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# ASSESSMENT OF BODY IMAGE IN EATING DISORDERS WITH THE BODY DYSMORPHIC DISORDER EXAMINATION

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**Summary**—The Body Dysmorphic Disorder Examination (BDDE) has several advantages for the assessment of body image in eating disorder patients. It measures distressing self-consciousness, preoccupation with appearance, overvalued ideas about the importance of appearance to one's self-worth, and body image avoidance and checking behaviors. The BDDE is relevant for any type of appearance complaint and is not limited to weight or body shape concerns. The BDDE measures the useful targets for body image therapy. In a sample of eating disorder patients, the Body Dysmorphic Disorder Exam had good internal consistency and was significantly correlated with other measures of body image. It added new information to the discrimination of women with eating disorders from clinical and nonclinical controls beyond that provided by other measures of body image.

A thorough and careful assessment of body image disorder symptoms in eating disorder patients is an important, but neglected concern in clinical practice. We were surprised to discover, for example, that body image was measured in only one-third of all controlled studies of medication or psychological therapies for bulimia nervosa.† Besides recommending that body image be measured more consistently, we also believe an assessment technique is needed that is more clinically suitable for the extreme body image disorder of anorexia and bulimia nervosa patients. The purpose of this paper is to present the Body Dysmorphic Disorder Examination, a new body image measure that was designed to fill this gap.

The rationale for assessing body image in eating disorders is the following. Eating disorders are not simply disorders of eating, but according to the diagnostic criteria (American Psychiatric Association, 1993) anorexia and bulimia nervosa are defined also by the co-existence of excessive concerns about physical appearance and body dissatisfaction. This sets apart anorexia and bulimia nervosa from other conditions that might involve some disturbance of eating. Moreover, in empirical studies of patients' symptoms, the best model for eating disorder pathology is a multidimensional one that includes extreme body dissatisfaction in combination with maladaptive eating and weight control and other psychopathology (Gleaves, Williamson & Barker, 1993).

Starvation, binge-eating, vomiting, and purging are usually the most distressing and urgent problems in bulimia and anorexia nervosa. However, we believe that body image disorder is the essential pathology because it is so important in the etiology and recovery from eating disorders. Regarding etiology, to date there are four longitudinal risk studies of eating disorder symptoms that measured body image along with other predictor variables such as psychopathology, stress, body weight, and puberty (Attie & Brooks-Gunn, 1989; Cattarin & Thompson, 1993; Garner, Garfinkel, Rockert & Olmsted, 1987; Striegel-Moore, Silberstein, Frensch & Rodin, 1989). All these studies found that body image at baseline was the best predictor of changes in eating disorder symptoms over time. Regarding recovery, body image seems to be the most consistent predictor of improvement and relapse after therapy in anorexia and bulimia nervosa (Fairburn, Peveler, Jones, Hope & Doll, 1993; Rosen, 1990). Furthermore, in a treatment study of bulimia nervosa by Fairburn and associates (Fairburn, Jones, Peveler, Hope & O'Connor, 1993), a program focused on modifying eating and vomiting only was dramatically inferior compared with a one that also

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†Ten out of the 31 controlled studies cited in a recent review by Leitenberg (1993) included a measure of body image.

targeted body image attitudes. In conclusion, given its importance in the pathology, etiology, and treatment of eating disorders, body image assessment should be part of patient evaluation.

Body image assessment techniques can be categorized as measures of perceptual, cognitive, or behavioral features (Rosen, 1990). For the purpose of this investigation we were interested in the latter two or the assessment of body image attitudes and the impact of these on behavior. Presently, the most commonly used measures are the Body Dissatisfaction scale of the Eating Disorder Inventory (Garner & Olmsted, 1984; Garner, 1991), Body Shape Questionnaire (Cooper, Taylor, Cooper & Fairburn, 1987), Multidimensional Body-Self Relations Questionnaire (Brown, Cash & Mikulka, 1990), and the discrepancy score between current and ideal body figure drawings (e.g. Williamson, Davis, Bennett, Gorenczny & Gleaves, 1989). In addition to these questionnaires, the Eating Disorder Examination (Cooper & Fairburn, 1987), a clinical interview, also taps into body image. Although useful and psychometrically sound, all these measures have one or more of the following limitations for eating disorder patients:

(a) The body image attitudes assessed are only superficial complaints of body dissatisfaction (e.g. "I feel satisfied with the shape of my body"). Body dissatisfaction is common today and even a high level does not distinguish eating disorder patients from other weight-preoccupied, but nonclinical populations (Garner, Olmsted & Garfinkel, 1983; Wilson & Smith, 1989). Body image attitudes need to be assessed in more depth.

(b) Body image behavior is not assessed, especially repetitive checking behavior and avoidance of situations that provoke self-conscious about appearance. These symptoms are important because they help maintain negative body image attitudes and can be disabling (Rosen, 1992).

(c) Assessing only weight or shape concerns presents a number of problems. First, eating disorder patients can have concerns about other aspects of physical appearance that might be even more involved in their negative body images than weight (e.g. complaints about height or facial features). Second, body image measures focused on weight issues are appropriate for women with eating disorders or similar body image complaints, but inappropriate for men or other clinical populations, e.g. many cosmetic surgery patients. Third, measures focused on weight or any other specific body characteristics do not tap into the more basic problem of preoccupation with physical appearance in general.

(d) Although norms are available, there is no objective criterion for a pathologic degree of body image symptoms. In addition, the existing questionnaires are not directly comparable to the diagnostic criteria in the DSM that refer to body image symptoms in anorexia and bulimia nervosa.

The new measure we developed, the Body Dysmorphic Disorder Examination (BDDE) (Rosen & Reiter, 1993), is named after the DSM diagnostic category, body dysmorphic disorder which refers to an excessive preoccupation with an imagined or slight defect in physical appearance. Items for the Body Dysmorphic Disorder Examination were constructed deductively according to a review of body image symptoms reported in body dysmorphic disorder case studies and the eating disorder literature. The two types of disorders, body dysmorphic and eating disorders are very similar in their phenomenology and development (Rosen, 1992). The resulting measure has a number of advantages compared to other measures of body image:

(a) In addition to body dissatisfaction, the Body Dysmorphic Disorder Examination measures distressing self-consciousness and preoccupation with appearance and overvalued ideas about the importance of appearance to one's self-worth.

(b) The Body Dysmorphic Disorder Examination assesses the frequency of various impairing or self-defeating body image behaviors, such as avoiding social or public situations due to feelings of self-consciousness about appearance, disguising or covering-up the perceived appearance defect with clothing, checking the defect in the mirror, and asking other people for reassurance.

(c) The Body Dysmorphic Disorder Examination does not assume a type of appearance complaint, but asks the respondent to specify the aspects of his or her appearance that are distressing at the present time. Also included are questions about appearance in general without regard to a specific defect. Thus, in addition to being appropriate for women with eating disorders, the BDDE is appropriate for men and for various clinical populations in which body image complaints are common such as body dysmorphic disorder, cosmetic and reconstructive surgery, dentistry, dermatology, social phobia, physical disability, obesity, and physical or sexual abuse.