

A Pilot Study of Acceptance and Commitment Therapy as a Workshop Intervention for Body Dissatisfaction and Disordered Eating Attitudes

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Body image dissatisfaction is a source of significant distress among non-eating-disordered women, but because it is subclinical it is generally not treated. It remains stable throughout adulthood, and has proven resistant to many prevention interventions. This study presents a pilot test of a practical alternative: a 1-day Acceptance and Commitment Therapy (ACT) workshop targeting body dissatisfaction and disordered eating attitudes. Women with body dissatisfaction (N=73) were randomly assigned to the workshop or to a wait list. Participants in both conditions also completed appetite awareness self-monitoring of hunger and satiety. After a brief 2-week follow-up, wait-list participants were also offered the workshop. Eating attitudes, body anxiety, and preoccupation with eating, weight, and shape improved in both arms of the study following the workshop. Participants in the ACT group showed significant reductions in body-related anxiety and significant increases in acceptance when compared to the wait-list control condition. ACT presented as a brief workshop intervention may be applicable for a broad range of women experiencing disordered eating attitudes and distress related to eating and body image; however, larger studies with longer follow-ups are needed.

Body image dissatisfaction, the negative evaluation of weight and shape (American Psychiatric Association, 2000), is a defining feature and predictor of relapse in anorexia and bulimia (Keel, Dorer, Franko, Jackson, & Herzog, 2005), but also predicts pervasive distress among women who do not have a formal eating disorder. Within this nonclinical group, body image dissatisfaction has been associated with higher Body Mass Indexes (McLaren, Hardy, & Kuh, 2003; Tiggerman & Lynch, 2001), disordered eating such as bingeing, purging, and chronic dieting (Lewis & Cachelin, 2001; Mintz & Betz, 1988; Tylka, 2004), higher levels of depression (Niemeier, 2004), anxiety (Bennett & Stevens, 1996), lower self-esteem (Grossbard, Lee, Neighbors, & Larimer, 2009), and overall a poorer quality of life (Ganem & Morera, 2009). Body image dissatisfaction within non-eating-disorder samples has been shown to remain stable across age cohorts from women in their 20 s to those in their 60 s (Bennett & Stevens; Lewis & Cachelin; Tiggerman & Lynch).

One approach to treating body image dissatisfaction and disordered eating pathology is to aim at prevention of clinically significant eating disorders. Towards this end,

psychoeducation has commonly targeted school-aged girls in efforts to decrease early signs of disordered eating and prevent the onset of eating disorders. School-based psychoeducational prevention programs with girls and young women have so far increased knowledge about disordered eating behaviors but have not been effective in altering these behaviors or associated body dissatisfaction (Mussell, Binford, & Fulkerson, 2000). Group interventions focused on increasing self-esteem (Steiner-Adair et al., 2002) and challenging sociocultural ideals regarding weight (Sapia, 2001) have shown promise, although maintenance of gains is a problem. Due to the historical ineffectiveness of prevention programs for eating disorders, dissonance-based interventions have been developed over the past several years (Stice, Shaw, Becker, & Rohde, 2008). Dissonance-based programs, as reviewed by Stice et al. (2008), intend to target and reduce internalization of the thin-ideal promoted in Western culture. The intervention is based on Stice's (1994) dual pathway model of bulimia, which posits that reducing internalization of the thin ideal in turn reduces negative affect and subsequent disordered eating pathology. A dissonance-based program to treat adolescent girls with body image dissatisfaction showed immediate reductions in disordered eating pathology and longer-term (6 and 12 month) reductions in binge eating and obesity (Stice, Shaw, Burton, & Wade, 2006). Similar results were shown in a 2008 study with adolescent girls with follow-up gains maintained up to 3 years (Stice, Marti, Spoor, Presnell, &

Keywords: ACT; body image dissatisfaction; eating disorders

1077-7229/11/181-197\$1.00/0

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Shaw, 2008). In addition to dissonance-based programs, an Internet-based program aimed at reducing risk factors for eating disorders in college students specifically targeted a reduction in body image dissatisfaction (Winzelberg et al., 2000). The program, Student Bodies, originally developed by Winzelberg et al. (1998), was an 8-week intervention aimed at improving body image and diet. The intervention included education, journaling, behavior change strategies, and an on-line discussion forum. Results showed significant reduction in body-image dissatisfaction and a drive for thinness at post and 3-month follow-up (Winzelberg et al., 2000). With the goals of reducing body image dissatisfaction and attachment to the thin-ideal, the dissonance-based programs and the Student Bodies program are offering hope of a working model for eating disorders prevention, especially for adolescents and college-aged students. Further research supporting these prevention models will be beneficial to targeting at-risk groups for eating disorders.

There exists, however, the longer-term problem of pervasive body image dissatisfaction and associated psychological distress among women, existing across age cohorts. While disordered eating has been shown to decrease in the 10 years post-college age, high levels of body image dissatisfaction do not decrease with age (Heatherton, Mahamedi, Striepe, Field, & Keel, 1997). Therefore, a large cohort of women do not develop a clinically severe eating disorder but continue to experience distress about their body image. Body image dissatisfaction has been shown at high levels in middle-aged cohorts and cohorts of women over 50 (Bennett & Stevens, 1996; Lewis & Cachelin, 2001; McKinley, 2006). This type of pervasive body dissatisfaction among women without formal eating disorders has been referred to as a "normative discontent" (Niemeier, 2004). As much as 40% of women have significant concerns or distress related to body image, weight, or food (Schweitzer, Rodriguez, Thomas, & Salimi, 2001; Tsai, Hoerr, & Song, 1998). Factor in the image of Body Mass Index as being the strongest predictor of body image dissatisfaction (McLaren et al., 2003), and the high rates make sense. In a society of plenty (in terms of food availability), with an ever-increasing rate of obesity and social demands to maintain a thin ideal, it is not surprising that a normative discontent exists. Body dissatisfaction is difficult to treat, in part because of the pervasive yet subclinical nature of the problem, as well as its social acceptability. This is a problem that, one could argue, women are socially expected to have in Western culture, especially if they are overweight. Addressing this normative discontent, the pervasive distress and associated disordered eating patterns experienced by a large percentage of women in Western culture is deserving of intervention.

When considering how to best address such a widespread problem, extended clinical interventions cannot be practically disseminated and are difficult to rationalize on the basis of preventing eating disorders per se. After all, women experiencing pervasive discontent may be maintaining disordered eating patterns (e.g., chronic dieting without maintaining weight loss), but may not evidence (presently or historically) a clinically significant eating disorder. Therefore, efforts at eating disorders prevention are likely not the most fitting way to address the problem of pervasive preoccupation and dissatisfaction with weight and shape. Instead of attempting to change beliefs about the thin ideal, acceptance may be a more useful intervention for older cohorts of women who may be overweight and who have experienced long-term struggles/preoccupations with efforts at weight loss and body image dissatisfaction. Acceptance may also be a useful intervention to address residual physical and emotional discomfort with the body following treatment for an eating disorder.

The processes of mindfulness, acceptance, and values targeted by third-generation cognitive-behavioral methods (Hayes, 2004) seem to fit the problem of body image dissatisfaction or the pervasive preoccupation with weight and shape. The conceptualization of the preoccupation of weight and shape, from a third-wave model, is that it serves the function of avoiding more difficult, less perceptively controllable emotions or situations (i.e., interpersonal relationships, grief, or loss) (Pearson, Heffner, & Follette, 2010). Disordered eating patterns (i.e., chronic dieting, overeating) can also serve an experiential avoidance function (Byrne, Cooper, & Fairburn, 2003; Heffner, Sperry, Eifert, & Detweiler, 2002) and are associated with rigid, all-or-nothing thinking patterns (Byrne et al., 2003). Higher levels of bulimic attitudes are associated with greater avoidance of negative emotion as measured by an emotional Stroop task (Seddon & Waller, 2000). Bulimic symptoms are higher in those who are experientially avoidant, and are lower in those who are dispositionally mindful (Lavender, Jardin, & Anderson, 2009). Acceptance and greater psychological flexibility when dealing with difficult weight-related thoughts and feelings correlates with healthier eating habits and lower levels of weight-related shame (Lillis, Hayes, Bunting, & Masuda, 2009). Therefore, the pervasiveness of body image dissatisfaction and associated disordered eating behaviors may be maintained via an experiential avoidance function.

There are also intervention data suggesting that acceptance and mindfulness-based methods may be helpful. Dialectical behavior therapy (DBT; Linehan, 1993) has been shown to be helpful with eating disorders (Telch, Agras, & Linehan, 2001). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) has been shown to be helpful both with weight-related self-stigma and

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