

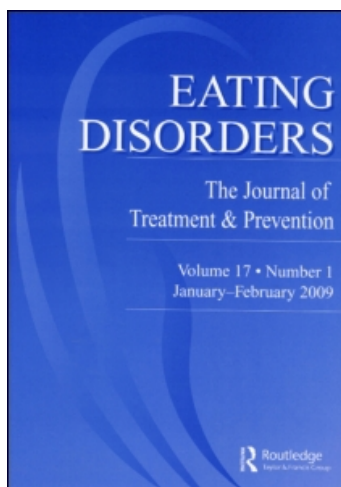
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Outcomes of Manualized Cognitive-Behavioral Body Image Therapy with Eating Disordered Women Treated in a Private Clinical Practice

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Body image change is an important component of the treatment of eating disorders, and cognitive behavioral body image therapy has substantial empirical support as efficacious in the improvement of body image difficulties and disorders. Most evidence comes from randomized, controlled, outcome studies and does not examine effectiveness for persons with clinical eating disorders in the context of “usual care” settings. The present study was conducted in a private practice and assessed 30 women with a range of eating disorder diagnoses. Following manualized group treatment based on Cash’s (1997) The Body Image Workbook, clients reported reduced body image dysphoria, greater body and appearance satisfaction on several dimensions, less psychological investment in their appearance, and a better evaluation of their fitness/health. The study’s limitations and implications are discussed.

Body image disturbances are certainly a salient component of eating disorders, such as anorexia nervosa and bulimia nervosa (American Psychiatric Association: APA, 2000; Cash & Deagle, 1997; Garner, 2002; Stice, 2002a), as well as binge eating disorder (Grilo, 2002; Schwartz & Brownell, 2004). Body dissatisfaction and excessive psychological investment in one’s physical appearance (especially weight and shape) serve as precursors of eating pathology and as maintaining factors in its exacerbation or relapse (Shisslak & Crago, 2001; Stice, 2002b). Thus, body image interventions would seem to

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be crucial in the treatment of persons with eating disorders. Some treatment protocols for bulimia nervosa do include a brief psychoeducational module to address body image issues (e.g., Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn, 1995, 2002). Somewhat greater therapeutic attention to body image may occur in certain treatment programs for anorexia nervosa (e.g., Garner, 2002; Probst, Vandereycken, Van Coppenolle, & Pieters, 1999; Vitousek, 2002). However, little is known about the additive efficacy of explicitly treating body image disturbances in these programs (Cash & Hrabosky, 2004).

Cognitive behavioral therapy (CBT) has emerged as an empirically supported intervention for persons with a “negative body image,” including those with disturbances as severe as body dysmorphic disorder (Cash & Hrabosky, 2004; Cash & Strachan, 2002; Jarry & Bernardi, 2004; Veale, 2002). One such body image CBT program is Cash’s (1997) manualized, eight-step *The Body Image Workbook*, which can be used efficaciously in either a therapist-guided or largely self-administered modality (Cash & Hrabosky, 2003, 2004; Strachan & Cash, 2002). To date, this program has not been explicitly evaluated for persons with current or recent eating disorders. However, outcome studies with “negative body image” participants have demonstrated concurrent reductions on measures of disturbed eating attitudes (Cash & Hrabosky, 2004).

An ultimate objective of the development and empirical validation of any psychosocial treatment is its dissemination and adoption in the “customary care” contexts of the delivery of mental health services. Of course, because randomized clinical trials are typically conducted in a unique, methodologically controlled context, generalization of findings to customary clinical practice is arguable (Ingram, Hayes, & Scott, 2000). An evidence-based practice not only applies empirically verified or efficacious procedures, but it also it attempts to ascertain the effectiveness of these procedures with clients who are the consumers of these services (Seligman, 1995).

The present investigation of Cash’s (1997) program examined the body image outcomes of clients in one clinical practice specializing in the treatment of women with eating disorders. Clients with concurrently or recently treated eating disorders attended one of ten therapist-directed, eight-session groups that used the structured *Body Image Workbook*. At baseline and post-treatment, they completed standardized assessments of multiple facets of body image that are included in the *Workbook*.

METHOD

Participants

Forty-three eating disordered women entered ten body image CBT groups conducted by the first author over a period of four years. Group size ranged from two to seven participants. Thirty of these enrollees completed the

program. Their ages ranged from 15 to 52 years, with a median age of 32. Most clients ($n=20$) received the diagnosis of eating disorder-not otherwise specified (ED-NOS), followed by bulimia nervosa ($n = 7$), and anorexia nervosa ($n = 3$). Among the ED-NOS clients, 13 met the diagnostic criteria for binge eating disorder (APA, 2000). Women were selected for the group from the first author's private practice or referrals from the community. Most were in concurrent individual psychotherapy for an eating disorder. Selection was based on the client's need or desire to feel better about her body, as well as the clinician's impression of her goodness of fit for group therapy.

Assessments

The Body Image Workbook (Cash, 1997) includes standardized assessments of multiple facets of body image. The assessments described here were completed after the first session and before the final session of treatment. In most instances, clients did so at home and were asked to return them to the therapist in the next session. All of these measures have been established to have acceptable reliability (internal consistency) and validity (Cash, 2005).

As administered in the *Workbook*, the well-validated Multidimensional Body-Self Relations Questionnaire (MBSRQ; Brown, Cash, & Mikulka, 1990; Cash, 2005) consists of several internally consistent, multi-item subscales: (1) Appearance Evaluation taps overall feelings of satisfaction and self-perceived attractiveness of one's physical appearance; (2) The Body Areas Satisfaction Scale (BASS) assesses one's dissatisfaction–satisfaction with discrete body areas or attributes (e.g., weight, mid-torso, lower torso, face, etc.); (3) Appearance Orientation measures the extent of cognitive-behavioral investment in one's looks; (4) Health/Fitness Evaluation refers to self-appraisals of being physically fit and healthy; and (5) Fitness/Health Orientation concerns one's level of investment in physical health and fitness.

The Body Image Ideals Questionnaire (BIQ; Cash, 2005; Cash & Szymanski, 1995; Szymanski & Cash, 1995) provides an index of body image evaluation derived from one's self-perceived discrepancies from ten physical ideals, each weighted by the importance of that ideal to the individual.

The Body Image Automatic Thoughts Questionnaire (BIATQ; Cash, Lewis, & Keeton, 1987) assesses the frequency of persons' positive and negative thoughts about their appearance in their daily life. The BIATQ index is the ratio of the frequency of negative body image thoughts to the sum of both positive and negative thoughts.

The Situational Inventory of Body Image Dysphoria (Cash, 2002, 2005) assesses the frequency of negative body image emotions in 48 situational contexts.

Description of Treatment

Treatment consisted of eight 90-minute group sessions, which closely followed the structure and content of *The Body Image Workbook* (Cash, 1997). Nearly all of the “Self-Discovery Helpsheets” and “Helpsheets for Change” were completed within the group sessions and shared aloud by the participants. The principal foci of each session are described as follows.

In Session 1, after a brief group “ice-breaker” in which clients introduce themselves and their reasons for attending the program, they share the results of their body image assessments with each other. They then use these profiles to set specific, individualized goals for change.

Session 2 focuses on the developmental and historical events, including cultural and social experiences, that predispose one to a negative body image. Participants learn how these vulnerabilities are activated and unfold in day-to-day thoughts, emotions, and behaviors, and how they may become self-perpetuating. The process includes the construction of a timeline of body image development, which they read to each other in group. The “Body Image Diary” is introduced, where participants learn to monitor ongoing body image experiences by attending to and recording the precipitants of distress and effects on their thoughts, emotions, and behaviors. This diary is used systematically throughout the program.

Session 3 begins the process of teaching effective coping. Clients are instructed to bring a blank, 90-minute audiotape to group, and all members participate in “Body and Mind Relaxation,” which integrates muscle relaxation, diaphragmatic breathing, mental imagery, and positive self-talk to promote skills for managing dysphoric body image emotions. These skills are applied in desensitization exercises to foster body image comfort and control in relation to distress-provoking stimuli. Group members are instructed to practice the relaxation using the recorded instructions and gradually “climb their ladder of success” using the body image desensitization schedule at home.

Session 4 identifies dysfunctional “appearance assumptions”—beliefs or schemas that mediate daily body image experiences. Clients learn to become aware of the influences of these assumptions in everyday life and to question and refute them.

Session 5 teaches clients to identify particular cognitive distortions in their “Private Body Talk” (body-related thought processes). It then offers specific strategies for modifying them. Clients are instructed to extend their diary-keeping to incorporate cognitive restructuring exercises for correcting these distortions and discovering the emotional and behavioral consequences of cognitive changes.

Session 6 teaches clients specific behavioral strategies for altering avoidant body image behaviors and appearance-preoccupied rituals that

might engender self-consciousness and reinforce a negative body image. These self-tailored strategies typically involve graduated exposure and response prevention interventions that clients develop within the group and set goals for accomplishing them outside of group.

Session 7 applies the metaphor of interpersonal relationship satisfaction (i.e., a good marriage or friendship) to promote a proactive, positive relationship with one's body. Clients engage in prescribed exercises for "body image affirmation" and "body image enhancement." This step emphasizes developing rewarding body-related activities by creating and increasing experiences of mastery and pleasure. Clients receive body image assessments to complete and bring with them to the final session.

In Session 8, clients review the results of their re-administered body image assessments, receive feedback about attained changes, and then set goals for further needed changes. A review of relapse-prevention strategies helps them identify and prepare for future situations that might induce negative body image experiences.

RESULTS

One-way repeated-measures analyses of variance were conducted on the eight outcome measures derived from the *Workbook's* standardized body image assessments. To reduce Type I error, alpha levels were set at .01. Table 1 presents pre- and post-treatment means and standard deviations, *F* ratios, and effect sizes (ES; partial η^2 coefficients). Although measures' scoring in the *Workbook* uses summed scores, they were converted to means for data analysis and reporting in this study. Statistical power limitations precluded a reliable comparison of outcomes as a function of specific eating disorder diagnosis.

TABLE 1 Means, Standard Deviations, and Pre- to Post-Treatment Body Image Effects

Body Image Variable	Pre-Treatment Mean (SD)	Post-Treatment Mean (SD)	<i>F</i> Ratio	Effect Size (partial η^2)
Body Areas Satisfaction (MBSRQ)	2.43 (0.53)	2.97 (0.65)	43.84**	.60
Appearance Evaluation (MBSRQ)	2.13 (0.76)	2.76 (0.97)	11.13*	.28
Self-Ideal Discrepancy (BIQ)	3.51 (1.40)	2.30 (1.22)	27.33**	.49
Body image Dysphoria (SIBID)	2.88 (0.55)	1.96 (0.75)	58.36**	.67
Thoughts Ratio (BIATQ)	0.83 (0.14)	0.62 (0.23)	33.46**	.54
Appearance Orientation (MBSRQ)	3.92 (0.74)	3.47 (0.72)	15.19**	.34
Fitness/Health Evaluation (MBSRQ)	3.04 (0.57)	3.40 (0.46)	11.49*	.28
Fitness/Health Orientation (MBSRQ)	3.20 (0.70)	3.51 (0.78)	1.21	.04

* $p < .01$ ** $p < .001$.

Clients showed significantly improved body satisfaction on the MBSRQ BASS ($p < .001$), the BIQ ($p < .001$), and the overall MBSRQ Appearance Evaluation scale ($p < .002$). On the BIATQ, clients reported a significantly reduced percentage of negative body image thoughts relative to positive and negative body image thoughts ($p < .001$). Sub-analyses indicated comparable increases in positive thoughts ($p < .001$; ES = .44) and decreases in negative thoughts ($p < .001$; ES = .50). Clients reported significantly less frequent body image dysphoria across a range of situational contexts (on the SIBID) ($p < .001$). Clients' cognitive-behavioral investment in their appearance on the MBSRQ Appearance Orientation scale also declined ($p < .001$).

Finally, with respect to nonappearance-related aspects of body image, although clients did not indicate a reliable change in investment in physical fitness and health (on the MBSRQ Fitness/Health Orientation scale; $p < .28$), they did convey improved evaluations of their fitness/health (MBSRQ Fitness/Health Evaluation scale; $p < .002$).

Data were examined on two key measures, body satisfaction (BASS) and body image dysphoria (SIBID), to determine whether any of these 30 clients actually deteriorated in their outcomes. Only one client, a 32-year-old Hispanic woman with binge eating disorder, worsened slightly (0.13 on a 5-point scale) on the BASS and moderately (0.54 on a 5-point scale) on the SIBID.

Finally, a comparison of clients' post-treatment scores with nonclinical adult female norms on these two measures (Cash, 2005) indicated that clients were still somewhat more body dissatisfied than the norm (by .35 *SD*) and somewhat more body image dysphoric (by .30 *SD*).

DISCUSSION

The present "customary clinical care" study of body image CBT with 30 women who were concurrently or recently treated for eating disorders confirmed significant improvements in their body image functioning subsequent to eight-session group treatment. Treatment was based on Cash's (1997) published, manualized program. In descending order of effect sizes, these changes included reductions in the experience of dysphoric body image emotions across a range of everyday life situations, greater satisfaction with various body areas or attributes, an improved ratio of positive to negative body image thoughts, a reduced disparity between self-percepts and body image ideals, less psychological investment in physical appearance, a more favorable global evaluation of appearance, and a better evaluation of fitness/health. Investment in physical fitness/health did not change.

Despite the substantial body image improvements among these women, after treatment they remained slightly more body image dissatisfied

and dysphoric than normatively “typical” women. For therapists who work with eating disordered patients, it will come as no surprise that they do not become fully and comfortably accepting of their body size, shape, and appearance after eight sessions. Perhaps our findings best reflect clients’ movement toward a truce in their long-standing battle with body loathing rather than a conversion to unconditional body acceptance. Future clinical studies should consider how such an armistice affects body image quality of life (Cash & Fleming, 2002; Cash, Jakatdar, & Williams, 2004).

Our findings are consistent with the research literature supportive of the efficacy of body image CBT (Cash & Hrabosky, 2004; Jarry & Bernardi, 2004). This study uniquely examined outcomes in a private clinical practice setting rather than within the confines of a methodologically controlled, clinical-trials administration of the treatment. Indeed, the strength of this study is the evaluation of outcomes with 30 clients across ten different therapy groups using the manualized program in such a customary care context. Of course, its scientific weaknesses pertain to having only one clinician, the absence of control conditions not possible in a clinical practice context, and the lack of an outcome assessment of eating pathology. Such data could clarify the relationship of body image changes to symptoms of eating disturbance. The future inclusion of standardized measures of eating behavior symptoms, ideally monitored over the course of treatment, is clinically and empirically important. Outcome investigations of body image CBT have indicated such changes among samples with less previous and concurrent eating pathology than the clients in this study (Cash & Hrabosky, 2004).

Another shortcoming of the study is uncertainty about the role of attrition from the program. Despite being initially advised of the importance of completing all sessions, 13 clients dropped out. They either discontinued all treatment, became “too busy” to attend a weekly group, or ultimately decided that the group was not for them. Many of these clients were likely not ready to feel better about their bodies or give up the illusion of perfection that dieting and body hatred seem to offer. Such discontinuation was challenging for the group leader and members. Intimate feelings were exposed during group sessions, and when members did not return, others were confused and disappointed. Although it was a very structured CBT group, group dynamics needed to be processed at these times. Other challenges included the inconsistent cooperation in completing assignments, such as body image diaries, at home. Although clients were reminded that practice would enhance the effectiveness of the techniques, some were unable or unwilling to give the time necessary for all homework.

Nevertheless, most clients seemed pleased at the end of the group by how much they learned from and enjoyed the experience. Qualitative evaluation forms conveyed that participants felt better, would recommend the group to a friend, and were glad to be a part of the program. Most conveyed that the experiential sharing among group members and the enthusiasm

and support of the leader made the group valuable to them. Obviously, we cannot discern the extent to which these factors versus the CBT components per se contributed to the observed body image outcomes. One study of group versus individual body image CBT, albeit not with eating disordered patients, found no differences between the two modalities (Grant & Cash, 1995).

We hope that our research and results will encourage other clinicians to conduct systematic assessments in the science-based clinical practice of body image CBT, as well as evaluate other innovative approaches in the body image treatment of persons with eating disorders (Cash & Pruzinsky, 2002; Striegel-Moore & Smolak, 2001). This work also illustrates the value of collaboration between clinical practitioners and scientists in collecting and disseminating evidence that can complement knowledge derived from the more traditional randomized clinical trials.

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