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Acceptance and Commitment Therapy as an Eating Disorder Intervention

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ACCEPTANCE AND COMMITMENT THERAPY AS AN EATING DISORDER INTERVENTION

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ACCEPTANCE AND COMMITMENT THERAPY AS AN EATING DISORDER INTERVENTION

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CONTENTS

LIST OF TABLES

ACCEPTANCE AND COMMITMENT THERAPY AS AN EATING DISORDER INTERVENTION

Sara Wallace August 2017 44 Pages

Directed by: Frederick Grieve, Tony Paquin, and Daniel McBride

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The purpose of this study is to determine if a new intervention using techniques from Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) in combination with activities from The Body Project (Stice et al., 2009), will be able to reduce negative body image concerns and increase mindfulness skills in college females. Prior to receiving the intervention, participants completed a pre-test measuring their current body image concerns as well as mindfulness abilities. The intervention was administered in a large, group setting and took approximately 35 minutes to administer. After receiving the intervention, participants completed the same assessment measures as the pre-test, but in a post-test form. Results indicate that there was a significant difference in body image after participants received the intervention of ACT and The Body Project. There was not a significant difference for the mindfulness facets measured in the study. This research contributes to a growing area of eating disorder treatment using ACT, and can help provide evidence for the benefits of using specific ACT and The Body Project activities for treating and preventing negative body image.

Introduction

The National Eating Disorder Association estimates that nearly 20 million women and 10 million men suffer from an eating disorder at some point in their life (Wade, Keski-Rahkonen, & Hudson, 2011). Due to these high reports of individuals with eating disorders, finding effective prevention and treatment options for eating disorders is a growing area of research. By completing the current study, it is hoped that a new intervention combining techniques from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and The Body Project (Stice, Rodhe, & Shaw, 2012) can be used as a prevention or treatment tool for eating disorders as well as increasing mindfulness levels in individuals who may have body image concerns.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013), a feeding or eating disorder occurs when there is a continuous pattern of disrupted eating or eating-related behavior that causes an individual to have impairment in his or her physical health and psychosocial capabilities. The disorder is often marked by lack of food intake or necessary nutrients for the individual to be able to maintain his or her health. In the DSM-5, there are several different kinds of feeding and eating disorders. The general public may be familiar with of some of these eating disorders, while others may not be as well known. One type of eating disorder commonly recognized by the public is bulimia nervosa. Bulimia nervosa occurs in individuals who maintain a normal (or above normal) weight for their age (body mass index [BMI] $\geq$ 18.5 and $<$ 30 in adults), as opposed to anorexia nervosa, which occurs in individuals weighing significantly less than individuals in their same age group (BMI $<$ 18.5). These BMI classifications are set based on the

DSM-5 criteria for each disorder. Bulimia nervosa involves binge eating episodes, using measures such as laxatives or purging to avoid weight gain, and having very negative views about body shape and weight. When the binge-eating episodes are recurrent and do not involve weight loss measures like laxatives or purging, a diagnosis of binge-eating disorder can be given. If the detailed criteria of any of these three disorders is partially met or presented in a different way, a diagnosis of other specified feeding or eating disorder or unspecified feeding or eating disorder may be given; criteria are presented below in Table 1.

Table 1

Diagnostic Criteria for Eating Disorders

	Criterion A	**Criterion B**	**Criterion C**	**Criterion D**	**Criterion E**
Anorexia Nervosa	Restriction of energy intake relative to requirements, leading to a significantly low body weight	Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain	Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of low body weight		
Bulimia Nervosa	Recurrent episodes of binge eating	Recurrent inappropriate compensatory behaviors in order to prevent weight gain	Binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months	Self-evaluation is unduly influenced by body shape and weight	The disturbance does not occur exclusively during episodes of anorexia nervosa
Binge-Eating Disorder	Recurrent episodes of binge eating	Binge-eating episodes are associated with three or more of the following: 1. Eating more rapidly than normal 2. Eating until uncomfortably full 3. Eating large amounts of food when not physically hungry 4. Eating alone because of fears of embarrassment by how much one is eating 5. Feeling disgusted with oneself, depressed, or very guilty after eating	Marked distress regarding binge eating is present	Binge eating occurs, on average, at least once a week for 3 months	Binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa and anorexia nervosa

It is important for today's professionals to understand the defining features of eating disorders and their courses in order to be able to provide the best treatment. For example, the DSM-5 notes that menstrual irregularity or amenorrhea (not having a menstrual period while still at an age capable of reproduction) is common in individuals with bulimia nervosa and anorexia nervosa. It is unknown, though, whether these health deficiencies are due to lack of nutrients, severe irregularities in weight, or the emotional distress that comes along with having the disorder (APA, 2013). When individuals use vomiting or laxatives repeatedly as a means to avoid gaining weight, it can have serious physical complications such as tears in the esophagus or gastric ruptures (Steinberg et al., 2014). These are serious medical complications that could potentially lead to fatal consequences.

Not only do individuals with eating disorders face serious health consequences, but also psychological and psychosocial consequences. They may become withdrawn from peers and family members and/or lose interest or pleasure in otherwise enjoyable activities (Steinberg et al., 2014). According to Mussell, Binford, and Fulkerson (2000), when these disorders go untreated for a long time, it is a slow and difficult journey back to health for individuals who are suffering. Because of this, it is important for health professionals to notice and treat symptoms as swiftly as possible (Mussell et al., 2000).

After an individual has been diagnosed with bulimia nervosa, the next step for the clinician to focus on is the disordered views the individual has of his or her body image. Sands (2015) conceptualizes body image as more than how an individual sees himself or herself externally as opposed to how the individual views his or her peers, but rather on what he or she is experiencing internally. She refers to this idea as the "body self" instead

of the individual's body image. Because of this change in how body image is defined, she recommends that embodiment (i.e., when an individual starts to embrace his or her body on the inside and not just on the outside) should become the main focus of treatment for the individual with an eating disorder (Sands, 2015). Sands further explains that when the individual begins to embrace embodiment, he or she can start to lose the need for an eating disorder.

The idea of embracing one's challenges and learning how to deal with them appropriately is very similar to the goal of ACT (Hayes et al., 1999). The aim of the current study is to apply ACT (pronounced as one word, rather than the individual letters) principles and determine if ACT is an acceptable treatment intervention for eating disorders, specifically bulimia nervosa. ACT involves an individual accepting the thoughts and emotions he or she is currently experiencing, choosing a positive direction to move towards, and taking action to follow through with the plan (Harris, 2009). In the first part of the treatment, individuals have to accept that they are going through a difficult time or facing a particular challenge. When doing so, many individuals may not handle these things in an effective way. One way ACT helps counteract this is through mindfulness techniques. Although mindfulness can be defined in a number of different ways based on spiritual or religious standpoints, the simplest definition is that "mindfulness means paying attention with flexibility, openness, and curiosity" (Harris, 2009, p. 8). To break this definition down further, an important factor in mindfulness is awareness of what the individual is experiencing, not just externally but internally as well. This idea is parallel to the first component in ACT. Next, mindfulness involves being flexible and open to change. This is similar to the second and third parts of ACT

that include choosing a direction to change and following through with it. Keeping this definition of mindfulness in mind, the final goal of ACT for an individual would be for him or her to be able to have a more flexible and curious way of living and accept what he or she cannot change.

It is hypothesized that, by using some ACT methods, this intervention will be an effective treatment for individuals who display symptoms of bulimia nervosa. By finding an answer to the research question under study, clinicians working with clients who have bulimia nervosa will be able to have additional empirical support for using ACT as a treatment option. Previous research on ACT as a treatment method for eating disorder will be discussed throughout the sections that follow.

Literature Review

In the following section, the fundamental ACT principles will be discussed to provide more information on the therapeutic approach, as well as why it is an effective treatment tool. ACT is based on six core processes: Acceptance, Defusion, Being Present, Self as Context, Values, and Committed Action (Hayes & Strosahl, 2004). These processes are known collectively as the ACT hexaflex. Acceptance occurs when the individual is able to accept what he or she is currently experiencing without making unnecessary attempts to alter the experience. Defusion involves separating thoughts from the individual's core personality. When an individual is able to defuse from his or her thoughts, he or she can simply view the thoughts as things that come and go rather than a core value of what makes up that individual. Defusion changes the relationship an individual has with his or her thoughts by allowing the individual to accept his or her thoughts and move forward regardless of the content of the thoughts. Self as Context

involves the individual being aware of his or her experiences, thoughts, or feelings, without being attached to them using techniques like mindfulness, metaphors, and experiential exercises. Being able to be aware of these things can enhance an individual's cognitive flexibility. Values are the things that make up who an individual is at his or her core. These values could include things such as beliefs, cultural components, learned lessons, political stances, and/or social influences. These are the things that drive the decisions a person makes. Lastly, Committed Action occurs when the individual is committed to taking the steps needed to live a healthier, more fulfilling lifestyle. Committed Action involves carrying out all of the skills the person learns in order to achieve his or her goals that he or she may not have been previously able to accomplish. Taking committed actions could include seeking out a therapist, attending sessions, putting what is learned into practice in his or her life, having motivation to change what is not working, and maintaining what is learned after therapy sessions have ended. These six components contribute to an individual's psychological flexibility and their ability to maintain healthy psychological functioning (Hayes & Strosahl, 2004). The primary mechanism of change for ACT is having a strong psychological flexibility, which is why the six components are important for the overall well-being of the individual (Ciarrochi, Bilich, & Godsel, 2010).

ACT uses metaphors, stories, exercises, behavioral tasks, and experiential processes to help develop an individual's psychological flexibility (Hayes & Strosahl, 2004). It uses these activities to help the individual accept his or her thoughts, learn to defuse from them, and live a mindful way in line with his or her values rather than try to remove the thoughts, which leads to psychological flexibility. The novel area of the ACT

therapy process is that there is not a "right" way to do it. There are guidelines, but those can be tailored or changed depending on the client and situation presented. This is not the case for other therapeutic techniques that have a set focus on what treatment should look like overall. While there are numerous techniques and exercises published in the various books about ACT, there is not a specific protocol to be followed.

ACT draws techniques from cognitive behavioral therapy, experiential therapy, gestalt therapy and other areas outside of the mental health field (e.g., mindfulness, Zen Buddhism, human potential movement), so new activities or techniques can easily be developed to fit the client or situation (Hayes & Strosahl, 2004). Because ACT draws its methods from all of these varying areas, it is a very functional therapy intervention and can be applied in almost every kind of clinical diagnostic treatment. In Harris' (2009) *ACT Made Simple*, he cites nearly 20 publications that support the efficacy of ACT in areas such as anxiety, depression, social phobia, obsessive-compulsive disorder, drug use, schizophrenia, smoking cessation, and weight control.

Avdagic, Morrissey, and Boschen (2014) found that, when treating individuals who have been diagnosed with generalized anxiety disorder, those who received ACT were nearly 30% more likely to maintain their treatment progress at the follow-up assessment than individuals who received Cognitive Behavioral Therapy (CBT). Woidneck, Morrison, and Twohig (2014) used ACT to treat adolescents who were diagnosed with posttraumatic stress disorder (PTSD). These individuals received 10 weeks of ACT, and were assessed at pretreatment, posttreatment, and at a three-month follow-up. The researchers determined that there was a mean reduction of symptoms at the follow up of 60 to 70% (Woidneck et al., 2014). Bricker, Bush, Zbikowskit, Mercer,

and Heffner (2014) conducted a pilot study where they used telephone-based ACT to treat smoking cessation. In this study, individuals received five telephone sessions of either ACT or CBT. Bricker and colleagues reported overall cessation rates for individuals in the ACT condition at 37% compared to just 10% cessation for individuals in the CBT condition. Because of the success of ACT with these diagnoses, it can be hypothesized that ACT could be a useful treatment in individuals diagnosed with bulimia nervosa.

Although there are multiple empirically supported treatment options available for adults with bulimia nervosa, only 50% of the individuals seeking treatment are able to reach remission of their symptoms (Wilson & Shafran, 2005). As such, it is important for further research to be conducted with respect to eating disorders. In a study published in 2013, Juarascio and colleagues wanted to determine if remission rates were increased after participants with bulimia nervosa completed multiple sessions in ACT as opposed to their usual treatment in an inpatient eating disorder hospital. Results indicated that the individuals who received ACT had lower rates of re-hospitalization and even increased rates of healthy eating behaviors than the treatment as usual group (Juarascio et al., 2013). This means that, as compared to their normal treatment, the patients began having normal patterns of eating even with a small amount of ACT. The authors suggest that, rather than the usual treatment options, providers should consider a full use of ACT to treat the disorder due to its significant results compared to what they are currently doing. Further evidence for the success of ACT to treat eating disorders was presented in a series of case studies over several months (Berman, Boutelle, & Crow, 2009). Berman and colleagues worked with three adult women diagnosed with anorexia nervosa using

ACT techniques. Two of the women had much stronger satisfaction with their bodies and less disordered eating after completing ACT. Although the third woman's results were not as strong, she had modest levels of improvement. Because individuals with anorexia nervosa share the same underlying body image concerns as individuals with bulimia nervosa, this study provides evidence for the results to be generalized to individuals diagnosed with bulimia nervosa.

In these studies (Berman et al., 2009; Juarascio et al., 2013; Wilson & Shafran, 2005), the women with the eating disorders had negative thoughts about their body images which lead to an increase in behaviors contributing to eating disorder symptomology. When treated with ACT, they learned how to defuse who they were from these ideas and how to live a more mindful, healthy life; which is exactly the purpose of ACT.

In the following sections, development of The Body Project (Stice, Rohde, Gau, & Shaw, 2009) as well as research on its effectiveness will be discussed. Stice, Shaw, Burton, and Wade (2006) completed a study that examined the efficacy of an eating disorder program using dissonance-inducing activities to reduce thin-ideal concerns in adolescent girls who report body image concerns. Dissonance occurs when there is an inconsistency between one's actions and one's beliefs (Festinger & Carlsmith, 1959). Festinger and Carlsmith (1959) indicate there are three ways to resolve dissonance including changing one's beliefs, changing one's actions, or changing one's perceptions of an action. In this study, participants were assigned to one of four conditions: an eating-disorder prevention program using dissonance-based activities, a prevention program for maintaining healthy weight, and two control conditions where participants either

participated in expressive writing or participated in assessments-only (Stice et al., 2006). Some of the dissonance activities used included defining the "ideal woman" by society's standards, discussing forms of "fat talk", and determining why both of those things are harmful not just to others, but also to the participants themselves. The participants in the dissonance-based activities condition showed significantly greater reduction in symptoms of bulimia nervosa and overall risk factors for eating disorders than the other three conditions. At a 12-month follow-up, the participants in the dissonance-based activities condition and maintaining healthy weight program showed decreased amounts of binge eating and obesity, indicating these two interventions are effective for treating eating disorders (Stice, Shaw et al., 2006). Based on the decrease in eating disorder symptomology for the participants, the results of this study provide evidence that the program was effective in treating negative body image concerns.

Following the research completed by Stice and colleagues (2006), seven more research articles were published (McMillan, Stice, & Rohde, 2011; Stice, Marti, Spoor, Presnell, & Shaw, 2008; Stice, Presnell, Gau, & Shaw, 2007; Stice, Rohde, Durant, and Shaw, 2012; Stice, Rohde, Gau, & Shaw, 2009; Stice, Rohde, Shaw, & Marti, 2011; Stice, Shaw, Becker, & Rohde, 2008) on the development and effectiveness of The Body Project (Stice et al., 2009), a program designed for adolescent females using dissonance-based activities and discussions to reduce symptoms associated with eating disorders and prevent future symptoms. Two different versions of the program were created for use; one version entails four, one-hour weekly sessions, while the other consists of six, 45-minute sessions (Stice, Rohde, & Shaw, 2012). The sessions are led by one or two individuals who have received training from a Body Project facilitator. Within the

sessions, the peer leaders assist with body image discussions, activities, homework assignments, and emotional support for group members.

Limitations of Existing Research

In the research completed by Berman and colleagues (2009), the three women reported overall improvements in body satisfaction and decreases in their disordered eating. Although the results were significant in this study (Berman et al., 2009), there are some weaknesses to using ACT as a treatment option. The therapy was developed in the early 1980s with the first controlled study of ACT completed in the late 1980s. After this, the research ceased until the late 1990s because the developers wanted to spend time focusing on the theoretical framework from which to develop their model. After the research was resumed, Hayes and colleagues released the first ACT manual in 1999 (Hayes & Strosahl, 2004). In the five years following the release of the ACT manual, over 35 case studies or clinical trials were completed using ACT (Hayes & Strosahl, 2004). Because this therapy is so new, the research (even though it is strong) is relatively limited compared to other forms of therapy. Many of the clinical trials completed are on small samples like that of Berman and colleagues (2009) which only included three participants.

The Current Study

For ACT to be used more frequently by mental health professionals, a greater amount of clinical research needs to be completed to add evidence for ACT's effectiveness in treating eating disorders such as bulimia nervosa. Because previous research is strong with supporting evidence for using ACT to treat eating disorders, it can

be hypothesized that ACT is a very effective treatment for all negative body image concerns. The current research is intended to build upon this same research base. Since ACT promotes that suffering and challenges faced by humans is a normal process, it is significantly less pathologizing than other treatment methods may be (Manlick, Cochran, & Koon, 2013). It is important for individuals to make the distinction that pain (e.g., disappointing life circumstances such as losing a job, ending a relationship, or a family member or friend passing away) is unavoidable, but suffering (i.e., how one deals with those circumstances) is not. ACT uses this principle to help an individual move forward from their perceived suffering. Manlick and colleagues (2013) explain that the focus of ACT is not on what is "wrong" with an individual, but is oriented towards methods to help that individual live a more purposeful life. Because ACT involves experiential components using metaphors and imagery, it provides immediate ease from distress in the session and this ease can occur even after just one session, as opposed to other therapies that may take multiple sessions to show a result. Lastly, there are nearly no risks associated with ACT. It does not require or ask an individual to change or alter his or her thoughts in any way, but rather helps an individual learn to stay in the present moment and accept what has happened in his or her life (Harris, 2009). The literature reviewed for this research does not discusses negative effects of participating in ACT, so this research has shown ACT to be a primarily positive treatment regardless of the amount experienced. ACT has shown some success as a treatment option for eating disorders, and The Body Project has shown success in treating negative body image. When activities from both interventions are combined into one new intervention, similar results are expected to occur.

In the current study, there are two hypotheses. First, individuals will have a reduction in body image concerns after receiving a combination of ACT techniques and The Body Project activities as an intervention. The second hypothesis under study is that individuals will report a greater level of mindfulness after receiving the new ACT/Body Project intervention than prior to the intervention. For the current study, mindfulness will be split into five facets: Observing, Describing, Acting with Awareness, Nonjudgement of Inner Experience, and Nonreactivity of Inner Experience. Baer, Smith, Hopkins, Krietemeyer, and Toney (2006) describe several different definitions of mindfulness, but they determined each definition is made up of multiple facets. In a meta-analysis comparing five self-report mindfulness measures, Baer and colleagues (2006) determined that Acting with Awareness, Nonjudgement on Inner Experience, and Nonreactivity to Inner Experience appeared in each of the measures examined. These authors discussed that while the Observing facet was not present in all measures, it would be a useful facet to determine the growth of mindfulness as a skill set. The analysis further revealed that the Describing factor was used for individuals to be able to define what they experience using words and the Acting with Awareness factor was present to determine the way individuals attended to the way their body moved (Baer et al., 2006).

Method

Participants and Design

Participants for this study included 149 individuals within two Greek organizations who are female undergraduate students at Western Kentucky University. By recruiting women through Greek organizations, a convenient sample was gathered to ensure the maximum amount of participants were present for all measures. Similarly, recruiting through Greek organizations was a convenient way to gather a large group of women in one setting. The age of participants ranged from 18 to 22 (M = 19.76, SD = 1.11). There were 131 (90.3%) Caucasian participants, 3 (2.1%) African American participants, 3 (2.1%) Hispanic participants, 1 (0.7%) Asian participant, 7 (4.8%) Multiracial participants, and 4 participants who did not list their ethnicity.

The design of this study is a within-subjects, repeated measures design with assessments that were administered before and after the developed intervention. The dependent variables are the participants' reported levels of mindfulness and body image. Both variables were measured before and after the given intervention.

Measures

Demographics. Basic demographic questions (i.e., age, race, gender, and education level) were assessed by a brief questionnaire. See Appendix A.

Body Image. The Body Assessment (BA; Lorenzen, Grieve, & Thomas, 2004) is a 25-item questionnaire that asks the individual to rate his or her attitudes towards specific parts of his or her body (i.e., weight, triceps, chin, and body build). The participant uses a five-point Likert scale to evaluate his or her body parts on a scale of 1 (*strongly negative*) to 5 (*strongly positive*). The scores for each item are added together

for an overall body satisfaction score. Since the BA measures overall body satisfaction (Lorezen et al., 2004), high scores on the BA indicate an individual has strongly positive views of his or her overall body image. The BA has strong internal consistancy, (Cronbach's alpha = .94), and the correlations among the 25 items range from $r = .51$ to $r = .80$ (Lorenzen et al., 2004). See Appendix B.

Mindfulness. The Five Facet Mindfulness Questionnaire Short Form (FFMQ-SF; Bohlmeijer, ten Klooster, Fledderus, Veehof, & Baer, 2011) is a 24-item questionnaire that measures the five mindfulness facets of observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. Items on the FFMQ-SF are scored on a five-point Likert scale on a scale of 1 (*never or rarely true*) to 5 (*very often or always true*). The FFMQ-SF includes four observing items (e.g., "I pay attention to physical experiences, such as the wind in my hair or sun on my face") and five items each for describing (e.g., "I'm good at finding words to describe my feelings"), acting with awareness (e.g., "I find it difficult to stay focused on what's happening in the present moment"), non-judging of inner experience (e.g., "I tell myself I shouldn't be feeling the way I'm feeling"), and non-reactivity to inner experience (e.g., "I watch my feelings without getting carried away by them"). The facets are scored by adding the scores from the individual items included in each. The scores range from 8 to 40 for all facets except non-reactivity (where the scores range from 7 to 35), with a higher score indicative of higher amounts of mindfulness (Bohlmeijer et al., 2011). The non-reactivity ($a = .72$) and observing ($a = .71$) subscales on the FFMQ-SF both have high reliability. See Appendix C.

Interventions

For the current study, an intervention using ACT techniques was used. This intervention used activities from *ACT Made Simple* (Harris, 2009) including Mindfulness of Breath, Defusion: Part 1, Defusion: Part 2, and A Taste of Defusion. The Mindfulness of Breath activity was chosen because it includes three of the six ACT core components in its message. It is also a relatively short mindfulness activity that is easily understood for individuals without previous mindfulness experience. All three defusion activities are centered on teaching an individual how to separate who he or she is at his or her core from his or her thoughts. Defusion is important for dismantling the negative body image ideals an individual may have about himself or herself. These activities were chosen because they are relatively short to present and complete, whereas other ACT activities may be more time consuming. Other ACT activities may also require more direct therapeutic approaches that would be difficult to administer in a large group setting. The intervention also uses the Thin Ideal Discussion, Challenging Body Talk, and Self-Affirmation Exercise activities from The Body Project program (Stice et al., 2012). For the Defusion exercises, participants were given a notecard to write down their thoughts. The notecard is used as a tool for the individual to become absorbed in a particularly distressing thought, then place distance between the individual and his or her thought. The other activities in the intervention do not require the participant to write down his or her thoughts, so this is the only material needed. See Appendix D.

Procedure

After receiving Institutional Review Board approval, the participants were recruited from Greek organizations though an email sent from the Greek Life

Coordinator. The participants were given a consent form to explain the details of the current study. Prior to the intervention, participants received a pre-test that assessed their current level of mindfulness and body image. The pre-test included both the FFMQ-SF and the BA. After completion of the pre-test, the intervention was conducted. The intervention took approximately 45 minutes to present to the participants as a group. The same researcher was used across both presentations. The time allotted was based upon the length of activities, discussion points, and verbal participation. Upon completion, participants were given a post-test to assess their levels of mindfulness and thoughts towards their body image after being presented with the intervention. The post-test also included the FFMQ-SF and the BA.

Results

Preliminary Analyses

The BA scores were added together to determine the total body image score. The FFMQ-SF facet scores were added together to create a total score for each of the five facets, rather than an overall mindfulness score. Cronbach's alpha was used to test reliability of both measures used in the study. The BA pre-test and post-test had Cronbach's alphas that were >.90, indicating excellent internal consistency. The FFMQ-SF facets' pre-test and post-test alphas ranged from .70 to .86, which indicates acceptable to good internal consistency. Please see Table 2 for the alphas for the BA and the FFMQ-SF facets. The effect sizes between the pre and posttest means for all measures were calculated using Cohen's d. Please see Table 3 for the effect sizes between pre and posttests.

Hypothesis Testing

The first hypothesis is that individuals will have a reduction in body image concerns after receiving a combination of ACT techniques and The Body Project activities as an intervention. Body image prior to the intervention differed significantly from body image after the intervention, $t\,(135) = -6.27$, $p < .00$, $d = 0.34$. The first hypothesis was supported, as reported negative body image for participants decreased after the intervention. Table 2 presents the total number of participants, maximum scores, minimum scores, mean scores, and standard deviations for the BA pre-test and post-test.

Table 2

Descriptive Statistics for Measures

	N	Minimum	Maximum	Mean	Std. Deviation	Alphas
BAPre	142	34.00	120.00	74.99	14.33	.91
ObservePre	144	4.00	20.00	13.65	2.95	.70
DescribePre	141	7.00	25.00	16.89	3.44	.80
NonReactPre	142	6.00	23.00	13.62	3.35	.73
ActAwarePre	145	8.00	25.00	16.06	3.26	.72
NonJudgePre	142	6.00	23.00	14.62	3.49	.74
BAPost	140	34.00	119.00	80.07	15.72	.94
ObservePost	134	6.00	20.00	13.88	3.25	.80
DescribePost	131	10.00	25.00	16.93	3.37	.76
NonReactPost	133	6.00	25.00	13.92	3.63	.83
ActAwarePost	135	5.00	25.00	15.87	3.63	.86
NonJudgePost	134	5.00	24.00	14.69	3.69	.79
Valid N (listwise)	119					

Note: BAPre = Body Assessment Pretest; ObservePre = Observe Pretest; DescribePre = Describe Pretest; NonReactPre = Nonreactivity to Inner Experience Pretest; ActAwarePre = Acting with Awareness Pretest; NonJudgePre = Nonjudgement on Inner Experience Pretest; BAPost = Body Assessment Posttest; ObservePost = Observe Posttest; DescribePost = Describe Posttest; NonReactPost = Nonreactivity to Inner Experience Posttest; ActAwarePost = Acting with Awareness Posttest; NonJudgePost = Nonjudgement on Inner Experience Posttest

The second hypothesis is that individuals will report a greater level of mindfulness after receiving the new ACT/Body Project intervention than prior to the intervention. Mindfulness as measured by the FFMQ-SF was split into five facets: Observing, Describing, Acting with Awareness, Nonjudgement of Inner Experience, and Nonreactivity to Inner Experience. Results of a series of paired-samples *t*-tests of the mindfulness facets indicated there were no significant differences between pre and posttests (all t's < 1.40, all p's $> .10$). Please see Table 3.

Table 3

Values for t-tests Effect Sizes

	t	*p*	d
BA	-6.27	.000	0.34
Observe	-0.91	.36	0.04
Describe	-0.54	.59	0.03
NonReact	-1.40	.165	0.08
ActAware	1.26	.21	0.07
NonJudge	-0.48	.97	0.00

Note: BA = Body Assessment; Observe= Observe; Describe = Describe; NonReact = Nonreactivity to Inner Experience; ActAware = Acting with Awareness; NonJudge= Nonjudgement on Inner Experience

Discussion

Due to the large number of individuals who are diagnosed with eating disorders, finding effective prevention and treatment options is a growing area of research. Not only should prevention and treatment options be developed for inpatient settings, but also for outpatient facilities, academic campuses, and social organizations. Mussell and colleagues (2011) reported that the prognosis of individuals who suffer from negative body image and/or an eating disorder worsens the longer he or she goes without treatment. By finding a quick and effective prevention and treatment intervention, these individuals may be able to seek symptom relief and weaken their distorted body image quicker than without such intervention. The purpose of the current study was to determine if a new intervention using techniques from ACT in combination with activities from The Body Project would be beneficial as a prevention and treatment tool for individuals who struggle with body image concerns.

The first hypothesis was that the participants' body image would improve following the intervention. The second hypothesis was that participants' mindfulness skills would improve after the intervention. The first hypothesis was supported. This indicates that after the intervention, participants had a more positive body image as identified by the BA posttest. The second hypothesis was not supported, as mindfulness did not improve significantly between the pre and post FFMQ-SF scores. Each of the mindfulness facet scores, except Acting with Awareness, had an increase in their means between the pre and post mindfulness measure. This indicates that, while the participants' mindfulness ability scores were not statistically significant, they did improve slightly after the intervention.

This research contributes to a large body of eating disorder and body image research. It can be included in treatment models, prevention methods, or provide general information about tools that can be used to alter an individual's negative body ideals. Not only does this research contribute to prevention and treatment of eating disorders and negative body image, but it can also be added to the list of things ACT has been proven to treat successfully (Harris, 2009). Similarly, it adds to a body of research conducted on the efficacy of The Body Project. One novel contribution this research adds to The Body Project research is the short time frame needed to implicate a positive change in body image. Stice, Rohde, and Shaw (2012) describe the usual Body Project time frame consists of either six, 45-minute sessions or four, one-hour weekly sessions. This research shows that less than an hour is needed to invoke change for the individuals who received the intervention consisting of ACT and The Body Project.

While there was a significant change in participants' reported body image, there was not a significant change in mindfulness skills. One potential explanation for this is the lack of mindfulness activities used in the intervention. There were five activities centered on body image, but only one mindfulness activity that was presented as the first activity of the intervention. This discrepancy between number of activities for body image and mindfulness could contribute to why the second hypothesis was not supported. Another limitation of the current study was that only female participants were used as a convenience sample. Since only females were used, the results of this study cannot be generalized to males as well. Similarly, using a random sample could provide a more accurate representation of the body image concerns in the general population, rather than just those reported in college females. While the number of men who report being

diagnosed with an eating disorder is half of the number of women who are diagnosed, finding prevention and treatment interventions for men is important as well. Although the results of this study show clear improvement in body image statistically, it is hard to determine how much the participants' body image improved clinically. For the relatively short intervention used in the study, it was expected that small changes in reported body image would be reported. Although large changes in body image were not immediately expected, it can be hypothesized that multiple small changes could lead to larger changes in body image over time. Further clarification and assessment is needed to conclude how much their body image improved clinically, if it will continue to improve after the study, and how long the body image improvements will last. There are limitations due to inability to measure beta and gamma instrumentation effects from participants. In addition, because the intervention was presented as a body image program, participants may have subconsciously altered their behaviors to improve their results on the measures. This indicates that demand characteristics could have influenced the results. Lastly, carry-over effects could have contributed to the lack of significance in the mindfulness facets. The 45-minute intervention between measures may not have been a long enough break for the participants to forget their previous answers; therefore, they may have answered the same questions similarly regardless of the intervention's effects.

Future research should include improving the mindfulness portion of the new intervention presented in this study in order to determine if mindfulness should still be included in the intervention. Similarly, future research could determine which activities from ACT and The Body Project used in the intervention are the most effective mechanisms of change for the individuals participating in the program. Once The Body

Project has been normed for males, the intervention presented in this study should be administered to a male sample as well to test the hypotheses that body image and mindfulness skills will improve after the intervention. Lastly, future research may include questions in the post test regarding how much or how little the individual thought his or her body image changed as a result of the intervention. Questions similar to this may help practitioners determine the clinical significance of the results of this and future research. These questions may also help control for beta and gamma instrumentation effects.

In conclusion, the results of the current study show that the combined intervention of ACT and The Body Project has the potential to be an effective prevention and treatment option for individuals with negative body image concerns. Even though the change between the pre and posttests was not statistically significant for improvements in mindfulness skills, mindfulness skills did show a slight increase in most facets measured for the participants. Implications of the current research are seen in terms of prevention and treatment for individuals with negative body image and eating disorders.

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Appendix A: Demographics

Directions: please circle/fill in the answer that best describes you:

1. Age: _____

2. Gender:

Female Male Describe in another way_____

3. Race/Ethnicity:

Caucasian Latino African American

Pacific Islander Hispanic Native American

Asian Multi-Racial Describe in another way_____

4. Relationship Status:

Single Dating Committed Relationship Married

Divorced Widowed Other: _____

5. Estimated annual family (parents) income: _____

6. College Major/Program: _____

7. Current educational status:

Freshman Sophomore Junior Senior

8. Clubs/Organizations currently involved in:_____

_____

_____

9. Have you ever worried about your eating habits? (Circle Answer)

Yes No **If yes**, please describe_____

10. Have you ever been diagnosed with an eating disorder? (Circle Answer)

Yes No **If yes**, please describe_____

Appendix B: Body Assessment Scale

The following are some areas in which people tend to be concerned about their bodies. Please circle the number that corresponds to how positive or negative you feel about each of the areas.

1. **Weight**	1 strongly negative	2	3 neutral	4	5 strongly positive	14. **Chest**	1 strongly negative	2	3 neutral	4	5 strongly positive
2. **Face (appearance)**	1 strongly negative	2	3 neutral	4	5 strongly positive	15. **Chin**	1 strongly negative	2	3 neutral	4	5 strongly positive
3. **Body Shape**	1 strongly negative	2	3 neutral	4	5 strongly positive	16. **Energy Level**	1 strongly negative	2	3 neutral	4	5 strongly positive
4. **Thighs**	1 strongly negative	2	3 neutral	4	5 strongly positive	17. **Body Build**	1 strongly negative	2	3 neutral	4	5 strongly positive
5. **Upper Body Strength**	1 strongly negative	2	3 neutral	4	5 strongly positive	18. **Physical Coordination**	1 strongly negative	2	3 neutral	4	5 strongly positive
6. **Waist**	1 strongly negative	2	3 neutral	4	5 strongly positive	19. **Buttocks**	1 strongly negative	2	3 neutral	4	5 strongly positive
7. **Reflexes**	1 strongly negative	2	3 neutral	4	5 strongly positive	20. **Calves**	1 strongly negative	2	3 neutral	4	5 strongly positive
8. **Health**	1 strongly negative	2	3 neutral	4	5 strongly positive	21**. Stomach**	1 strongly negative	2	3 neutral	4	5 strongly positive
9. **Shoulders**	1 strongly negative	2	3 neutral	4	5 strongly positive	22. **Physical Condition**	1 strongly negative	2	3 neutral	4	5 strongly positive
10. **Physical Stamina**	1 strongly negative	2	3 neutral	4	5 strongly positive	23. **Triceps**	1 strongly negative	2	3 neutral	4	5 strongly positive
11. **Agility**	1 strongly negative	2	3 neutral	4	5 strongly positive	24. **Abdominal Muscles**	1 strongly negative	2	3 neutral	4	5 strongly positive
12. **Biceps**	1 strongly negative	2	3 neutral	4	5 strongly positive	25. **Legs**	1 strongly negative	2	3 neutral	4	5 strongly positive
13. **Lower Body Strength**	1 strongly negative	2	3 neutral	4	5 strongly positive						

Appendix C: Five Facet Mindfulness Questionnaire- Short Form (FFMQ-SF)

Below are several statements. For each statement, check the appropriate box that describes how often the statement fits for you.

	Never or Almost Never True	Rarely True	Sometimes True	Often True	Very Often or Always True
1. I'm good at finding words to describe my feelings.					
2. I can easily put my beliefs, opinions, and expectations into words					
3. I watch my feelings without getting carried away by them.					
4. I tell myself I shouldn't be feeling the way I'm feeling.					
5. It's hard for me to find the words to describe what I'm thinking.					
6. I pay attention to physical experiences, such as the wind in my hair or sun on my face.					
7. I make judgments about whether my thoughts are good or bad.					
8. I find it difficult to stay focused on what's happening in the present moment					
9. When I have distressing thoughts or images, I don't let myself be carried away by them.					
10. Generally, I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.					
11. When I feel something in my body, it's hard for me to find the right words to describe it.					
12. It seems I am "running on automatic" without much awareness of what I'm doing.					

13. When I have distressing thoughts or images, I feel calm soon after.					
14. I tell myself that I shouldn't be thinking the way I'm thinking.					
15. I notice the smells and aromas of things.					
16. Even when I'm feeling terribly upset, I can find a way to put it into words.					
17. I rush through activities without being really attentive to them.					
18. Usually when I have distressing thoughts or images I can just notice them without reacting.					
19. I think some of my emotions are bad or inappropriate and I shouldn't feel them.					
20. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.					
21. When I have distressing thoughts or images, I just notice them and let them go.					
22. I do jobs or tasks automatically without being aware of what I'm doing.					
23. I find myself doing things without paying attention.					
24. I disapprove of myself when I have illogical ideas.					

Appendix D: Intervention

MINDFULNESS OF BREATH

I invite you to sit with your feet flat on the floor and your back straight, and either fix your eyes on a post or close your eyes. Bring your attention to your breathing, and observe it as if you're a curious scientist who has never encountered breathing before. (Pause 5 seconds) Notice the air as it comes in through your nostrils… and goes down the bottom of your lungs. (Pause 5 seconds) And notice it as it flows back out again. (Pause 5 seconds) Notice the moving in and out of your nostrils… how it's slightly warmer as it comes out… and slightly cooler as it goes in. Notice the subtle rise and fall of your shoulders… (Pause 5 seconds) and the gentle rise and fall of your rib cage… (Pause 5 seconds) and the soothing rise and fall of your abdomen. (Pause 5 seconds) Fix your attention on one of these areas, whichever you prefer: on the breath moving in and out of the nostrils, on the rising and falling of the rib cage, or the abdomen. (Pause 5 seconds) Keep your attention on this spot, noticing the movement-in and out- of the breath. (*Pause 20 seconds*) Whatever feelings, urges, or sensations arise, whether pleasant of unpleasant, gently acknowledge them, as if nodding your head at people passing by you on the street. (Pause 5 seconds) Gently acknowledge their presence and let them be. (Pause 5 seconds) Allow them to come and go as they please, and keep your attention on the breath. (*Pause 20 seconds*) Whatever thoughts, images, or memories arise, whether comfortable or uncomfortable, simply acknowledge them and allow them to be… Let them come and go as they please, and keep your attention on the breath. (*Pause 20 seconds*) From time to time, your attention will wander as you get caught up in your thoughts. Each time this happens, notice what distracted you, then bring your attention back to the breath. (*Pause*

20 seconds) No matter how often you drift off, whether a hundred times or a thousand- your aim is simply to note what distracted you and to refocus on your breath. (*Pause 20 seconds*) Again and again and again, you'll drift off into your thoughts. This is normal and natural and happens to everyone. Our minds naturally distract us from what we're doing. So each time you realize your attention has wandered, gently acknowledge it, notice what distracted you, and return your attention to the breath. (*Pause 20 seconds*) If frustration, boredom, anxiety, impatience, or other feelings arise, simply acknowledge them, and maintain your focus on the breath. (*Pause 20 seconds*) No matter how often your attention wanders, gently acknowledge it, note what distracted you, and then refocus on your breath. (*Pause 10 seconds*) And when you're ready, bring yourself back to the room and open your eyes.

THIN-IDEAL DISCUSSION

Now we are going to define the thin-ideal for women to understand exactly what we are discussion. What are we told the "perfect woman" looks like? Just shout out aspects of the "perfect woman" and I will write them up on the board.

(Thin, attractive, perfect body, toned, large-chest, tall, white teeth, clear complexion…)

So the "perfect woman" is… *(Read back the list on the board playfully highlighting the incompatible features.*)

We call this "look"- this thin, toned, busty woman…-"the thin-ideal." Now before we discuss the thin ideal further, it is important to contrast this thin ideal with the healthy ideal because they are not the same thing. With the thin ideal, people go to extreme measures to look like a supermodel, including some very unhealthy weight control behaviors and excessive exercise. The goal of the thin ideal is to attain thinness that is

neither realistic nor healthy. The healthy ideal is the way your unique body looks when you are doing the necessary things to appropriately maximize your physical health, mental health, and overall quality of life. With the healthy ideal, the goal is health, fitness, functionality, and longevity. A healthy body has both muscle and adequate fat tissue. The healthy ideal involves feeling good about how our body both feels and works.

Has this "thin ideal" always been the ideal for feminine attractiveness? Has there ever been a time in history when the "perfect woman" looked different?

(*No, differs with differing times. Solicit different beauty examples over time e.g., Marilyn Monroe, figures in Renaissance period, models today*).

Where did this thin ideal come from?

(Media, fashion industry, diet/weight loss industry)

How is the thin ideal promoted to us?

(Media: tv shows, magazines, diet/weight loss industry)

How do thin ideal messages from the media impact the way you feel about your body?

(Feeling inadequate because they do not look like a model, dislike own body, negative mood)

What does our culture tell us will happen if we are able to look like the thin ideal?

(We will be loved, successful, wealthy, and happy.)

Will coming closer to this thin ideal really make these things happen? Another way to think about this is to ask: do celebrities, who often come the closest to the thin ideal, have perfect lives.

(No, they will have little impact and have a plethora of other problems like substance addiction, no real friends, etc.)

CHALLENGING BODY TALK

We've spent a lot of time discussing the obvious pressures to be thin that we encounter on a regular basis from the media, friends, and family. However, sometimes we put ourselves or others under pressure to try to attain this thin-ideal. We often do not notice some of the more subtle ways the thin ideal keeps going.

Can any of you think of some ways that you or others might promote the thin-ideal without even knowing it?

(Complementing other's weight loss, commenting on what or how much you're eating, complaining about your body, and talking about celebrities who are either very thin or look as though they've gained weight.)

I am going to read some statements women commonly make. These statements are all forms of fat talk. Please take a moment and listen to the statements as I read them aloud.

1. I wish I could be as skinny as you.
2. Do I look fat in this?
3. You look amazing! How much weight have you lost?
4. No one will date me if I don't drop a few pounds.
5. You think you're fat? Look at my love handles!
6. Did you see that girl he is dating? She's such a whale.
7. She totally shouldn't be wearing those pants! Her butt is huge.
8. I'm so fat.
9. She has gained so much weight since last semester
10. Buy it a size smaller, it'll be good motivation for you

How do these statements keep the thin ideal going?

If you stopped saying statements on this list, how would it affect others around you? How would your feelings towards your own body change if you were to stop talking this way?

DEFUSION: PART 1 (NEED INDEX CARDS)

Well what I would like to do, if that is okay with you, is have you jot down some of your thoughts on this card. Would that be okay with you?

Sure

Thanks. So when your mind is really beating you up, really getting stuck into you about what's wrong with you, and what's wrong with your life- if I could listen in at those times, sort of plug into your mind and listen in to what it's saying, what it's telling you, what would I hear?

Just really negative stuff, like, um, you're stupid, you're lazy, and no-body likes you.

Okay. Take a couple minutes and jot a few of these thoughts on your index card. Does your mind tell you any really dark or scary stories about the future? When you really feel hopeless, what are the things your mind is saying to you?

DEFUSION: PART 2

Okay, so this is the sort of stuff your mind says to you?

I'm going to ask you to do a couple things with this card. They may seem a bit odd, but I think you'll get a lot out of them. Is that okay?

First I would like you to hold the card tightly, with both hands, and hold it right up in front of your face like this so you can't see me, so all you can see are those thoughts on the card. That's right- and hold it up so close that it's almost touching your nose. Now

what's it like trying to have a conversation with me while you're all caught up in those thoughts?

Do you feel connected with me? Can you read the expression on my face? Do you feel truly engaged with me? If I was juggling right now, or doing a mime act, would you be able to see what I was doing?

And what is your view of the room like while you're all wrapped up in those thoughts?

So notice what's going on here. Here's your mind telling you all these nasty stories, and the more absorbed you become, the more you're missing out on. You're cut off from the world around you, you're cut off from me, and you're cut off from everything except these thoughts. Notice, too, that while you're clutching this stuff, it's hard to do anything that enriches your life. Hold the card as tightly as you can with both hands. Try to pull your neighbors card out of their hands. Now if I asked you to take an exam, or go for an interview, or hug someone you love, or have a meaningful conversation with a close friend while you're holding on tightly to this, could you do it?

When your mind hooks you with these thoughts, not only do you get cut off from the world around you and disconnected from other people, but it's also much, much harder to do the things that make your life work.

Now let's try something else. Place the card on your lap and let it sit there for a moment. How is that, compared to having it right in front of your face? Do you feel more connected with me? More engaged to the world around you?

Now notice how those thoughts haven't gone away. They're still there. And if you want to, you can still get all absorbed in them. Check it out for yourself. Look down at the card in your lap and give it all your attention. Notice how as you get absorbed in those

thoughts, you get cut off from me- and you lose touch with the world around you. Now look back at me. And notice the room around you. Now which do you prefer- to get sucked into your thoughts down there or to be out here in the world interacting with me? Even if you prefer to interact with the world around you, you may still get distracted by those thoughts. Our minds train us to believe that everything they say to us is very important and we must pay attention. The thing is there's nothing written on that card that's new, is there? I mean you've had those thoughts, what hundreds, thousands of times?

So notice, you have a choice here. You can either look down and get all absorbed in this stuff, in all these thoughts that you've had zillions of times, or you can just let it sit there and you can engage with the world. The choice is yours. Which do you choose?

Now you see what we're up against. That's what our minds do. They hook you. But notice how different it is when you unhook yourself. Notice that if now I asked you to take an exam, or go for an interview, or go for a swim, or hug someone you love- now you could do it so much more easily. And now you can also take in the room and appreciate all this fantastic furniture and wonderful décor provided by WKU. And if I start juggling balls or doing a mime show- now you'll be able to see it.

We have a fancy name for this process. We call it "defusion." And what I'd like to do, if you're willing, is take you through a couple of simple diffusion techniques, and we'll see what happens. Does that sound okay?

A TASTE OF DEFUSION

Okay, look back at your card and remember those thoughts your mind says to you. Now pick the thought that bothers you the most and use it to work through the following exercises.

Put your negative self-judgement into a short sentence- in the form "I am X." For example, *I'm a loser or I'm not smart enough*.

Now fuse with this thought for ten seconds. In other words, get all caught up in it and believe it as much as you possibly can.

Now silently replay the thought with this phrase in front of it: "I'm having the thought that…" For example, *I'm having the thought that I'm a loser*.

Now replay is one more time, but this time add the phrase "I notice I'm having the thought that…" For example, *I notice I'm having the thought that I'm a loser*.

What happened? Did you notice a sense of separation or distance from the thought? Do you think the thought seemed to move out in front of you rather than being stuck in your mind?

So that's part of what we mean by defusion: you start to separate from your thoughts and give them some space to move around in.

SELF-AFFIRMATION EXERCISE

As we come to the end of the session, I would like to encourage you to continue to challenge some of your body related concerns. Part of doing this is talking about our bodies in a positive rather than a negative, way and helping our minds to rid those negative thoughts. Here are some ideas on how to get started doing this:

1. Choose a friend or family member and discuss one thing you like about yourselves.
2. Keep a journal of all the good things your body allows you to do (e.g., do a long hike, play tennis well etc.).
3. Pick a friend to make a pact with to avoid negative body talk. When you catch your friend talking negatively about their body, remind them of the pact.
4. Make a pledge to end complaints about your body, such as "I'm so flat chested" or "I hate my legs." When you catch yourself doing this, make a correction by saying something positive about that body part, such as, "I'm so glad my legs got me through soccer practice today."
5. The next time someone gives you a compliment, rather than objecting ("No, I'm so fat"), practice taking a deep breath and saying, "Thank you."
6. Make a pledge to look in the mirror and once a week, write down at least 15 positive qualities about yourself including physical, emotional, intellectual, and/or social qualities.

Can each of you choose one of these ideas or one of your own and do it sometime in the next week?

Consider this an "exit exercise" for today's program. Doing these kinds of things makes it more likely that you will talk about yourself in a more positive way. Think of which specific activity you can do. Would anyone like to share their plan?

(*If anyone shares, respond with "Great that sounds like a solid plan!")*

Once again, thank you for your participation in this group program. I've been very impressed with your thoughtful comments and participation and they are very much appreciated!