Development and validation of the Body-Focused Shame and Guilt Scale

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ABSTRACT

Body shame is described as central in clinical literature on body dysmorphic disorder (BDD). However, empirical investigations of body shame within BDD are rare. One potential reason for the scarcity of such research may be that existing measures of body shame focus on eating and weight-based content. Within BDD, however, body shame likely focuses more broadly on shame felt in response to perceived appearance flaws in one's body parts. We describe the development and validation of the Body-Focused Shame and Guilt Scale (BF-SGS), a measure of BDD-relevant body shame, across two studies: a two time-point study of undergraduates, and a follow-up study in two Internet-recruited clinical samples (BDD, obsessive compulsive disorder) and healthy controls. Across both studies, the BF-SGS shame subscale demonstrated strong reliability and construct validity, with Study 2 providing initial clinical norms.

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1. Introduction

Body dysmorphic disorder (BDD) is a serious mental illness, in which individuals worry excessively about imagined or very slight appearance defects. In an attempt to minimize defects and the associated worry, individuals with BDD also engage in repetitive compulsive behaviors, such as ritualized grooming, repetitive mirror checking, and camouflaging body parts of concern (American Psychiatric Association, 2013). BDD is classified as an obsessive compulsive related disorder (OCRD) in the DSM-5, as the pattern of obsessions and compulsions in BDD share similarities to the phenomenology of obsessive compulsive disorder (OCD; APA, 2013; Phillips et al., 2010). However, even in comparison to OCD, BDD stands out as an especially debilitating mental illness. It is associated with housebound rates as high as 30% (Phillips et al., 2006), in addition to higher rates of social impairment, occupational impairment, depression, and suicidality than those observed in other mental illnesses (e.g., Phillips et al., 2006).

One factor that may help explain these notably poor outcomes among BDD sufferers is an intense experience of shame. Body shame has been described as a key component to obsessive thoughts regarding the self-perception of one's body as early as 1903 (Janet, 1903). Since then, body shame has remained pivotal to conceptualizations and case descriptions of BDD (Albertini

& Phillips, 1999; Cororve & Gleaves, 2001; Phillips, 1999; Rosen, 1995). For example, possible developmental models of shame have been suggested within both cognitive behavioral and social learning conceptualizations of BDD (Neziroglu, Khemlani-Patel, & Veale, 2008). In the wider emotions literature, shame is linked with withdrawal, depression, impairment, and suicidality (Tangney & Dearing, 2002), which may help to explain the elevated rates of such outcomes in BDD. Despite these severe correlates of shame, a recent review indicates that empirical research examining shame in BDD is scarce (Weingarden & Renshaw, 2015).

One reason there may be so little empirical investigation of shame in BDD is that, to the best of our knowledge, no self-report measure of BDD-relevant body shame currently exists. In the scarce empirical studies of shame in BDD, two studies have measured shame with a single item about whether shame acts as a barrier to treatment-seeking (Buhlmann, 2011; Marques, Weingarden, LeBlanc, & Wilhelm, 2011) and one study utilized an implicit association task that assessed body shame associations among individuals with BDD (Clerkin, Teachman, Smith, & Buhlmann, 2014). Although there are existing self-report measures of body shame (e.g., Body Image Guilt and Shame Scale, BIGSS; Thompson, Dinnel, & Dill, 2003), these measures tend to capture weight- and eating-based shame, which is more likely to occur in individuals with eating disorders. Unlike eating disorders, primary concerns in BDD are not weight or eating based; rather, they tend to focus on the skin, facial features, or other specific body parts (APA, 2013). The Experience of Shame Scale – Body subscale (ESS; Andrews, Qian, & Valentine, 2002) is another measure of body shame, but it seems to more closely assess BDD criteria themselves

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rather than shame (e.g., "Have you worried about what other people think of your appearance?;" "Have you avoided looking at yourself in the mirror?"). Thus, extant measures appear insufficient for capturing the type of body shame one would likely experience within the context of BDD.

The present study aimed to develop and validate a measure of body-focused shame that is relevant to the shame experience within BDD. To develop this measure, we first turned to the broader literature regarding measurement of shame. Shame is defined as a deeply painful emotion that is felt when a person judges him- or herself as defective or bad (Tangney & Dearing, 2002). Shame, which focuses broadly on judging *oneself* as bad, differs from other self-conscious emotions, such as guilt, which is experienced when a person judges his or her *behavior* as bad. In addition, shame tends to be a stronger predictor than guilt of widespread negative outcomes, including social impairment and withdrawal, depression, and suicidality (Andrews et al., 2002; Hastings, Northman, & Tangney, 2000; Kim, Thibodeau, & Jorgensen, 2011; Tangney, Wagner, & Gramzow, 1992).

Existing measures of self-conscious emotions such as shame and guilt vary greatly. Some studies assess these constructs through single, direct questions requesting a Likert rating of shame, guilt, and/or other emotions, whereas others use multi-item measures that also directly refer to *shame* and/or *guilt*. These assessment methods may be limited in several ways. First, they often assess multiple emotions simultaneously in one item. For example, a single item may ask participants to rate *shame and guilt*. Moreover, when participants are asked to directly rate *shame*, this requires that participants understand the distinctions between shame and other self-conscious emotions. Yet, evidence suggests that people do not accurately distinguish one self-conscious emotion from another, but rather tend to confuse and blend them (Tangney & Dearing, 2002)

To address these measurement issues, Tangney, Wagner, & Gramzow (1989) developed several versions of a scenario-based measure of generalized shame-, guilt-, and externalization-proneness called the Test of Self-Conscious Affect (TOSCA) scales (Tangney et al., 1989). The TOSCA scales present a series of scenarios likely to produce a shame, guilt, or externalizing response. Instructions ask participants to rate their likelihood of responding in each of these possible ways (i.e., a shame-driven response, a guilt-driven response, an externalization of blame-driven response). Rather than relying on the oft-confused terms "shame" and "guilt," responses present phenomenological descriptions of what shame (or guilt) would *feel* like. In addition, the measure is not ipsative in nature; participants rate their likelihood of responding in shame-prone *and* guilt-prone ways, rather than choosing between one or the other. This type of measure has the benefit of assessing participants' proneness to each of these distinct emotions (which are not mutually exclusive), without relying on the participants' knowledge of these nuanced distinctions. The TOSCA scales have demonstrated strong reliability and validity (for a summary, see Tangney and Dearing, 2002). One of the leading body shame measures, the BIGSS, was modeled after the TOSCA's format. The BIGSS also demonstrates strong reliability and validity but is focused primarily on weight- and eating-based shame (Thompson et al., 2003). Given the methodological strengths of scenario-based measures of self-conscious emotions, we modeled our scale after these existing measures.

1.1. Development of the Body-Focused Shame and Guilt Scale

Drawing on this shame literature, as well as clinical and empirical knowledge of BDD, we developed the Body Focused Shame and Guilt Scale (BF-SGS; see Appendix). Modeled after the TOSCA and BIGSS, the BF-SGS presents scenarios that are likely to evoke

self-conscious emotions regarding one's body parts (e.g., "You go to the mall, and everybody seems better looking than you"). Following the TOSCA's format, we created not only shame-driven response options (e.g., "You would feel so awful that you'd want to hide"), but also guilt-driven (e.g., "You would think, "I should spend more time trying to improve my appearance"") and externalization-of-blame (e.g., "You would think, 'They don't lead busy lives, so they are able to spend more time on their appearance'") response options. In line with the standard of other scenario-based measures, we included guilt and externalization items in order to provide a wider range of potential responses, rather than only having shame-based response options. Furthermore, there is not a well-developed research base investigating the role of guilt in BDD. Thus, the guilt subscale also provides a method for empirically evaluating the role of guilt in BDD.

Some items for our measure were adapted from the BIGSS (Thompson et al., 2003) to be relevant to body parts, as opposed to weight or eating, and additional items were developed in consultation with clinical experts and through drawing from BDD conceptualizations. Seventeen items were initially generated and refined. Subsequently, items were reviewed by a leading shame and guilt researcher (third author), a leading BDD researcher (fourth author), an obsessive–compulsive related disorders researcher (second author) and a team of clinicians specialized in treatment of OCRDs, including BDD. Following input from these experts, items were edited again and refined to develop the final version of 13 scenarios and associated items.

We then conducted two studies of the psychometric properties of this new measure. First, to gather basic data on internal consistency, test-retest reliability, and convergent and discriminant validity, we tested the BF-SGS in an undergraduate sample with a wide range of mild to elevated appearance concerns, at two time points. In this study, we included the TOSCA-4 and BIGSS, as well as measures of BDD and OCD symptom severity. We used the measure of OCD symptoms to evaluate discriminant validity of our measure by comparing associations of the BF-SGS with BDD symptoms to associations of the BF-SGS with OCD symptoms. OCD symptoms were chosen as a stringent basis of comparison because, while symptoms of both OCD and BDD include obsessions and compulsions, only BDD symptoms focus on appearance-related issues. Thus, we expected the BF-SGS to demonstrate stronger associations with BDD symptom severity compared to OCD symptom severity. Next, in Study 2, we tested the BF-SGS across three Internet-recruited groups: a BDD group, an OCD group, and a healthy control (HC) group. These data allowed us to determine if findings from Study 1 would be replicated in clinical groups, while also obtaining clinical norms for the measure.

2. Study 1

2.1. Materials and methods

2.1.1. Participants

The final Time 1 (T1) sample consisted of 283 undergraduate students enrolled in Psychology courses at a highly diverse university in the mid-Atlantic region. Participants completed study measures online for psychology course credit. A majority of participants were female (81.6%) and single (87.3%). Participants ranged in age from 18 to 45 ($M=21.25$, $SD=3.84$). Approximately half of participants (53.4%) reported their race as White, while 22.3% identified as East Asian, Southeast Asian, or Middle Eastern, 8.8% identified as African American, 11% identified as another race, and 4.6% did not report race.

Ninety-three participants completed Time 2 (T2). Participants who completed T2 did not differ significantly from T2