

Targeting Body Compassion in the Treatment of Body Dissatisfaction: A Case Study

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Abstract

Mindfulness and acceptance-based cognitive-behavioral therapies (MAB CBTs) are increasingly used in the treatment of body image disturbances. This case report describes an adjunct treatment component targeting body compassion in the course of an MAB CBT for an individual with body dissatisfaction. Body compassion is a new body-focused mindfulness and acceptance-based (MAB) construct that specifically describes the facets of the relationship individuals have with their bodies. The course of treatment included the originally planned MAB CBT protocol plus the additive component for five weekly 50-min individual sessions. During these sessions, body compassion was the primary treatment target. This phase of treatment utilized cognitive defusion, mindfulness, and self-compassion exercises. Over the course of this phase of treatment, the patient's body compassion and body image flexibility significantly improved. The patient's presenting symptoms also abated. Improvements were maintained at 1-, 3-, and 18-month follow-up time points. This case study illustrates several clinical strategies and provides initial support for body compassion as a viable treatment target for individuals struggling with body dissatisfaction.

Keywords

body compassion, body image, body dissatisfaction, mindfulness, acceptance

I Theoretical and Research Basis for Treatment

Having a negative body image has been implicated in numerous health domains, including an individual's reduction of positive health behaviors such as going to the doctor, exercising, and eating a well-balanced diet (Vartanian & Novak, 2011); and an increase in negative health outcomes and maladaptive health behaviors, including an increase in mood disorders (Jackson et al., 2014), increased risk of eating disorders (Masheb & Grilo, 2003; Stice, 2002), and poor interpersonal functioning (Cash, Theriault, & Annis, 2004). Of these, the most well-known and researched health outcome of negative body image is disordered eating behavior. Conversely, individuals with a positive/adaptive/resilient body image are more likely to engage in positive health behaviors and less likely to engage in negative health behaviors (Tylka, 2011).

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Body image is a broad construct that envelops the cognitions, emotions, and behaviors individuals have toward their body's appearance, competence, and health. The majority of contemporary research on body image is theoretically informed by a cognitive-behavioral model (Cash, 2008, 2011; Cash & Lavallee, 1997). In studies of global self-esteem, body satisfaction and appearance-related esteem are considered to be the major contributors to how individuals regard themselves as a whole (Tiggemann, 2011).

Cognitive-Behavioral Model of Body Image

Important concepts within the cognitive-behavioral model of body image include *body image evaluation*—evaluative beliefs and levels of satisfaction and dissatisfaction with one's own body, and *body image investment*—the importance of the body in self-evaluation in the cognitive, behavioral, and emotional realms (Cash, 2011). Body image evaluations are largely informed by discrepancies between individuals' internalized body-related ideals/values and their self-schemas and perceptions of their own body's characteristics (Cash, 2011; Cash & Szymanski, 1995). An individual's body image schema(s) reflects core beliefs regarding the importance of body and appearance in life and sense of self (Cash, 2011; Cash, Melnyk, & Hrabosky, 2004).

The cognitive-behavioral model demonstrates the following: Specific cues or events (internal or external) in a given context activate information processing of one's own body determined by the individual's schema. The context and/or cues can include a number of different events, such as seeing a reflection of oneself in a mirror, exercising in a fitness club, or experiencing sensations of pain/pleasure. Therefore, individuals with an appearance-schematic attend more closely to, and place more importance on, information related to their body (Cash, 2011). If an individual has problematic body-related schemas, the resulting internal dialogues may reflect cognitive distortions, engaging a feedback loop that reinforces the problematic schema, perceptions of self, and resulting behavioral challenges, such as eating disordered behavior or avoidance of contexts in which the body will be the focus (e.g., working out at the gym, swimming, or visiting the doctor). Previous case studies have successfully used a cognitive-behavioral foundation for treatment targeting residual body dissatisfaction following eating disorder treatment (Stewart & Williamson, 2003).

Self-Compassion

Self-compassion is framed as a positive self-attitude, counter to self-esteem and its associated tendencies toward self-centeredness and downward social comparison. Self-compassion has been defined as consisting of three components and their inverses: self-kindness (vs. self-judgment), common humanity (vs. isolation), and mindfulness (vs. overidentification; Neff, 2003b). Neff (2003b) has described self-compassion as

being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's own experience is part of the common human experience. (p. 224)

The idea of relationship to thought/emotion/experience is inherent in Buddhist psychology and contemporary aspects of mindfulness (Brach, 2003; Salzberg, 1997). This relationship is, in part, captured via the self-compassion scale, a valid 26-item measure with reliable scores that is significantly related with less depression and anxiety, and with greater life satisfaction (Neff, 2003a).

Self-compassion has been examined in assessment of body image-related disturbances, including intuitive eating (Schoenefeld & Webb, 2013), body image dissatisfaction, body shame (Ferreira, Pinto-Gouveia, & Duarte, 2013), body preoccupation, weight concerns, eating guilt

(Wasylikiw, MacKinnon, & MacLellan, 2012), and binge eating (Webb & Forman, 2013). The bulk of available data examining the influence of self-compassion in issues of body image are based on adolescent to college-aged women. Results have suggested body comparison and appearance contingent self-worth (body-related threats) are unrelated to body appreciation when self-compassion is very high (Homan & Tylka, 2015). Self-compassion has also been identified as a possible protective factor against poor mental health as it relates to self-objectification, with results suggesting that higher levels of self-compassion are associated with weaker connections between self-objectification and negative body and eating attitudes (Liss & Erchull, 2015).

Mindfulness and Acceptance-Based (MAB) Treatment of Body Image

Applying MAB concepts, such as self-compassion, to the treatment of body dissatisfaction requires a shift in view of the body from one of judgment and comparison with societally defined benchmarks, to one of openness and curiosity. For example, in an investigation of the use of self-compassion meditation training as an intervention to improve body satisfaction, participants in a 3-week self-compassion meditation training group reported significantly greater reductions in body dissatisfaction, body shame, and self-worth based on appearance than the waitlist control group; in addition to greater increase in levels of self-compassion and body appreciation as compared with the control group, and at 3-month follow-up, the improvements were maintained (Albertson, Neff, & Dill-Shackleford, 2014). Similarly, in a case series study of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012) targeting the behavioral outcome of emotional eating, the authors utilized experiential exercises to foster more adaptive ways of relating to negative internal experiences, including body dissatisfaction (Hill, Masuda, Moore, & Twohig, 2014).

Perhaps exploring an MAB approach toward maintaining a sense of openness to, and equilibrium with, one's bodily experience would be supportive of positive outcomes and is a worthwhile avenue of exploration in research and clinical applications. Although measures with a positive focus have recently emerged (Tylka & Wood-Barcalow, 2015), there are few body image-related measures directly reflecting the shift toward MAB approaches. There are some exceptions, including the recently developed Body Image–Acceptance and Action Questionnaire (BI-AAQ; Sandoz, Wilson, Merwin, & Kellum, 2013) and the Body Image Psychological Inflexibility Scale (BIPIS; Callaghan, Sandoz, Darrow, & Feeney, 2015). Both the BI-AAQ and BIPIS are consistent with the ACT model and focused on the desired outcome of higher levels of psychological flexibility, versus a more broad mindfulness-based focus within a cognitive-behavioral model.

Body Compassion

Due to its broad scope, self-compassion, and its assessment via Neff's (2003a) self-compassion scale, may not fully capture individuals' relationship to their body and body image-related events. There may be a distinct advantage in specifically approaching the relationship *with the body* with compassion. Body compassion, a new body-focused MAB construct, provides an opportunity for intervention and measurement of the relationship individuals have with their bodies. The aim of the initial development and validation of the construct of body compassion was to bridge body image and self-compassion. As MAB approaches to inquiry and intervention increase, appropriate and relevant MAB measures are needed to assess their efficacy. The Body Compassion Scale (BCS; Altman, Linfield, Salmon, & Beacham, 2017) was developed to provide a measure anchored in an MAB perspective, while still addressing the multidimensionality of body image. The initial development of the BCS utilized exploratory factor analysis to determine the factor structure of the BCS. A follow-up study validating the BCS employed confirmatory factor analysis. Three factors emerged: defusion, common humanity, and acceptance (Altman

et al., 2017). *Defusion* is a component of body compassion that is comparable with the notion of defusion put forth in ACT (Hayes et al., 2012). It refers to the ability to experience one's body from the stance of an observer, rather than as the body itself. An increase in defusion is associated with decreased attachment to body image evaluations as "truth," thereby loosening the grip these evaluations (positive or negative) have on one's global self-concept. An example item from the Defusion subscale of the BCS is "When my body fails at something important to me I become consumed by feelings of inadequacy." The *common humanity* component of body compassion is the same as that in self-compassion (Neff, 2003b), with a shift in emphasis from the global self to the physical self—the body. It is rooted in Buddhist thought and the idea that all human beings are interconnected (Barnard & Curry, 2011). It is the recognition of this interconnectedness and the shared human experience of navigating life through the physically tangible interface of the body that is reflected in the notion of body compassion; this recognition is infused with an ease of allowing for the myriad physical manifestations of the body, in self and others. An example item from the Common Humanity subscale of the BCS is "When I am at my lowest during times of physical symptoms, illness or injury, I know I am not alone in feeling this way." The *acceptance* component of body compassion is also similar to the description of acceptance by Hayes and colleagues (2012). Acceptance in body compassion is the intentional embrace of the appearance, state of health, and function of one's body exactly as it is in the present. An example item from the Acceptance subscale of the BCS is "I am accepting of my looks just the way they are."

Self-compassion and other MAB interventions share an important focus on shifting one's relationship to experience, rather than on shifting the experience. However, to date, none are directly addressing the tangible, physical experience of the body as the only element of self that is always in the present moment. The body is always experiencing what is happening *as it happens*, and is itself constantly shifting through stages of development, contributing to the dynamic interplay and exchange with life. This shift in focus away from the general self, to the very real experience grounded in the body, is an important avenue for exploration and development of future interventions. This is particularly so in the experience of body dissatisfaction—a common clinical concern, rooted in the body—which is associated with many clinical disorders and contributes to distress and impaired engagement with life even at subclinical levels. Body compassion presents a viable treatment target in mindfulness and acceptance-based cognitive-behavioral treatment (MAB CBT).

In the present case, body compassion was the treatment target during a brief additive five-session component. This additive component was designed to increase the client's body compassion through exercises targeting defusion, common humanity, and acceptance. This treatment plan involves the following: *functional analysis and hypotheses generation, body thoughts log, compassionate body scan, and a body compassion letter.*

2 Case Introduction

Isaac was a 40-year-old Filipino-American man self-referred to a university-based community psychological services clinic. The patient's identity has been disguised to maintain confidentiality. He first sought services at the clinic to support his efforts to lose weight after hitting a plateau in his progress. At his initial intake, he had a body mass index (BMI) of 37 (5'6", 229 lb; *Obesity Category*) and had lost 15 pounds in the previous month (244 lb, BMI = 39.4). Isaac was an engaged and committed client throughout the therapeutic process. The first 10 months of treatment aimed to reduce Isaac's distress regarding his weight loss efforts and to shift his focus toward valued-living through the use of MAB techniques. However, both the therapist and Isaac felt "stuck" in their work together and identified an important underlying issue of body dissatisfaction. The therapist, a colleague, and a supervisor with combined expertise in body image and MAB CBTs collaboratively designed a brief intervention targeting body compassion.

3 Presenting Complaints

Per Isaac's report, his pervasive concerns about his body, particularly his weight and appearance, were interfering with his ability to engage in meaningful interactions in all domains of his life. In particular, his body dissatisfaction was impacting his interactions at home with his wife and children, his performance at work, and his participation in meaningful activities he had previously enjoyed, such as singing at church and volunteering at his son's sporting events.

4 History

Isaac was married and had a teenage son and daughter. All family members lived together, and the children attended school full-time. Isaac reported his body dissatisfaction as interfering with his marriage as he felt less attractive and feared his wife would lose interest in him. He sought her approval for his weight loss and became discouraged when she did not seem to notice that he had lost weight.

Isaac was in overall good health. Although he had a family history of diabetes, he had no chronic illnesses, significant past injuries or conditions. Other than over the counter medication for seasonal allergies, he did not take any medications and denied any substance use. Isaac also reported being in psychotherapy once—specifically for management of symptoms related to attention deficit hyperactivity disorder (ADHD), with which he was diagnosed 12 years prior. After receiving the ADHD diagnosis, he took medication, but discontinued it after a brief trial due to unpleasant side effects. Upon interview, he reported that he still experienced symptoms of ADHD, but he felt able to manage symptoms without medication.

Isaac did not endorse any significant life events involving trauma. He did report that the death of his godmother 6 months prior to presenting at the clinic was difficult for him. After her death, he noted that he gained weight which interfered with his attempts to lose weight during that time period.

Isaac had a bachelor's degree in telecommunications and in college had the goals of working in the television/entertainment industry. He attended his first year of college in his hometown, before transferring to a university several states away his sophomore year for academic reasons. He reported his weight gain becoming an issue around his junior year of college, and he progressively put on more weight. Isaac did not report any specific impetus for the weight gain beyond poor diet patterns. Upon graduation, he found employment as a computer programmer, a profession he had remained in for a number of years. While he reported enjoying his job, he also found it boring and isolating at times as his boss worked remotely in another city. Isaac maintained his interest in a more creative occupation and on the side provided "voice-over works" in commercials and other similar opportunities.

Isaac was the only child of his parents, who were born in the Philippines. His parents were still alive and married. Isaac reported that his body dissatisfaction began in middle school, which extended from an awareness of his ethnic minority status. He recalled feeling different from his largely European American peers not only due to his darker skin color but also to his larger physical build. He described several specific instances in which he felt his body, both in size and color, differentiated him from his peers throughout his adolescent and teen years. Nevertheless, Isaac reported strong social support from his friends throughout this developmental time.

When Isaac began his career, his parents moved to the same city to be closer to him, which he describes as typical in Filipino culture. He reported valuing his family and would frequently visit his parent's house for family meals (at least once a week). Of note, Isaac stated the Filipino culture emphasizes always finishing the food on one's plate, and he described his extended family as having larger physical builds. He reported that he felt at ease with his body when in the presence of his family or while visiting extended family in the Philippines due to

their similar physical appearances. However, he struggled with having a physique he felt conflicted with the cultural messages of the preferred male body type of his Filipino family and that of American culture.

Isaac was involved in several community organizations. He held several roles in his church, including “director of worship.” He reported being a musician in his spare time, as well as the sports announcer for the middle and high school football games. Despite his social integration, he reported feeling “lonely” and disconnected from his social network.

He began an individualized personal training regimen about 2 months prior to seeking psychological services. Isaac worked with a personal trainer, who he often referred to in sessions and considered a key resource in his weight loss efforts. In addition, he reported altering his diet in several ways. Isaac created a low calorie diet consisting of vegetables, fruits, and proteins, and tried to refrain from snacking. His wife was supportive of the dietary change and helped keep balanced foods in the household. Early in treatment, one of Isaac’s main concerns was his snacking, particularly on potato chips. He recalled instances of eating excessive amounts of food within a 2-hr period, where he felt he could not control what and how much he was eating. He denied any compensatory behaviors such as vomiting. He was able to identify that these “binge snacking” behaviors tended to happen at work or at home before bedtime, typically as a consequence of feeling “bored” or “apathetic.” He reported feeling “shame” and “guilt” after snacking. Isaac did not meet criteria for any eating disorder.

5 Assessment

Specific assessment measures were selected to evaluate the effectiveness of a brief MAB CBT specifically targeting body compassion in the treatment of body dissatisfaction. Assessment measures in this case study were administered at five time points: pre (Time 1), post (Time 2), 1-month follow-up (Time 3), 3-month follow-up (Time 4), and 18-month follow-up (Time 5). Each measure is described below.

BCS

The BCS is a 23-item measure consisting of a total score and three subscales. These subscales include Defusion, Common Humanity, and Acceptance. Items are rated on a scale from 1 (“almost never”) to 5 (“almost always”) for statements such as “I am accepting of my looks just the way they are” and “I try to see my body’s failings as something everyone experiences in one way or another.” Internal consistency for subscale scores are as follows: Defusion = .92, Common Humanity = .91, and Acceptance = .87. The Cronbach’s alpha of .92 for all 23 item scores is excellent, supporting the use of a total score. Among the development sample which included both men and women, BCS $M = 72.88$, $SD = 16.46$ (Altman et al., 2017).

BI-AAQ

The BI-AAQ is a 12-item measure assessing an individual’s body image flexibility (Sandoz et al., 2013). It was developed from previously established psychological flexibility questionnaires (Bond et al., 2011) and adapted to assess body-related thoughts and feelings. Respondents are asked to rate how applicable each statement is on a 7-point Likert-type scale ranging from 1 (“never true”) to 7 (“always true”). The BI-AAQ produces a unidimensional score by reverse scoring and summing all items. Higher scores indicate a greater degree of body image flexibility. Overall internal consistency for BI-AAQ scores was a Cronbach’s $\alpha = .93$ and good test–retest reliability of .8. Among the development sample that included both men and women, BI-AAQ $M = 66.2$, $SD = 15.8$ (Sandoz et al., 2013).

Appearance Evaluation (AE) and Body Areas Satisfaction Scale (BASS)

The AE and BASS are subscales of the more extensive Multidimensional Body-Self Relations Questionnaire–Appearance Scales (MBSRQ-AS; Brown, Cash, & Mikulka, 1990). The MBSRQ-AS is a 34-item scale derived from the longer 69-item scale. It includes the following subscales: Appearance Evaluation, Appearance Orientation, Overweight Preoccupation, Self-Classified Weight, and the Body Areas Satisfaction Scale. The MBSRQ-AS is widely used in research as well as in clinical application. Although a total score may be derived, authors recommend that scores are summed within each subscale (Cash, 2000). Among men in the normative sample, internal consistencies on scale scores range from good (.79) to excellent (.89) (Brown et al., 1990). For purposes of this case study, we used only the body image evaluation indices of AE and BASS. Among men in the normative sample, AE mean score was 3.49 ($SD = 0.83$) and BASS mean score was 3.5 ($SD = 0.63$). Items on the AE include “I like the way my clothes fit me” and “I like my looks just the way they are.” The BASS items assess dissatisfaction–satisfaction with body areas and attributes such as “face (facial features, complexion)” and “mid-torso (waist, stomach).”

Social Physique Anxiety Scale (SPAS)

The SPAS is a 12-item measure of social anxiety related to the body’s form and structure (Hart, Leary, & Rejeski, 1989). Items are rated on a 5-point Likert-type scale from 1 (“not at all characteristic of me”) to 5 (“extremely characteristic of me”) for statements such as “Unattractive features of my physique or figure make me nervous in certain social settings” and “I am comfortable with how fit my body appears to others.” Among men in the development sample, SPAS $M = 30.1$, $SD = 8.49$ (Hart et al., 1989).

6 Case Conceptualization

Over the course of his first 10 months of treatment, Isaac developed an understanding of basic concepts of mindfulness, primarily focused on his eating behavior. During this time period, he was exposed to the practices of a guided eating meditation and urge surfing. Through these practices, he developed an increased awareness of how often he used food as a mechanism for regulating his distress; however, beyond increasing his awareness of some patterns of behavior, these practices and the attendant core processes of mindfulness and acceptance were not translating into his everyday life outside of therapy. Through these foundational sessions, it became apparent that Isaac’s distress ran deeper than his eating behaviors and plateau in weight loss. He had persistently negative body image evaluation and an increasing body image investment. His thoughts and internal dialogues about his body led to negative conclusions about his body’s appearance, fitness level, and health. Concurrently, it seemed no matter the investment of time, money, and energy put forth by Isaac in personal training, therapy, and nutrition focused on losing weight, he was not able to move past the weight loss plateau, and his mood and interpersonal relationships were suffering. He said,

I don’t like my physical appearance. When I think about my appearance or see myself in a mirror, I feel sad, frustrated, angry, regretful, and tired. I feel like giving up on the efforts needed to live a healthier lifestyle. The sadness, frustration, and anger are all related to the regret. I wish I would have treated myself better. I wish I looked the way I did a number of months ago. It feels like this never ends and that I’m always going to look like this. I feel like I cannot seem to win this battle with my weight and my appearance.

Furthermore, the thoughts and behaviors associated with his body dissatisfaction were continuously present throughout the day, impacted his confidence levels at work and home, and resulted in persistent checking behaviors when in view of his reflection in a mirror as well as

constant adjustments of his appearance (e.g., pulling his shirt away from his stomach and examining the results), and avoidance of contexts in which his body would be visible to others (e.g., wearing a t-shirt at his son's outdoors sporting events).

Isaac and his therapist identified body dissatisfaction as the underlying issue of much of his distress. He expressed interest in continuing from an MAB approach to address his body dissatisfaction. Viewing Isaac's case through the lens of body compassion, he was fused with his body and its appearance as defining him and was unable to view the body as a vehicle through which he was experiencing life and could engage in meaningful behaviors. The discrepancy between Isaac's internalized body-related ideals and his perceptions of his own body led to an increasing sense of isolation, cutting him off from an awareness of the common humanity inherent in living in a body. Isaac also lacked acceptance of his body as it was in the present, instead constantly striving to change his body via weight loss and viewing this as a vehicle to greater happiness and fulfillment in life. Given Isaac's experience of these three factors, body compassion was a pertinent and powerful treatment target for a brief MAB CBT addressing his body dissatisfaction.

7 Course of Treatment and Assessment of Progress

Treatment consisted of a five-session additive component of body compassion embedded within an ongoing therapeutic relationship. The therapist and client identified body dissatisfaction as the primary underlying issue and agreed to spend 5 weeks engaging in this targeted additive intervention. Following the 5-week additive treatment, therapy returned to a more general life focus continuing to weave in concepts and practices introduced during the body compassion additive sessions. The initial additive session was the 30th overall session for the therapist and client, and the fifth and final session of the additive component was the 34th overall session. Follow-up measures specific to the body compassion additive were completed at 1-, 3-, and 18-month post-additive sessions. The therapist was a clinical psychology doctoral student.

The additive component was designed to increase Isaac's body compassion through exercises targeting defusion, common humanity, and acceptance. See Table 1 for a session-by-session overview of emphases and activities. This treatment plan involved the following:

- Functional analysis and hypotheses generation—in session development of a hierarchy of when body dissatisfaction gets in the way of engaging in meaningful activities.
- Body thoughts log—designed to track experiences of body dissatisfaction in daily life, including context (time/event), thought, believability/fusion (0-100), emotion (0-100), behavior, and function (i.e., how is this serving me?).
- Compassionate body scan—a body scan intentionally infused with a compassionate stance toward the body (Pollak, Pedulla, & Siegel, 2014).
- Body compassion letter—an adaptation of the self-compassion letter (Neff, n.d.), with a particular emphasis on body-centered thoughts, feelings, and experiences. Introduced in session as a take home activity, reviewed in the following session.

Isaac continued with treatment for a total of 67 sessions. His remaining treatment focused on utilizing cognitive-behavioral and acceptance-based models for maintaining a more compassionate relationship with his body, increasing value-based activities, and managing stress related to work and family. Therapy continued to incorporate increasing self-awareness of cognitive/emotional/behavioral patterns contributing to body-specific distress, but expanded to address larger contexts of his functioning (i.e., work and home life). Isaac and the therapist also more deeply explored Isaac's unique cultural context and his experiences as an ethnic minority.

Strategies in the remaining months of therapy included continued body scan, relaxation practices, value clarification activities, cognitive defusion strategies, and behavioral activation with valued activities. In particular, therapy continued to include increasing awareness and defusion

Table 1. Body Compassion Treatment Session Activities and Client Quotes.

Session	Emphases	Activities	Quotes
1	<i>Defusion</i>	Overview of five-session focus on body compassion; functional analysis and hypotheses generation; introduction to body thoughts log	"A lot of it is because if I look good or know I look good, I do a lot better. I play piano a lot better, I sing a lot better."
2	<i>Defusion, Acceptance</i>	Review of body thoughts log from week; introduce body compassion letter; compassionate body scan	"I put so much emphasis on how I look and that's where the value is . . . I feel so shallow . . . so superficial. I wish I was less concerned about my appearance because there is so much more to me than that, but I can't seem to get past my own appearance . . . I have to ask myself, 'Why is this so important?' and it comes back to the fact that I look different from everyone else wherever I am, except for when I am in the Philippines . . . When I am with my family, I feel completely at ease . . ."
3	<i>Defusion, Acceptance, Common Humanity</i>	Review of body thoughts log from week; review body compassion letter; compassionate body scan	Example from log: He had walked into something in a doorway, "'I'm too big to fit through the hallway now because I ate Wendy's.' I rated this believability very low, although that is the column I still have the most trouble with. The thought came to my mind, and I was like 'that's stupid,' but I was still angry . . . I feel like the thought 'I'm too big,' I don't know how that served me. Probably some punishment to myself. Then 'that's stupid' was protective of myself. And the anger that followed was probably just frustration . . ." "The body scan was very helpful. It helped in the sense that it helped me relax and think about myself in a loving way."
4	<i>Defusion, Acceptance, Common Humanity</i>	Review of body thoughts log from week; compassionate body scan	Example from log: He couldn't wear a shirt that he wanted to because it didn't fit, "I got upset, but it didn't last long. I just picked out another shirt." "I've noticed parts of my body that need rest a lot more, and I've been able to notice my shoulders, like where it was injured before."
5	<i>Defusion, Acceptance, Common Humanity</i>	Review of additive body compassion treatment processes	"I don't want to be so concerned about that weight, that number that it consumes me. [He asked his personal trainer for blind weigh-ins.] So I haven't looked at the scale for a couple weeks . . . I really want to concentrate more on, um, I feel like because I feel like I was thinking so much about the number and all of the behavior was about the number, it wasn't fun anymore. I really enjoyed going to the gym and checking things off the list; I really liked going to the store and going to the natural foods section and finding fruits and vegetables I haven't eaten before or things that were healthier . . ."

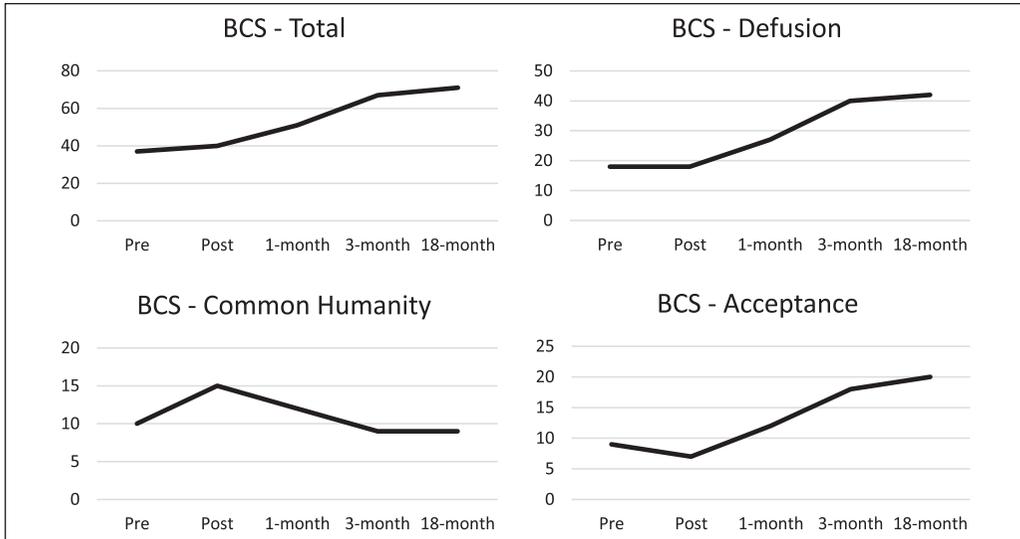


Figure 1. Body compassion total and subscale scores pre, post, 1-month, 3-month, and 18-month follow-ups.

Note. BCS = Body Compassion Scale.

from rigid thinking regarding his weight loss (i.e., number of pounds lost as a metric of psychotherapeutic gains), and expanding his awareness to other meaningful metrics for overall health and well-being. As such, Isaac grew to more deeply appreciate how his family life, meaningful work, and community engagement serve as stronger reflections of his psychotherapeutic progress than his weight loss.

Assessment of Progress

Isaac's BCS scores during all time points are depicted in Figure 1. Overall, his total body compassion and all body compassion subscale scores increased from baseline to 18-month follow-up with the exception of the Common Humanity subscale. Scores on all measures are listed in Table 2. Isaac's scores in body image flexibility (BI-AAQ), appearance evaluation (AE), body areas satisfaction (BASS), and social physique anxiety (SPAS) all improved from baseline to 1-month follow-up and beyond. His scores on the MAB measures (BCS and BI-AAQ) improved from baseline to posttreatment measurements, indicative of increases in Isaac's body compassion and body image flexibility. During the same time period, his scores on the cognitive measures either decreased (AE and BASS) or remained the same (SPAS), indicative of worsening appearance evaluation, body areas satisfaction, and consistent social physique anxiety. At 1-month follow-up, all scores were improved upon from baseline. This pattern of scores is consistent with expectations for an MAB CBT—Initially as body compassion and body image flexibility increase, through development of sustained awareness via MAB practices (body thoughts log, compassionate body scan, body compassion letter), distress may also increase, until the skill of acceptance is further developed, ultimately alleviating distress. While Isaac's score on the Defusion subscale of the BCS had remained the same from baseline to posttreatment, his score on the Acceptance subscale of the BCS had actually declined from baseline to posttreatment, offering further evidence of this process. Over the course of treatment beyond the intensive focus of the additive sessions, as Isaac continued to practice and further develop his MAB skills, particularly in defusion and acceptance, his improvement steadily increased across all measures from 1-month follow-up to the final 18-month follow-up measurement (see Table 2).

Table 2. Measure Scores at Baseline, Posttreatment, 1-Month, 3-Month, and 18-Month Follow-Ups.

Measures	Baseline	Posttreatment	1-month follow-up	3-month follow-up	18-month follow-up
BCS Defusion	18	18	27	40	42
BCS Common Humanity	10	15	12	9	9
BCS Acceptance	9	7	12	18	20
BCS Total	37	40	51	67	71
BI-AAQ	35	40	46	68	75
AE	1.71	1.57	2.29	3	3
BASS	3	2.33	3.33	3.67	3.78
SPAS	54	54	51	48	35

Note. BCS = Body Compassion Scale; BI-AAQ = Body Image–Acceptance and Action Questionnaire; AE = Appearance Evaluation; BASS = Body Areas Satisfaction Scale; SPAS = Social Physique Anxiety Scale.

8 Complicating Factors

No significant complicating factors were identified. Isaac was a high-functioning adult man with difficulties with his internal experience related to his body. Isaac did experience increases in stress as expected during demanding projects and deadlines at work and held himself to high standards in his performance in all domains. However, he was able to manage stress effectively, maintain a more compassionate view of his body, and engage in supportive health behaviors such as eating a well-balanced diet, exercising regularly, and meditating.

9 Access and Barriers to Care

There were no barriers to care in this case. Isaac had the financial resources to participate in weekly therapy with no additional burden. He also had the support of his family throughout treatment. The only potential barrier to full engagement in therapy was Isaac's full schedule of community, church, and family commitments; however, time did not present a barrier.

10 Follow-Up

Isaac completed all outcome measures at 1-month follow-up, and his scores indicated further improvement in every domain except the common humanity factor of body compassion (Table 2). A key clinical marker of these improvements was observed in Isaac's recognition of the joy he experienced through singing solos in church. Previously, his level of fusion with the appearance of his body on stage at the microphone stand had precluded his ability to recognize and enjoy the deep sense of joy, satisfaction, and value he received from participating in this activity. At 3-month follow-up, Isaac's scores again improved in every domain except the common humanity factor of body compassion (Table 2). At this time point, a key clinical marker of his improved scores was observed in Isaac's walking the track at his son's football practice in his form-fitting t-shirt, rather than his typical bulky sweatshirt. After having done this activity, he realized he had simply been in the moment, enjoying the sensation of the sun and breeze on his skin, rather than being consumed by thoughts/worries of negative evaluations of his body by the other parents, coaches, and kids. All measures were also completed at 18-month follow-up, and Isaac's scores again indicated that improvements were enhanced or maintained in every domain (Table 2). At the time of this measurement, it had been several months since Isaac's last therapy session and no clinical markers were collected with the completion of the measures.

I I Treatment Implications of the Case

Body compassion is a viable and helpful target in the treatment of body dissatisfaction. This is the first intervention study specifically targeting the three identified factors of body compassion: defusion, common humanity, and acceptance. Targeting body compassion as an additive component in an MAB CBT supported the modified use of existing techniques, such as self-compassion-oriented exercises (Neff, n.d.) shifted to focus on the body. By formatting these exercises to specifically address the body, it allowed this additive treatment to directly address the core component (body dissatisfaction) of Isaac's distress and difficulties in daily life. Body dissatisfaction is common among clients presenting for a variety of concerns. This case study suggests it may be helpful to specifically target body compassion as an additive component in addressing body dissatisfaction and supporting clients' process of decentering from defining the body as the self.

The downturn in Isaac's common humanity score in the three follow-up measures is particularly interesting. Unprompted, at the 1-month follow-up, he commented that the common humanity items did not seem relevant to him. Further investigation should be done to understand the mechanism at play in these results. There are a number of potential reasons for this score pattern—It may be an issue of gender, setting, contextual factors such as negative social interactions outside of therapy, or it may be that the wording of the common humanity items elicits/highlights the comparative element present in body dissatisfaction rather than engendering a sense of connectedness with others.

Several cultural considerations must also be taken into account for this case. First, the assessment measures used (BCS, BI-AAQ, AE, BASS, SPAS) have not been normed on Filipino-Americans. Filipinos have higher rates of depression when compared with other Asian cultures (Kuo, 1984); however, this may be an underrepresentation due to the tendency to deny, somatize, and endure emotional problems (Araneta, 1993). Also, there is a stigma surrounding mental illness in Filipino culture, which may lead to underreporting distress (Tsai, Teng, & Sue, 1981). The literature points to interesting trends in body image among Filipino and Filipino-American men. In one study, Filipino men reported higher levels of disordered eating, dieting, and body dissatisfaction than Caucasian men (Edman & Yates, 2005). Another study differentiated among Asian subgroups finding that Filipino men had the highest BMI of all male groups but followed a female pattern of strong body/self-dislike and preference for a smaller body (Yates, Edman, & Aruguete, 2004). Given the research, Isaac's body dissatisfaction is in line with cross-cultural findings and may be expected given his cultural heritage.

I2 Recommendations to Clinicians and Students

MAB treatments have been shown to be effective interventions for body image-related disturbances such as body dissatisfaction, eating-related difficulties, and weight-related concerns, among others (e.g., Albertson et al., 2014; Ferreira et al., 2013; Schoenefeld & Webb, 2013; Wasylikiw et al., 2012; Webb & Forman, 2013). The present case study contributes to the existing evidence base for MABs by providing preliminary support for body compassion as a potential treatment target. Body compassion and its three factors (defusion, common humanity, and acceptance) provided a supportive framework for directly addressing underlying issues of body dissatisfaction with a client initially presenting for support losing weight. Targeting body compassion could be particularly valuable to clinicians and students working with clients struggling with body image-related disturbances at clinical and subclinical levels. Further research is needed with larger samples to evaluate the potential efficacy of body compassion as a primary treatment target in MAB CBTs.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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