



Brief research report

Body image in patients with body dysmorphic disorder: Evaluations of and investment in appearance, health/illness, and fitness

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ABSTRACT

Body image is an important aspect of body dysmorphic disorder (BDD) which has received little investigation. Ninety-two BDD participants who participated in one of three BDD pharmacotherapy studies completed the Multidimensional Body-Self Relations Questionnaire, which assesses attitudinal body image, specifically evaluations of and investment in appearance, health/illness, and physical fitness. Scores were compared to population norms. Compared to norms, BDD participants were significantly less satisfied with their appearance. Less satisfaction was associated with more severe BDD and greater delusionality. Men with BDD were significantly more invested in their appearance compared to male population norms. Compared to population norms, males and females with BDD felt less physically healthy and females were less invested in a healthy lifestyle. However, compared with population females, females with BDD were less alert to being ill. These findings suggest that patients with BDD differ from population norms in a number of important aspects of body image.

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Introduction

Body dysmorphic disorder (BDD) is characterized by a distressing or impairing preoccupation with an imagined or slight defect in appearance that causes clinically significant distress or functional impairment. BDD appears relatively common and is associated with high rates of morbidity (Phillips, 2005). Although body image dissatisfaction is considered by some to be a core feature of BDD (Cororve & Gleaves, 2001; Rosen & Rameriz, 1998), this topic has received little investigation.

Body image is conceived as one's attitudinal dispositions toward the physical self (Cash & Pruzinsky, 2002). Body image is multidimensional and encompasses perceptions, thoughts, feelings, and behaviors not only about physical appearance but also one's body's competence, or "fitness," and its biological integrity, or "health/illness" (Cash, 2000). This topic has received much attention among students (Miller et al., 2000) and cosmetic surgery patients (Sarwer et al., 2003). However, this important construct has received only scant empirical attention in individuals with BDD.

One study that compared 51 individuals with BDD to 45 individuals with an eating disorder found comparable levels of body image dissatisfaction on the Body Dysmorphic Disorder Examination (BDDE) (Rosen & Rameriz, 1998). A more recent study

(Hrabosky et al., 2009) that compared multiple facets of body image among BDD patients and eating disorder patients found that the BDD group reported greater overall body dissatisfaction than clinical controls and was comparable to the eating disorder groups. In addition, participants with BDD reported greater self-evaluative investment in and more appearance-managing investment than those with anorexia nervosa. Participants with BDD also reported greater overall body image disturbance and a more negative impact of body image on quality of life than participants with anorexia or bulimia nervosa.

Choi, Pope, and Olivardia (2002) examined attitudinal aspects of body image using the Multidimensional Body-Self Relations Questionnaire (MBSRQ; Brown, Cash, & Mikulka, 1990; Cash, 2000) in 24 male weightlifters with muscle dysmorphia, a form of BDD that consists of preoccupation with leanness and muscularity. Participants with muscle dysmorphia reported poorer body image and greater appearance dissatisfaction than males without muscle dysmorphia. One BDD study ($n = 200$) examined gender similarities and differences in body image, finding that women had greater body image disturbance than men on the BDDE (Phillips, Menard, & Fay, 2006).

Important yet overlooked dimensions of body image are the body's competence, or "fitness," and its biological integrity, or "health/illness" (Brown et al., 1990; Cash, 2000). While data are limited, BDD patients appear to have poorer perception of their physical well-being compared to community norms. Sixty-two individuals who were seeking consultation or treatment in a BDD specialty research and clinical program (Phillips, 2000) had lower

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scores than U.S. population norms on the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36; Ware, 1993) subscales that assessed physical health status and physical-health related quality of life. However, those with BDD had somewhat better scores than outpatients with type II diabetes, a recent myocardial infarction, or clinical depression (Phillips, 2000). Comparable results were found among 176 individuals with BDD, one-third of whom were not receiving mental health treatment and two-thirds of whom were receiving treatment (primarily in the community) (Phillips, Menard, Fay, & Pagano, 2005). To our knowledge, no prior study has examined self-evaluations of fitness among individuals with BDD.

This report used a reliable and valid measure of body image (MBSRQ) to assess attitudinal aspects of body image—specifically, evaluations of and investment in physical appearance, health/illness, and fitness in male and female BDD patients compared to a normative sample. To our knowledge, this is the first study to examine body image using a broad definition that includes evaluations of appearance, health/illness, and fitness in BDD. We hypothesized that, compared to population norms, BDD patients would be less satisfied with and more invested in their appearance. We also hypothesized that patients with more severe BDD and less insight (i.e., greater delusional) regarding their appearance would be less satisfied with how they look. We additionally hypothesized that BDD patients would report poorer evaluations of their physical health than those reported in population norms. We were particularly interested in BDD patients' evaluations of their health/illness, given that BDD is classified as a somatoform disorder in DSM-IV, and little is known about this important aspect of BDD.

Method

Participants

The study included 92 adult outpatients with current BDD who participated in a BDD pharmacotherapy study: 66 in a placebo-controlled fluoxetine trial, 22 in open-label trials, and 4 in a fluoxetine augmentation study. Inclusion and exclusion criteria that are standard for pharmacotherapy studies were used (Phillips, Albertini, & Rasmussen, 2002). Written informed consent was obtained from all participants; the study was approved by the hospital IRB. The MBSRQ and other measures were completed before initiation of pharmacotherapy.

Sixty (65.2%) participants were female, and 32 (34.8%) were male. The sample's mean age was 32.3 ($SD = 10.6$). A majority of participants were single ($n = 58$; 63%), nearly one-half were employed full-time ($n = 44$; 47.8%), and slightly more than one-third had completed at least some college ($n = 31$; 33.7%). The most common body areas of concern were skin (76.1%), hair (67%), nose (32.6%), and weight (32.6%). The most common comorbid disorders were major depression ($n = 39$; 42.4%), social phobia ($n = 32$; 34.8%), and obsessive compulsive disorder ($n = 18$; 19.6%). One participant (1.0%) had anorexia nervosa, and 4 (4.1%) had bulimia nervosa. Participants with a comorbid eating disorder were not included in statistical analyses.

Assessments

Participants completed the MBSRQ, a widely used 69-item self-report questionnaire that assesses self-attitudinal aspects of body image, which includes affective, cognitive, and behavioral components (Cash, 2000). The MBSRQ has acceptable reliability and validity (Brown et al., 1990; Cash, 2000).

The MBSRQ has 10 subscales that assess satisfaction with and investment in one's appearance, health/illness, fitness, and

weight. These subscales are: (1) Appearance Evaluation: this 7-item scale assesses feelings of physical attractiveness or unattractiveness and satisfaction or dissatisfaction with one's looks; (2) Body-Areas Satisfaction: this 9-item scale is similar to the Appearance Evaluation subscale except that it assesses satisfaction or dissatisfaction with discrete body features: (face, hair, lower torso, mid-torso, upper torso, muscle tone, weight, height, and overall appearance); (3) Appearance Orientation: this 12-item scale assesses cognitive-behavioral appearance investment in and importance of one's appearance; it does not necessarily assess dysfunctional investment in one's appearance (Cash, Melnyk, & Hrabosky, 2004); (4) Overweight Preoccupation: fat anxiety, weight vigilance, dieting, and eating restraint are measured by this 4-item scale; (5) Self-Classified Weight: this 2-item scale provides a self-appraisal of weight, from very underweight to very overweight; (6) Health Evaluation: feelings of physical health and/or freedom from physical illness are measured by this 6-item scale; (7) Health Orientation: this 8-item scale assesses the extent of investment in a physically healthy lifestyle; (8) Illness Orientation: extent of alertness to being or becoming ill are measured by this 5-item scale; (9) Fitness Evaluation: this 3-item scale assess feelings of being physically fit or unfit; and (10) Fitness Orientation: this 13-item scale measures the extent of investment in being physically fit or athletically competent. In the present sample, the internal consistency for most of the subscales was acceptable (range = .62–.91), however the internal consistency for the Health Evaluation subscale for men was slightly lower than expected ($\alpha = .52$). Alphas for the individual scales are presented in Table 1.

MBSRQ population norms are based on a stratified (sex-by-age distribution) random sample drawn from a U.S. national survey of 1070 females and 996 males (Cash, 2000; Cash, Winstead, & Janda, 1986).

Current BDD severity was assessed with the Yale-Brown Obsessive Compulsive Scale Modified for BDD (BDD-YBOCS). This reliable and valid, 12-item semi-structured clinician-administered measure assesses preoccupation with perceived appearance defects, associated compulsive behaviors such as mirror checking and grooming, insight, and avoidance (Phillips et al., 1997). Higher scores indicate more severe BDD symptoms. In the present sample, the internal consistency for the BDD-YBOCS was good ($\alpha = .82$). Current delusional (insight) of beliefs about appearance (e.g., how convinced individuals are that their appearance flaws appear abnormal) was evaluated with the Brown Assessment of Beliefs Scale (BABS), a reliable and valid 7-item, semi-structured clinician-rated measure (Eisen et al., 1998); higher scores indicate greater delusional. In the present sample, the internal consistency for the BABS was good ($\alpha = .88$). Comorbidity was assessed with the Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon, & First, 1992).

Statistical analysis

Means and standard deviations were calculated. Differences between BDD participants and published norms for males and females were examined using one sample *t* tests. Pearson correlations assessed relationships between selected variables. We report as significant all *p* values less than .05, two-tailed. Because of the exploratory nature of these analyses, we did not adjust *p* values for multiple comparisons. Some findings, especially those close to a threshold of $p < .05$, could therefore represent chance associations. Effect size estimates for *t* tests were determined with Cohen's *d* ($d = 0.2$ is a small effect size, 0.5 is a medium effect size, and 0.8 is a large effect size).

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