distortion:

- Replace "shoulds, musts, and oughts" with language that communicates your disappointment rather than judgment.
- Think, "I don't have to have a perfect body to be decent looking", or "Nobody is complaining about me but me".
- Reject societal ideals of extreme thinness, or ideals that are unrealistic or sexist.
- Consider that there will always be someone both better and worse-looking than you. It is irrelevant to make such comparisons.
- Recognize that a compliment to someone else does not have to be a criticism to yourself.
- If you have to compare, go both ways – think of someone you are better-looking than, if you are going to think about how you are less attractive than someone.

Magnifying Glass Distortion:

- Raise your awareness about if you are micro-focusing on one area and forgetting about positive or neutral areas of your looks.
- When you start self-criticism in the mirror, stop it and force yourself to say, "I caught myself picking on myself again, I am going to stop, give myself a half-smile, and walk away, saying something accepting to myself.
- If you think about a negative aspect of your looks, make yourself spend an equal amount of time being aware of a positive aspect of your looks.

Blame Game Distortion:

- Catch yourself blaming your looks and say, "stop blaming!". Say " I am going to leave my appearance out of this and focus on what I can do to make things better."
- Let your wise minded voice say, "I know I am blaming my looks because I don't like them, but that does not mean my looks are actually the cause for the problem here."

Mind Misreading Distortion:

- Accept that what you are doing is reading the thoughts and opinions of others. If these thoughts strongly resemble your own, it is pretty likely you are engaging in projection.
- Say, "I am bright, but I can't read minds. The only mind I can read is my own."

- Do you have any evidence that your mind reading is inaccurate?
- Talk back assertively to the self talk when it is disparaging. Say, "I need to stop reading into what others are thinking. I need to change what I am thinking, instead."
- Consider, "if it isn't my appearance that is bothering someone else, what might it be?"

Misfortune Telling Distortion:

- Recognize your pessimism may stem from the expectation you will feel self-conscious.
- Recognize how anxiety about appearance may be a stand-in for other anxieties in the future.

Other skills for coping with cognitive distortions include

- Simply noticing that you are having the thoughts and label them "eating disorder thoughts".
- Observe that the thoughts are present, and you don't have to act on the thoughts, or be defined on them.

Group Exercise: Facilitator self discloses regarding an experience of applying DBT skills to entangle self from a Cognitive Distortion. The group then applies these skills to one of the distortions described in this session

Homework: Helpsheets in Cash with plan for application of dialectical skills added

Session 7

Erasing Body Image Rituals

Discovering Your Appearance Checking Rituals

What are Appearance Checking Rituals? Checking Rituals are compulsive behaviors that are focused on inspecting, checking, and rechecking appearance. They are often preceded by recurrent thoughts that something is wrong with your looks.

What is the purpose of Checking Rituals? To seek and obtain relief from unsettling worries about appearance-they can be willful, deliberate attempts to avoid worrying. They can also be mindless automatic reactions.

Examples of Checking Rituals:

- Intrusive thoughts telling you to inspect your appearance; these thoughts are difficult to dismiss without taking action.
- When you pass a mirror or other reflecting surface, you often reflexively check to make sure that your appearance is okay.
- You frequently visit the restroom to check your appearance even though you have no good reason to believe that anything is truly wrong with your looks.
- You frequently weigh yourself to find out if you've gained or lost any small amount.
- You often pinch or squeeze areas of your body to determine how fat or thin they are.
- You repeatedly check how your appearance compares to others when you are in social situations.

Discovering Your Appearance Fixing Rituals

What are Appearance Fixing Rituals? These rituals usually coexist with Checking Rituals and involve elaborate and meticulous efforts to manage or modify your appearance.
What is the purpose of Fixing Rituals? Like Checking Rituals, Appearance Fixing Rituals are an attempt to avoid worry and insecurity in social situations. They may be a distraction from deeper concerns such as how acceptable or worthy you feel as a person.

Examples of Appearance Fixing Rituals:

- Spending an extraordinarily long time in the bathroom getting ready and getting dressed. Perhaps others have made remarks about how long it takes you to get ready.
- You primp and fuss with your clothes, hair and/or makeup more than you know you should. You just can't leave it alone. You may worry about various outfits making you "look fat."
- Different situations demand that you change what you are wearing. Otherwise, you worry that your appearance is inadequate.

- Gaining a couple of pounds or the experience of feeling fat compels you eat less or to exercise more intensely for a few days.
- When you see yourself in a mirror, you reflexively adjust some aspect of your appearance, even though nothing is really amiss.
- You regularly make significant modifications to your appearance, such as changing hairstyles or hair colors, or getting makeovers.

Taking care of our body is a good thing. However, when we feel like we must perform our rituals in order to feel okay, then we are being controlled by them. Appearance Preoccupied Rituals fuel beliefs such as "If I don't look perfect, bad things will happen or people won't like me."

Ways to Erase Rituals Using Exposure and Response Prevention:

- **Obstructing Your Rituals:** You block the path for your ritual to occur. Think about a ritual that you need certain "tools" for (e.g. a mirror, scales) Can you alter your environment to remove the tool?

- **Delaying Your Rituals:** This works well for Checking Rituals.
  - Notice your inner urges to check. Accept that they occur but allow your mind to go on to other things.
  - Realize that checking rituals serve self-protective purposes: they interrupt your preoccupied thoughts and feelings of discomfort. Try to detach your thoughts from the ritual; recognize the urge but remind yourself that you don't have to check.
  - Postpone the checking for a set period of time, say 15 minutes.
  - Learn to use mindful or pleasurable experiences to soothe yourself during the anxious time of waiting: nurture your new, kind inner voice, breathe deeply, distract.

- **Restricting Your Rituals:** Place a time limit on your ritual by playing "Beat the Clock". First, determine how long it takes you now; set a reasonable goal; gradually lower the time allowed. Reward your progress by using the extra time to do something you love.

- **Rationing Rituals**: This involves setting a limit on the number of times you can engage in a ritual within a certain period of time. Gradually reduce the ration to zero. For example, put your rituals on a schedule. Set a beginning and ending time. If you miss your "appointment" you must wait until the next one. If the urge occurs outside of your appointment, you must also wait.

- **Resisting by Rebellion:** You rebel by resisting the ritual cold turkey. You may want to try this first on weaker rituals; try gradually increasing the time for your rebellions.
  - Use mindful acceptance, body-and-mind relaxation, and corrective thinking as your allies.
  - Try to remain in the situation until the urge to perform the ritual subsides. You mindfully observe the urge and its weakening.

How to Build Your Ladder of Success for Erasing Rituals:

- Use the *What Are My Rituals? Helpsheet* to evaluate how confident you are that you could refrain from the ritual in its normal situation. Give yourself a self-efficacy rating from 0 to 100. Arrange the rituals in order of self-efficacy on the *Helpsheet for Change: Ladder of Success for Erasing It*. Put the highest rated ritual on the bottom, and the lowest rating at the top.

- Start with the ritual at the bottom. Write out your plan using the format of *Helpsheet for Change: My Plan for Erasing It.*

PACE yourself: **P**repare
Act
Cope
Enjoy

1. Visualize yourself effectively carrying out your plans.
2. Go for it.
3. One rung at a time, keep climbing your ladder.

Take a minute to picture what life might be like without your rituals or evasive actions!

Homework: Writing Asssignment: How do I get to a Place of Mindful Acceptance

Session 8

Healing the Relationship with my Body Partner

Achieving and Pleasing with Positive Physical Activities: Mastery and Pleasure

- Mastery and Pleasure Activities
  a. Mastery Activities –activities which give a sense of satisfaction through the experience of achievement or accomplishment
  b. Pleasure Activities- activities which are positive in and of themselves, regardless of experience of accomplishment or achievement
- Three Types of Physical Activities
  c. Physical health and fitness
  d. Sensate experiences
  e. Physical Appearance
- *Self-discovery Helpsheet: Survey of Positive Physical Activities* (pp. 173-176)
- *Helpsheet for Change: My Positive Physical Activities* (pg 178)

Helpsheet for Change: My Positive Health and Fitness Activities (pg. 180)

- Engage in two or three per week which you rated as a 2 or 3 for pleasure or mastery on the helpsheet
- Correlation between regular exercise and feeling better about health, fitness and appearance
- Kinds of motivation
  a. Be more attractive or lose weight (tendency towards negative body image is possible)
  b. Improve physical competence, fitness, health,
  c. Mood and Stress management
  d. Social aspect
- Effects of kinds of motivation for health and fitness physical activities
  - Most psychological benefits when for reasons other than appearance
  - Empirical research supports that engaging in physical activity training improves body image
  - Focus on motivations b-d, as opposed to a, promotes the experience of pleasure and mastery for health related activities

Helpsheet for Change: My Positive Sensate Activities (pg.181)

- These activities fall in the pleasure category (as opposed to mastery)
- Engage in two or three per week

Helpsheet for Change: My Positive Appearance- Oriented Activities (pg 183).

- 3 types of Groomers
  - Insatiable Groomers – groom to hide; minimal to no satisfaction with appearance; constant focus on fixing appearance

- Gloomy Groomers – do not attend to their appearance because they feel as though nothing they could do would be helpful or they are afraid to draw attention to what they look like
- Flexible Groomers – balance between the above two extremes; enjoy their looks and use grooming as a way to highlight, or play with their appearance, rather than hide or fix it

- Use Facing-It and Erasing It Strategies from Previous Lessons
- Engage in 2 or 3 per week which you rated as a 2 or 3 for pleasure or mastery on the helpsheet

Mindfulness Exercises for Positive Physical Activities[1]

1. **Awareness of the Positions of the Body: Distress Tolerance Handout 4.**
This can be practiced in any time and place. Begin to focus your attention on your breath. Breathe quietly and more deeply than usual. Be mindful of the position of your body, whether you are walking, standing, lying, or sitting down. Know where you walk, stand, lie, or sit. Be aware of the purpose of your position. For example, you might be conscious that you are standing on a green hillside in order to refresh yourself, to practice breathing, or just to stand. If there is no purpose, be aware that there is no purpose.

2. **Awareness While Taking a Slow Motion Bath: Distress Tolerance Handout 4** (Applicable to Sensate Activities)
Allow yourself 30-45 minutes to take a bath. Don't hurry for even a second. From the moment you prepare bath water to the moment you put on clean clothes, let every motion be light and slow. Be attentive of every movement. Place your attention to every part of your body, without discrimination or fear. Be aware of each stream of water on your body. By the time you've finished, your mind will feel as peaceful and light as your body. Follow your breath. Think of yourself as being in a clean and fragrant lotus pond in the summer.

FEEL (*Feeling Experience Enriches Living)*

4 FEEL Steps[2]

1. **Select** one of your physical activities from your Positive Health and Fitness Activities Helpsheet for Change.

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[1] From *Skills Training Manual for Treating Borderline Personality Disorder* by Marsha Linehan. Copyright 1993 The Guilford Press.

[2] Adapted from *The Mindfulness & Acceptance Workbook for Anxiety by*. Forsyth, J., Eiffert, G. *Copyright 2007.* Original exercise has 7 steps, but has been modified for the purposes of this DBT Body Image Group.

2. **Begin** your selected health and fitness activity and continue it for 30-60 seconds after physical discomfort begins.

3. **Apply your mindful acceptance skills**. "Continue to simply observe, with kindness and gentleness, for one or two minutes after you stop each exercise. Simply observe and make space for what you're experiencing" (Forsyth, Eiffert 2007, p. 219*).*

4. **Reflect on your practice.** "Gently reflect on the exercise you just did. Look at your ratings. Did you experience high levels of unwillingness, struggle avoidance? If so, try repeating the exercise again more slowly. As you do, watch for sticky, judgmental thoughts like 'This isn't working' or 'I can't stand this anxiety anymore.' See if you can simply notice these thoughts from your Wise Mind perspective. The next time you do the exercise, approach it from an observer perspective, and when sticky thoughts show up, notice them, and gently say to yourself, 'I am having the thought that this isn't working' or 'I am having the thought that I can't stand this anxiety anymore' or 'I am having the thought that this is too much.' Or simply label them all as 'thinking'" (Forsyth, Eiffert 2007, p. 219*).* ***However, there will also likely be pleasurable feelings and thoughts that arise, given that you selected these particular activities based on the satisfaction they provide based on mastery and/or pleasure. Notice these feelings with the same skills with which you notice negative thoughts and feelings that arise.***

Follow Up Activity: Affirmative Actions: Affirming Your Changes

- Take an hour to enjoy and reflect on the steps you've taken in your body image improvement . Be specific.
    - In what ways are you different in how you think, feel, and behave?
    - Talk about how you feel about these changes.

Appendix B

Informed Consent

Dear Group Member,

We are looking forward to your participation in the upcoming "Resolving Negative Body Image" group. This group is a new development in our "Path to Mindful Eating" program. As is common with new additions to a treatment program, we will be gathering a significant amount of data on how you make progress throughout the group. In order to assess your progress, we will be asking you to complete multiple questionnaires in both the first and the last group sessions. We will then compare the data from these questionnaires to determine the kind of progress you have made.

The data that we gather will be analyzed to determine which aspects of negative body image have most and least improved with this group treatment. Results will be used in research, which may be written up and published in scholarly journals or presented at conferences. All of the data will be kept completely anonymous, meaning that we will not have your name, or any other identifying information, associated with it when it is used in research.

Andrea Erb, BS, and Rachel Mueller, BA are doctoral students in clinical psychology at George Fox University. They are being supervised by Susannah Castle, PsyD, Clinical Psychologist. Both Andrea and Rachel have volunteered to co-lead this group. They will be using the data generated from the group to complete research projects toward the completion of their graduate degrees.

Please be aware that your participation in this group, and in the research studies that we are gathering data to complete, is completely voluntary, and you may withdraw at any time.

Please sign below to indicate:

- that you have been informed of the research being conducted with this group,
- that you have been given time to ask questions as needed, and
- that you agree to allow your anonymous assessment data to be used in any research arising from this group format.

Signed:_____ Date_____
Printed name:_____

Appendix C

Curriculum Vita

Curriculum Vitae

RACHEL E. A. MUELLER, M.A.
309 W Sherman Drive
Newberg, OR 97132
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rmueller07@georgefox.edu

EDUCATION

Student in a Doctoral Program of Clinical Psychology, 8/2007 to present
M.A. in Clinical Psychology, 5/1/2009
Graduate Department of Clinical Psychology: *APA Accredited*
George Fox University, Newberg, OR

Bachelor of Arts, Psychology, 5/2005
University of Dallas, Irving, TX

One Semester Study Abroad Program, 1/2003 - 5/2003
University of Dallas, Rome, Italy

AWARDS AND GRANTS

Student Recognition Letter, George Fox University, 8/2010

Richter Travel Grant, George Fox University, 8/2010

Richter Scholarship, George Fox University, 1/2009
Award to fund research for doctoral dissertation

Presidential Fellowship, St. Louis University, St. Louis, MO, 4/2007

Jourard Award, American Psychological Association, Division, 32, 8/2006
Student Paper Award

Adrian van Kaam Award, University of Dallas, 5/2005

Dean's List for Academic Excellence, University of Dallas, 8/2001-5/2005

Trustee Scholarship, University of Dallas,8/2001-5/2005

SUPERVISED GRADUATE CLINICAL EXPERIENCE

Evergreen Clinic, Preinternship, Portland, OR, 6/2010 to present
Duties: therapy, learning disability assessment, projective and diagnostic assessment and report writing in a reduced-fee, non-profit clinic.
Supervisor: Brian Goff, Ph.D.

Willamette Family Medical Center, Salem, OR, 7/2009 to present
Duties: Program development, long and short-term therapy with clinic patients, cognitive and psychodiagnostic assessment, consultation with medical providers.
Supervisor: Charity Benham, Psy.D.

Oregon State University Counselling and Psychological Services, Corvallis, OR, 9/2008 to 5/2009
Duties: Therapy for enrolled students.
Supervisors: Brett Vicario, Ph.D., Shailagh Clarke, Ph.D., Jen Metheny, M.S., Pre-doctoral Intern, Supervisor of Supervisor: Marcey Bamba, Ph.D.., Clinical Director.

Portland Dialectical Behavior Therapy Center, Portland, OR, 1/2009 to 5/2009
Duties: Group therapy curriculum development and co-facilitation of mindfulness based body-image group, outcome research.
Supervisor: Susannah Castle, Psy.D.

George Fox University Graduate Department of Clinical Psychology
Pre-Practicum, Newberg, OR, 1/2008 to 5/2008
Duties: Therapist for two female college students.
Supervisors: Mary Peterson, Ph.D., Meg Boden Alvey, M.A.

PROGRAM DEVELOPMENT EXPERIENCE

Implementation of Mental Health Program, Willamette Family Medical Center**,** Salem, OR, 9/2009 to 9/2010
Duties: Developed therapy and assessment services as part of the first mental health program in medical clinic serving a diverse and underserved population; consulted with medical providers regarding integration of patient care.

Curriculum Development and Implementation: Resolving Negative Body Image Group, Portland DBT Center, Portland, OR, 12/2008 to 5/2009
Duties: Developed group curriculum based on DBT principles for women recovering from eating disorders, implemented and co-facilitated group, conducted outcome research.

ASSESSMENT COURSES INCLUDING SUPERVISED EXPERIENCE

Projective Assessment Course, George Fox University Graduate Department of Clinical Psychology, Newberg, OR, 9/2009 to 12/2009
Tests Administered, Scored and Interpreted: Thematic Apperception Test, Rotter Incomplete Sentences Test, and House-Tree-Person Test.

Neuropsychological Assessment Course, George Fox University Graduate Department of Clinical Psychology, Newberg, OR, 1/2010 to 5/2010
Tests Administered, Scored, and Interpreted: Cognitive and memory assessments (including WAIS-IV, WRAML-II), as well as a variety of neuropsychological functioning tests, including the Halstead-Reitan Battery, RBANS, TOMM, and D-KEFS.

Cognitive Assessment Course, George Fox University Graduate Department of Clinical Psychology, Newberg, OR, 1/2010 to 5/2010
Tests Administered, Scored, and Interpreted: Variety of intelligence, learning, and memory assessments, including the WISC-IV, WAIS-IV, WRAT-IV, PPVT-III, WRIT, and WRAML-II.

Personality Assessment Course, George Fox University Graduate Department of Clinical Psychology, Newberg, OR, 1/2008 to 5/2008
Tests Administered, Scored, and Interpreted: MCMI-III, PAI, MMPI-II, 16PF, and Integrated report writing.

ADDITIONAL GRADUATE CLINICAL DEVELOPMENT

Psychodynamic Case Conceptualization Group, 9/2009 to present
Monthly group discussion of a case presentation according to a psychodynamic framework, led by Kurt Free, Ph.D.

Best Practices in Culturally Relevant Assessment, 10/27/2010
Grand Rounds, George Fox University**,** Newberg, OR
Presenter: Eleanor Gil-Kashiwabara, Ph.D.

Evidence Based Psychodynamic Therapy: Continuing Education Workshop, 8/10/2010
APA Annual Convention, San Diego, CA
Presenters: Richard Summers, MD and Jacques Barber, Ph.D.

Current Guidelines for Working with Gay, Lesbian, and Bisexual Clients: The new APA Practice Guidelines, 3/10/2010
Colloquium, George Fox University, Newberg, OR
Presenter: Carol Carver, Ph.D.

Association for Women in Psychology Conference, 2/15/2010, Portland, OR

Assisted with selling of books related to conference presentations.

Make Every Session Count: An Attachment Based, Emotionally Focused, Interpersonal Approach, 10/16/2009*,* Eugene, OR
Presenter: Hanna Levenson, Ph.D.

PAIN: Medical, Psychological, and Psychoanalytic Perspectives, 9/26/2009
Northwest Center for Psychoanalysis, Portland, OR
Presenter*:* Marilyn Jacobs, Ph.D., ABPP

Multi-cultural Counseling: An Alternative Conceptualization, 9.23.2009
Fall Colloquium at George Fox University, Newberg, OR
Presenter: Carlos Taloyo, Ph.D.

DBT 2-Day Overview and Skills Training, 4/2009
Portland DBT Center**,** Portland, OR
Presenter: Mark Schorr, LPC.

OTHER CLINICAL EXPOSURE

Research Assistant and Outreach Support Worker, St. Patrick's Church, Soho, London, United Kingdom, 9/2006 to 06/2007
Duties: Formulated project work plans and organizational chart to be used in grant applications for St. Patrick's addict support group. Served as liaison and support worker for St. Patrick's homeless and addict projects.

Student in St. Patrick's School, Outreach to Inner City Homeless and Isolated Individuals, Soho, London, United Kingdom, 10/2005 to 05/2006
Duties: Engaged the homeless, addicts, and poor in Soho through ministries such as Open House (a sit down meal) and Street Ministry.

Member of Planning Team for Community Based Mental Health Care, Las Obras de la Nuestra Madre (New organization providing community based mental health care to the Latino population)**,** Dallas, TX, 10/2005 to 05/2006
Duties: Attended planning meetings and communicated with founder/director of program.

Mentor for "At Risk" Children at Local Elementary School, Walgreen Mentoring Program, Irving, TX, 2/2004 to 5/2005
Duties: Tutored two elementary school girls during third and fourth grade, played games, mentored, and led character development discussions.

Undergraduate Intern, Psychological Services of Catholic Social Services, *APA Accredited Internship Site,* Lincoln, NE, 5/2004 to 8/2004

Duties: Shadowed psychotherapy sessions, attended clinical team discussions and supervision. Conducted history of psychology research.
Director: Kathryn Benes, Ph.D.

TEACHING AND SUPERVISORY EXPERIENCE

Teaching Assistant for Projective Assessment Class, George Fox University, Newberg, OR, 8/2010 to present
Duties: Assist with class demonstrations of Rorschach administration, scoring of quizzes, and reviewing students' Exner system scoring assignments and interpretation reports.

Teaching Assistant for Clinical Foundations Class, George Fox University, Newberg, OR, 8/2010 to present
Duties: Meet weekly with group of first year doctoral students to develop their foundational clinical skills, provide regular feedback and supervision on professional papers and students' recordings of therapy practice videos with one another and undergraduate students, consulted weekly with Director of Clinical Training to facilitate student development.
Supervisor: Mary Peterson, Ph.D., Director of Clinical Training

Oversight Mentor, George Fox University, Newberg, OR, 9/2010 to present
Duties: Meet weekly with second year student to facilitate growth towards clinical competency goals and provide feedback. Consult with student's clinical advisor.
Supervisor: Nancy Thurston, Ph.D.

Guest Lecturer, George Fox University**,** Newberg, OR, 11/2010
Presented on Psychodynamic Therapy to General Psychology Class

Guest Lecturer, Linfield College**,** McMinnville, OR, 1/2009
Duties: Taught lecture on eating disorders with an emphasis on DBT treatment approaches for undergraduate Cognition Class.

Substitute Instructor, George Fox University**,** Newberg, OR, 1/2008
Duties: Taught lecture on puberty for undergraduate Adolescent Development Class.

ACADEMIC SERVICE AND OUTREACH

Admissions Committee Member, George Fox University, Newberg, OR, 11/2009 to present
Duties: Reviewed doctoral applicant admissions files, participated in admission selections, assisted with planning and facilitation of interview days.

Co-leader in Outreach to Residence Life, Oregon State University**,** Corvallis, OR, 2/2009
Duties: Co-presented on positive psychology to campus residents.

Co-Leader in Outreach to Oregon State University Campus, Oregon State University Corvallis, OR, 11/2008
Duties: Demonstrated use of biofeedback equipment to students.

Co-leader in Outreach to Veterinary School, Oregon State University**,** Corvallis, Oregon, 10/2008
Duties: Co-presented on stress management to first year veterinary medicine students.

Peer Mentor, George Fox University, Newberg, OR, 8/2008 to 5/2009
Duties: Served as academic and social support to assigned incoming first-year student.

President of Psi Chi, University of Dallas, Irving, TX, 8/2004 to 5/2005
Duties: Organized academic forum, charity drives, and movie discussion nights.

RESEARCH EXPERIENCE

Doctoral Dissertation, COMPLETED: 6/2010
Impact of DBT Treatment on the Relationship between Women's Overall Self-Concept and Body-image.
Committee Members: Clark Campbell, Ph.D. (chair), Kathleen Gathercoal, Ph.D., Melanie Hulbert, Ph.D.
Submitted for publication, 10/2010.

Research Vertical Team, George Fox University, Newberg, OR, 5/2009 to present
Participated with students across cohorts to complete research towards doctoral dissertation completion and supplemental research.
Supervisors: Clark Campbell, Ph.D., Kathleen Gathercoal, Ph.D., and Mark McMinn, Ph.D.

Conference Presentations (chronologically)

Erb, A., Mueller, R., Castle, S. (2010). Effectiveness of a mindfulness-based body-image group for women in DBT treatment for eating disorders. Poster presented at 2010 APA Annual Convention, San Diego, CA.

Mueller, R., Kearns, R., McConnell, C., Kunze, K., Lloyd, C., Morgan, D., Gathercoal, K. (2010). Glass ceiling: Women's perceived and actual upward mobility in academia. Poster presented at 2010 APA Annual Convention, San Diego, CA.

Erb, A., Mueller, R., Castle, S., (2009). Integrating mindfulness with CBT body-image group therapy for eating disordered clients in a dialectical behavior therapy program. Poster accepted at 2009 Academy of Eating Disorders International Conference: "Cultivating Global Perspectives," Cancun, Mexico. Conference cancelled due to H1N1 virus.

Mueller, R. (2006). A phenomenological inquiry into the meanings of feeling fully alive. Paper presented at APA Annual Convention, New Orleans, LA.

Mueller, R. (2006). Feeling fully alive: Phenomenological findings. Poster presented at 2006 APA Annual Convention, New Orleans, LA.

Mueller, R. (2005). Experiences of femininity: A phenomenological inquiry. Paper presented at Duquesne Critical Psychology Conference Paper Presentation, Duquesne University, Pittsburgh, PA.

PROFESSIONAL AFFILIATION

American Psychological Association, Student Affiliate, 2005 to present
Northwest Center for Psychoanalysis, Affiliate, 2010 to present

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REFERENCES

Available on request.