Accepted Manuscript

Title: Turning eating psychopathology risk factors into action: The pervasive effect of body image-related cognitive fusion

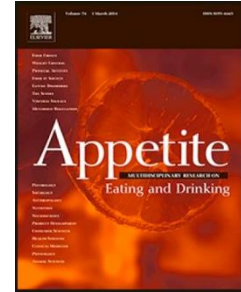Author: Cláudia Ferreira, Lara Palmeira, Inês A. Trindade

1 RUNNING HEAD: Cognitive fusion and eating psychopathology

2

3 **Turning eating psychopathology risk factors into action: The pervasive effect of**

4 **body image-related cognitive fusion**

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22 Highlights

23 ● The mediational role of body image-related cognitive fusion (CF_BI) is

24 explored.

25   •   Path analysis' results show the pervasive role of CF_BI on eating

26   psychopathology.

27   •   This integrative model explained 66% eating psychopathology severity.

28   •   CF_BI mediates the link of body and social rank issues with eating

29   psychopathology.

30   •   CF_BI should be targeted in the prevention and treatment of eating

31   disorders.

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34   Word count: 3643 (excluding references, abstract, figure and table)

35   **Abstract**

36   Body image dissatisfaction and unfavourable social comparisons are significant

37 risk factors to eating psychopathology. Nevertheless, the impact of these negative

38 experiences depends on the cognitive and emotional processes involved. Previous

39 research has shown that cognitive fusion is a nuclear process linked to psychological

40 inflexibility, but its role on body image and eating difficulties remains unclear. This

41 study aims to explore a model of the mediational role of body image-related cognitive

42 fusion (CF-BI) on the relationship between body dissatisfaction, unfavourable social

43 comparisons, and eating psychopathology in a sample of 345 female students.

44   Results from path analyses show that the impact of unfavourable social

45 comparisons on eating psychopathology is fully mediated by CF_BI. Moreover, CF-BI

46 also revealed a mediational effect on the relationship between body image

47 dissatisfaction and the severity of eating symptoms, in spite of the fact that a direct

48 effect of body dissatisfaction still exists.

49   The tested model highlights the crucial role that cognitive fusion, in the specific

50   domain of body image, plays in the relationship between risk factors and the severity of

51   disordered eating attitudes and behaviours. Furthermore, these findings present

52   empirical support for the relevance of addressing acceptance and cognitive defusion

53   techniques to prevent and treat eating disorders.

54

55   **Key-words**: body image-related cognitive fusion; eating psychopathology; social rank;

56   BMI; body image dissatisfaction

57

Introduction

Research has been highlighting the existence of multiple risk pathways in the development of eating psychopathology (Stice, 2001). Furthermore, body image dissatisfaction has been considered one of the key components of eating disorders (e.g., Stice, Marti, & Durant, 2011). More specifically, body image dissatisfaction can be due to the perception of a significant discrepancy between one's real body image and one's desired one, which in turn can precede eating disordered attitudes and behaviours, such as dieting (Higgins, 1987; Stice et al., 2011). Moreover, body image dissatisfaction has been associated with unfavourable social comparisons (Myers & Crowther, 2009; Trampe, Stapel, & Siero, 2007). In fact, unfavourable social comparisons (the tendency to perceive the self as inferior, inadequate and undesirable) appear to be associated with nuclear features of eating psychopathology, even when other variables are controlled for (Troop, Allan, Treasure, & Katzman, 2003).

The need to be accepted, valued and chosen by others is a universal and central aspect in humans, as well as other species (Gilbert, Price, & Allan, 1995). Related to this fundamental need is the process of social comparison, which can be conceptualized as an adaptive mechanism that allows the estimation of one's status within the group. When one realizes the main characteristics valued by the group, one can adapt behaviours or attributes and make efforts to improve those domains in order to raise his status and avoid being rejected. In fact, the display of features considered by the group as attractive and valued often defines one secure social rank (Barkow, 1980). Therefore, presenting qualities (e.g., forms of beauty; Gilbert, 2002) valued by the group will offer important social advantages (e.g., positive social attention, approval and favourable appreciation from others). On the other hand, the perception of lower attractiveness or low social rank may turn relationships with the self and with others insecure and

83   threatening, putting one at risk of being criticized or rejected (e.g., Gilbert, 1992). This

84   often leads to negative consequences such as shame and defensive responses like

85   anxiety and anger (Gilbert et al., 1995).

86   Furthermore, several studies argue that unfavourable social comparisons play a

87   crucial role on the development of different psychopathological conditions, including

88   eating disorders (e.g., Allan & Gilbert, 1995; Troop et al., 2003). Namely, it has been

89   suggested that negative social comparisons based on physical appearance have an

90   impact on body image dissatisfaction, and lead to an increased tendency to diet and seek

91   thinness in both adolescents and adults (Myers & Crowther, 2009; Pinto-Gouveia et al.,

92   2012).

93   In Western societies, having a valued physical appearance, has become a major

94   domain of one's social rank (Buote, Wilson, Strahan, Gazzola, & Papps, 2011; Ferreira,

95   Pinto-Gouveia, & Duarte, 2013b; Gilbert, 2002) and is used to gather positive social

96   attention (Ferreira, Pinto-Gouveia, & Duarte, 2013a; Gilbert, 2002; Troop et al., 2003).

97   In fact, a thin body image (similar to the ones portrayed by models or celebrities) has

98   been linked not only to feminine attractiveness, but also to positive attributes such as

99   health, success, intelligence and happiness (Kanazawa & Kovar, 2004; Sypeck et al.,

100   2006; Webster & Driskell, 1983).

101   To sum up, and although literature has been highlighting the role of body image

102   dissatisfaction and unfavourable social comparisons in the development and

103   maintenance of eating psychopathology, the mediational processes involved in this

104   relationship remain less than clear. In fact, even though the majority of women are

105   dissatisfied with their body image and show perceptions of unfavourable ranking,

106   especially when comparing themselves with ideal models of physical attractiveness,

107   only a minority develop an eating disorder. This seems to suggest that emotional

108   regulation processes may play a crucial role in these psychopathological conditions.

109   Growing evidence highlight that psychopathology is due not only to the presence of

110   undesirable internal experiences, but mainly to the cognitive and emotional processes

111   used to respond to them (Segal, Teasdale, & Williams, 2004).

112   In fact, Acceptance and Commitment Therapy (ACT) conceptualizes

113   psychopathology as a condition of psychological inflexibility intrinsically linked to

114   cognitive fusion, which arises when individuals become entangled with their private

115   events (e.g., thoughts, emotions; Hayes & Gifford, 1997). In this line, cognitive fusion

116   is defined as one's tendency to become caught up with the content of internal

117   experiences (Luoma & Hayes, 2003). Thus, when fused with their thoughts, individuals

118   tend to respond to them as if they were facts or represent the truth, triggering

119   experiential avoidance strategies (attempts to avoid, escape, modify or control the

120   experience) and turning these internal experiences more painful. For example, someone

121   entangled with their body dissatisfaction experiences (e.g., "I'm too fat") may refuse

122   social events like meeting with friends or going to the beach, even if these are

123   pleasurable and valued activities. Thereafter, one's life choices may become focused on

124   controlling these unwanted internal experiences, which may compromise other personal

125   or social goals (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

126   In conclusion, as it substantially increases one's experiential avoidance, cognitive

127   fusion has been portrayed as a key component of psychological inflexibility and as a

128   source and maintenance factor of harmful behaviours and emotional distress (Hayes,

129   2004; Hayes, Strosahl, Bunting, Twohig, & Wilson, 2004).

130   Recent theoretical and research findings consider that eating disorders can be

131   viewed as an illness of psychological inflexibility or failed attempts to regulate negative

132 sensations, thoughts and feelings (Baer, Fischer, & Huss, 2006; Merwin et al. 2011).

133 However, regarding body image and eating psychopathology issues, cognitive fusion is

134 a subject little explored. Even so, only a few studies have emphasized its relation to

135 such conditions (e.g. Merwin & Wilson, 2009; Ferreira, Trindade, Duarte, & Pinto-

136 Gouveia, 2013). Additionally, Hayes and Pankey (2002) found that patients with

137 anorexia nervosa entangle themselves frequently with thoughts about their body image.

138 Moreover, a recent study suggests that body image-related cognitive fusion plays an

139 important role on eating psychopathology (Trindade & Ferreira, 2014).

140 The current study aims to complement these recent findings through the

141 examination of a novel and integrative model for eating psychopathology. This model

142 intends to explore the impact of risk factors for eating disorders (e.g. body mass index

143 (BMI), body dissatisfaction and social rank) through body image-related cognitive

144 fusion. It is hypothesized that body image-related cognitive fusion plays a mediation

145 role on the relationship between nuclear risk factors and the severity of eating

146 psychopathology.

147

148 **Methods**

149 *Participants*

150 The research was conducted in a sample that aimed to represent the risk population for

151 eating psychopathology in relation to age and sex characteristics. The study included

152 345 female students aged between 13 and 36 ($M = 17.87$; $SD = 2.89$) years-old, and

153 with a mean of 11.43 ($SD = 2.47$) years of education. On average, participants had a

154 BMI of 21.15 ($SD = 2.79$).

155 *Measures*

156   *Demographic Data.* In the research protocol participants were asked about their

157   age, completed educational level, current height and weight (and with such information,

158   BMI (Wt/Ht^2) was calculated).

159   *Figure Rating Scale (FRS; Thompson & Altabe, 1991; Ferreira, 2003).* The FRS

160   was developed to assess body image dissatisfaction, and is comprised of a series of nine

161   schematic figures of different sizes arranged in an increasing manner, according to its

162   number (1-9). Participants are requested to select the silhouettes that best represent their

163   present and ideal body images; the divergence between the two silhouettes offers a

164   measure of body dissatisfaction (BD). The scale has shown good temporal, convergent

165   and divergent validities (Thompson & Altabe, 1991).

166   *Social Comparison Rating Scale (SCRS; Allan & Gilbert, 1995; Gato, 2003).* The

167   SCRS is a 11-item scale that measures the relative perception of one's social standing.

168   Items regard rank and attractiveness characteristics and are followed by a 10-point

169   Likert scale with bipolar constructs (e.g. Inferior/Superior). For each item, the

170   participants are asked to select a number which best portrays their social position in

171   relation to others. Lower scores indicate higher levels of unfavourable social

172   comparisons. The Cronbach's alphas of the scale were shown to range from .88 to .96 in

173   clinical populations, and between .90 and .91 in student populations (Allan & Gilbert,

174   1995). The Portuguese version presented similar reliability values.

175   *Social Comparison through Physical Appearance Scale (SCPAS; Ferreira et al.,*

176   *2013b).* The SCPAS is a self-report measure of one's subjective perception of social

177   position and group fit, based on physical appearance. Similarly to the SCRS,

178   participants are asked to assess their perceived rank on a Likert scale ranging from 1 to

179   10 with bipolar constructs (e.g. Inferior/Superior). The scale is comprised of two parts,

180   in which participants are asked to compare themselves physically to peers (part A) and

181   models (part B). In this study only part B was used since we intended to assess

182   participants' physical comparisons related to distal targets, namely models, actresses

183   and celebrities. Lower scores characterize gradually higher levels of unfavourable social

184   comparisons based on physical appearance. The SCPAS' part B presented good internal

185   reliability in the original study (.96).

186   *Cognitive Fusion Questionnaire: Body Image (CFQ-BI; Ferreira et al., 2013).*

187   The CFQ-BI is a 15-item self-report scale that measures body image-related cognitive

188   fusion. It was created by adapting CFQ-28's items (Gillanders et al., 2010) into

189   statements concerning only body image issues (e.g., the item "My thoughts cause me

190   distress or emotional pain" on CFQ-28 was adapted as "My thoughts relating to my

191   body image cause me distress or emotional pain." in CFQ-BI). CFQ-BI presents a

192   unidimensional factor structure as the CFQ reduced version which comprises 7 items

193   (Gillanders et al., 2014). The participants are instructed to choose a number on a 7-point

194   Likert scale which best translates the truthfulness of each statement according to

195   themselves. Higher scores indicate higher levels of body image-related cognitive fusion.

196   In the original study, the CFQ-BI presented a Cronbach's alpha of .96 and good

197   temporal, discriminant, convergent and divergent validities (Ferreira et al., 2013).

198   *Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994;*

199   *Machado, 2007).* A variation of the Eating Disorder Examination interview, the EDE-Q

200   is a self-report measure which evaluates the participant's attitudes and behavioural

201   characteristics of eating psychopathology. It comprises four subscales: restraint, eating

202   concern, shape concern and weight concern. The global score of EDE-Q represents the

203   severity of eating psychopathology. The EDE-Q can be used to discriminate eating

204   disorder cases and additionally has been shown to have good reliability (Fairburn,

205   2008).

206   All of the Portuguese versions of the used measures were previously validated in

207   samples with similar characteristics than the ones used in this study. The study

208   variables' Cronbach's alphas are presented in Table 1.

209

210   *Procedures*

211   The research protocol and the sample's collection process were approved by the

212   ethical committees of the educational institutions enrolled in the present study.

213   Participants were students recruited from several middle and high schools, and also

214   from the University of Coimbra. They were appropriately informed about the voluntary

215   and confidential nature of their collaboration, as well as of its finality. A written consent

216   signed by the participant and his or her guardian (in underage cases) was required in

217   order to collaborate in the investigation. Participants completed the self-reported

218   measures during class (approximately 30 minutes), in the presence of their teacher and

219   one of the researchers, who provided further explanations when required, to assure

220   correct completion of the questionnaires. Those who did not participate in the study

221   were given a task by their teacher or professor.

222

223   *Data analysis*

224   Data analyses were performed using IBM SPSS Statistics 20 (IBM Corp, 2011)

225   and Path analyses were examined using the software AMOS.

226   *Pearson correlation coefficients* were performed to explore the association

227   between: BMI, general social comparison, social comparison through physical

228   appearance models, body dissatisfaction and the severity of eating disorders

229   symptomatology (Cohen, Cohen, West, & Aiken, 2003).

230   *Preliminary   data   analyses*   were   executed   to   examine   the

231   adequacy of the data.

232   *Path analyses* (MacKinnon, 2008), a structural equation modeling (SEM), was

233   conducted to estimate the presumed relations among variables in the proposed

234   theoretical model (Figure 1). Path analysis is a well-known and appropriate statistical

235   methodology that allows for the simultaneous examination of structural relationships

236   and permits the examination of direct and indirect paths at the same time (e.g.,

237   Schumacker & Lomax, 2004). The Maximum Likelihood method was used to estimate

238   all model path coefficients and to compute fit statistics. Several goodness-of-fit

239   measures were used to assess the plausibility of the overall model, such as Chi-Square

240   ($\chi 2$), Normed Chi-Square ($\chi 2$/d.f.), Tucker Lewis Index (TLI), Comparative Fit Index

241   (CFI), and the Root-Mean Square Error of Approximation (RMSEA) with 95%

242   confidence interval.

243   To test mediation effects, the bootstrap procedure was used (with 2000

244   resamples) to create 95% bias-corrected confidence intervals around the standardized

245   estimates of total, direct and indirect effects. This method is considered one of the most

246   reliable and powerful to test the significance of the direct, indirect and total effects

247   (Maroco, 2010). The effect is considered statistically significant ($p < .05$) if zero is not

248   included on the interval between the lower and the upper bound of the 95% bias-

249   corrected confidence interval (Kline, 2005).

250

251   **Results**

252   *Descriptives*

253   Means and standard deviations for the study variables are presented in Table 1.

254   ----------------------------------- Insert Table 1 around here --

255   *Correlations*

256   Pearson's correlation coefficients (two-tailed) are presented in Table 1. Results

257   showed that BMI was significantly correlated with all variables in study, with exception

258   to the SCRS. Additionally, unfavourable social comparisons (assessed by the SCRS and

259   SCPAS_models) were associated with higher levels of BD and with eating

260   psychopathology (EDE-Q). Moreover, BD was strongly associated with the global

261   indicator of eating psychopathology. Finally, the CFQ_BI revealed moderate positive

262   associations with BMI, BD, high positive correlations with EDE-Q's global scores and

263   negative correlations with the social comparison measures (SCRS and SCPAS_models).

264

265   *Path analysis*

266   Firstly, data was analysed for multivariate outliers using Mahalanobis distance

267   statistic. In fact, some cases presented values that indicate the presence of outliers,

268   although extreme values were not detected. It was decided to maintain the outliers,

269   because we believed they represent the normal variability in the population. Indeed, it

270   has been suggested that, in these cases, data are more likely to be representative of the

271   population if outliers are not removed. Furthermore, Skewness and kurtosis values did

272   not show a serious bias to normal distribution (SK < |3| and Ku < |8-10|; Kline, 2005)

273   and multicollinearity was not identified as all variables presented VIF values < 5.

274   The aim of path analysis was to test whether body image-related cognitive

275   fusion mediated the effects of BMI, body dissatisfaction and the perception of an

276   unfavourable social rank on eating psychopathology severity.

277   Initially, the hypothesized model was tested through a fully saturated model (i.e.,

278   zero degrees of freedom), consisting of 27 parameters. Given that fully saturated models

279   always produce a perfect fit to the data, model fit indices were neither examined nor

280   reported.

281   The initial model explained 67% of eating psychopathology. In this model, four

282   path coefficients were not statistically significant: the direct effect of BMI → CFQ_BI

283   (t statistics = .110; p = .912), SCRS → EDE-Q (t statistics = .651; p = .515),

284   SCPAS_models → EDE-Q (t statistics = -1.589; p = .112), BMI → SCRS (t statistics =

285   -1.624; p = .104).

286   In the next step, the initial model was respecified with those four nonsignificant

287   individual paths being progressively removed. Then, the reduced model was tested

288   (Figure 1). The evaluation of the final adjusted model revealed an excellent model fit,

289   with a non-significant chi-square of $\chi^2(4, N = 345) = 5.294$, p = .258. Besides, the

290   analysis of well-known and recommended goodness of fit indices (Kline, 2005)

291   indicated a very good model fit (χ^2/d.f. = 1.323; CFI = .999; TLI = .995; RMSEA =

292   .031, CI = .000; .092).

293   --------------------------------- Insert Figure 1 around here --

294   *Mediation Analysis*

295   From the examination of the unstandardized solution, it was verified that all

296   individual path coefficients of the final model were statistically significant and in the

297   expected directions. Concerning the analysis of total, direct and indirect effects, a

298   positive and statistically significant direct effect (albeit weak) was found between BMI

299   and the global score of the EDE-Q (β = .086) based on the bootstrap 95% CI (.007;

300   .158, p = .028). Additionally, in relation to the mediation analysis, an indirect effect of

301   general social comparison (SCRS) on the EDE-Q was found. More specifically, this

302 indirect effect through the CFQ_BI was negative (β = -.113) based on 95% CI (-.186; -

303 .039, *p* = .003). Moreover, another indirect effect was found between social

304 comparisons based on physical appearance and the EDE-Q. This effect through the

305 CFQ_BI was also negative (β = -.197) based on 95% CI (-.284; -.119, *p* = .001).

306 Concerning BD, both direct and indirect effects on the EDE-Q were found. The

307 indirect effect through the CFQ_BI was positive (β = .159) based on 95% CI (.106;

308 .217, *p* = .001). Also, the direct effect between BD and the EDE-Q was positive (β =

309 .268) based on 95% CI (.187; .343, *p* = .001). The total effect, that represents the sum of

310 the standardized direct effect with the standardized indirect effect was .427 based on

311 95% CI (.337; .510, *p* = .001).

312 Overall, the model accounted for 33% of body image-related cognition fusion

313 and for 66% of eating psychopathology severity.

314

315 **Discussion**

316 This study presents a novel model that aims to explain eating psychopathology in

317 a sample of female students. Comprising the well-known risk factors for eating

318 disorders, this model starts to clarify the pervasive effect of cognitive fusion as a key

319 process to explain the link between perceived body image flaws, low social rank and the

320 severity of eating psychopathological symptoms.

321 The tested model explained 66% of the variance of eating psychopathology, and

322 allowed us to confirm that body image-related cognitive fusion is a crucial emotional

323 regulation process to understand the development of maladaptive attitudes and

324 behaviours regarding one's body and eating patterns.

325 Consistent with previous research, in the present study, body dissatisfaction, BMI

326 and rank variables were associated with disordered eating attitudes and behaviours. In

327   fact, these results support the existing literature that suggests that body image

328   dissatisfaction and perceptions of low rank among women are intrinsically related to

329   body and eating difficulties (Pinto-Gouveia et al., 2012; Stice et al., 2011).

330   Additionally, our findings revealed that a higher BMI is directly linked to unfavourable

331   social comparisons based on physical appearance and to body dissatisfaction.

332   Furthermore, BMI also showed a positive (albeit weak) impact on the EDE-Q's global

333   score. These results may be explained by the common association between weight, body

334   shape, attractiveness and self-worth (Kanazawa & Kovar, 2004; Webster & Driskell,

335   1983). Thus, women with higher BMI that perceive their body image as significantly

336   discrepant from the valued one may present higher tendencies to engage in inflexible

337   weight control strategies in order to attenuate their perceptions of inadequacy.

338   Overall, these findings can be explained by the existent pressure in Western

339   societies to accomplish an extremely thin body shape, which has become a central

340   domain to achieve a secure social status within the group (e.g., Ferreira et al., 2013b).

341   Indeed, the attempts to control one's body image in order to obtain an attractive one

342   (e.g., similar to the models) seem to emerge as a strategy to improve women's social

343   rank and as a way to assure being valued and accepted by others (e.g., Pinto-Gouveia et

344   al., 2012).

345   Nevertheless, although the majority of women engage in comparisons with ideal

346   models of physical attractiveness and present normative body image dissatisfaction and

347   perceptions of unfavourable social rank, these features do not necessarily lead to eating

348   psychopathology. In fact, our results highlight the crucial role of body image-related

349   cognitive fusion as a mediational process involved in these relationships. More

350   specifically, in our model, the association between unfavourable social comparisons

351   (global and based on the physical appearance domain) and higher scores on the global

352   index of eating psychopathology is fully mediated by higher levels of body image-

353   related cognitive fusion. It seems that it is only when women become caught up with

354   their body image perceptions and thoughts that unfavourable social comparisons impact

355   on disordered eating attitudes and behaviours.

356   Furthermore, in line with previous research (e.g., Stice et al., 2011) body

357   dissatisfaction predicted higher severity of eating psychopathology symptoms.

358   Additionally, our model adds to the existent literature by revealing a mediational effect

359   through body image-related cognitive fusion. Taken together, these results offer new

360   insights by suggesting that eating disorder´ symptoms may emerge when one tends to

361   respond to one's body dissatisfaction and unfavourable social comparisons' contents as

362   if they were facts or represent the truth. This suggests that being entangled with one's

363   body image thoughts and emotions may result in behaviours excessively and improperly

364   regulated by verbal processes, instead of making them correspond to contextual cues or

365   personal goals. Consequently, experiential avoidance strategies may be activated

366   turning unwanted internal events more painful.

367   Nevertheless, these novel findings underlie some limitations. Firstly, the use of a

368   cross-sectional design precludes conclusions regarding causality. In this sense,

369   longitudinal studies are needed to determine the directionality of the associations and to

370   corroborate the mediational role of body image-related cognitive fusion in the

371   relationships between social rank, body dissatisfaction and increased vulnerability to

372   eating disorders. Secondly, the convenience nature of the research sample, female

373   students, can compromise the generalization of the data. However, the age and sex

374   characteristics of our sample match the risk population's features. Thirdly, this model

375   can be considered limited due to the fact that eating disorders are multidetermined and

376   that other emotional regulation process may be involved. However, we intentionally

377 restrained this model in order to specifically explore the role of body image-related

378 cognitive fusion.

379 These results are of particular interest and offer an important contribution to

380 clinical work, by suggesting that increased levels of eating psychopathology may arise

381 when one gets entangled with one's perceived body image flaws and unfavourable

382 comparisons with others. In conclusion, this study contributes to fill the dearth of

383 literature regarding the role of cognitive fusion in eating psychopathology, proposing

384 that this emotional process is a key component for the comprehension of disordered

385 eating, and should be clearly targeted in programs of prevention and treatment of eating

386 disorders.

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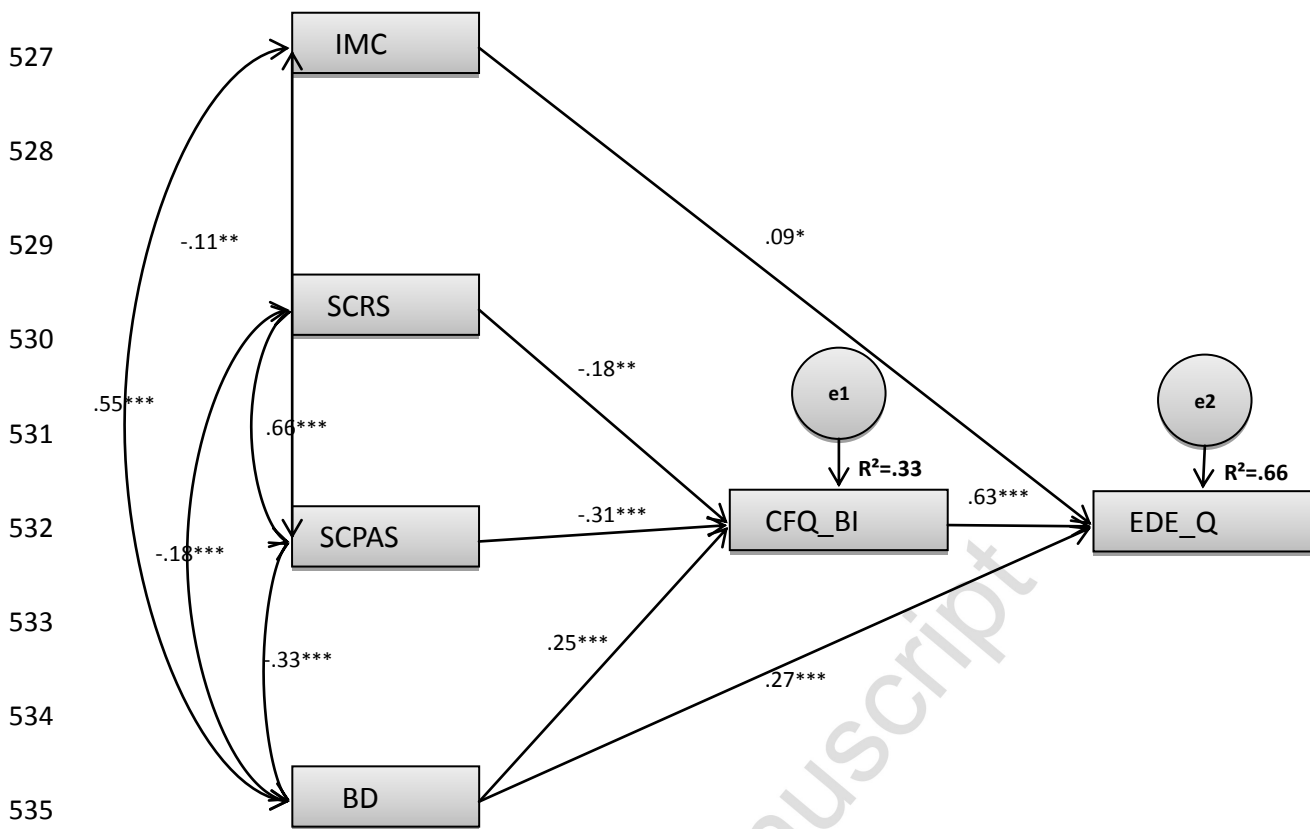
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525

Table 1

Means (M), Standard Deviations (SD), Cronbach's alphas and Intercorrelation scores on self-report measures (N = 345)

Measures	*M*	*SD*	α	BMI	SCRS	SCPAS_models	BD	CFQ_BI
BMI	21.15	2.79	-	-				
SCRS	65.31	13.69	.89	-.09	-			
SCPAS_models	55.36	18.02	.96	-.17**	.67***	-		
BD	.56	.93	-	.57***	-.23***	-.36***	-	
CFQ_BI	36.29	20.94	.97	.21***	-.44***	-.52***	.40***	-
EDE-Q	1.44	1.30	.96	.37***	-.36***	-.48***	.57***	.76***

Note. * $p <.050$. ** $p <.010$. *** $p <.001$. BMI = Body Mass Index; SCRS = Social Comparison Rating Scale; SCPAS_models = Social Comparison trough Physical Appearance Scale_Models; BD = Body Dissatisfaction; CFQ_BI = Cognitive Fusion Questionnaire_ Body Image; EDE-Q = Eating Disorder Examination Questionnaire.

526

527

528

529   -.11**

530

531   .55***

532   -.18****

533

534

535

SCRS

.66***

SCPAS   -.31***

-.33***

BD

IMC   .09*

e1   R²=.33

CFQ_BI   .63***   e2   R²=.66

-.18**

.25***   EDE_Q

.27***

536   Figure_1. Final Path Model

537   *Note*. Standardized path coefficients among variables are presented. All path coefficients are

538   significant at the .05 level.

539   [*]*p* < .05; [**]*p* < .01; [***]*p* < .001; BMI = Body Mass Index; SCRS = Social Comparison Rating

540   Scale; SCPAS_models = Social Comparison through Physical Appearance Scale_Models; BD =

541   Body Dissatisfaction; CFQ_BI = Cognitive Fusion Questionnaire_ Body Image; EDE-Q =

542   Eating Disorder Examination Questionnaire.