Social Science & Medicine 70 (2010) 1641–1647

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

"He's a good-looking chap aint he?": Narrative and visualisations of self in body dysmorphic disorder☆

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ARTICLE INFO

Article history:
Available online 12 February 2010

Keywords:
UK
Narrative
Photographs
Body dysmorphic disorder
Self
Purity

ABSTRACT

Body Dysmorphic Disorder (BDD) is a condition marked by a distressing preoccupation with an imaginary or minor defect in a facial feature or a localised part of the body. However, the link between such excessive preoccupation and perceptions of self throughout the life course has rarely been examined. The aim of this study was to examine narrative accounts of the self across different life-time periods. Eleven participants diagnosed with BDD in England were recruited from the National Obsessive Compulsive Disorder (OCD) clinic and a BDD self-help group. In the context of a semi-structured interview participants presented photographs of themselves across a variety of time periods and drew a self-portrait to prompt memory and generate discussion. Transcribed interviews were analysed using Michele Crossley's (2000) narrative analytic approach. The findings suggest that the majority of participants perceived their past self as excessively attractive. Rather than believing that the alteration of their current appearance would rid them of BDD, participants indicated that a return to their former infantile and pure self that was devoid of blemish, defects and emotional responsibility would provide comfort. These findings indicate that the difficulties associated with appearance are less to do with beauty per se, but are more likely associated with narratives of loss, aging and decline and death.

Introduction

Body Dysmorphic Disorder (BDD) is defined in the Diagnostic and Statistical Manual of Mental Disorders –IV-TR (2000) as a condition marked by excessive preoccupation with an imaginary or minor defect in a facial feature or a localised part of the body. The diagnostic criteria specify that the condition must be sufficiently acute to cause a decline in the patient's social, occupational, or educational functioning (DSM-IV-TR; American Psychiatric Association, 2000). BDD affects both men and women, manifesting itself in differing ways. Whilst men appear to be more worried about genitals, build, and thinning hair, women seem more concerned about skin, stomach and breasts (Phillips, Menard, & Fay, 2006). However, a common feature for both genders is the fundamental belief that the self is defective due to flawed appearance (Cororve & Gleaves, 2001; Phillips, 2005; Veale, 2004b). Thus negative perceptions of self in individuals diagnosed with BDD has been specifically linked to the particular association of appearance with self-worth. To effectively address issues of selfhood in the context of BDD, our aim is to outline an approach that attends to the participants' narrative context, as well as to the social-cultural background of embodiment and body modification more generally.

BDD and the self

Veale and Lambrou (2002) postulate that people diagnosed with BDD view the self as an aesthetic object and have an unrealistically high artistic standard, perhaps as a result of being more aesthetically sensitive than others. As such, like people with social anxiety, they view their self from a particular spatial perspective, which is as an outside observer (e.g. Clark & Wells, 1995). Phillips (2005) found that for people diagnosed with BDD, their perceived defect is of the utmost importance to their construction of self, and that they judge their 'defective' areas very negatively and inaccurately, whilst rating other aspects of their appearance in a more positive and accurate manner. Veale (2000) reports that many patients with BDD have cosmetic and 'DIY' surgery. Whereas cosmetic surgery is usually performed by a surgeon, 'DIY' surgery is an attempt by

☆ The authors would like to acknowledge Professor Naomi Fineberg for kindly providing access to the OCD clinic at the QEII hospital, Welwyn Garden City and for her helpful input on a previous draft of the manuscript, and Dr David Veale and Dr Martin Anson for kindly providing access to the Body Dysmorphic Disorder self-help group at The Priory, North London and for their helpful input on a previous draft of the manuscript.

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doi:10.1016/j.socscimed.2009.11.042

patients to drastically change their appearance by themselves, without a surgeon. Veale (2000) found that many patients are disappointed with the results of such surgery, which can lead to an increase in BDD symptoms.

It is important to explore why people diagnosed with BDD have such views of the self and also why these views are maintained. It is argued that the self is developed from memories, experiences and significant other people (Bentall, 2003; McAdams, 1993; Osman, Cooper, Hackmann, & Veale, 2004). The over identification of appearance with the self may occur as a result of various factors such as a perfectionist personality, teasing in school, or a traumatic event. Recent research suggests that more than three-quarters of individuals with BDD reported a perception of childhood maltreatment (Didie, Tortolani, Pope, et al., 2006), defined as physical, emotional, and sexual abuse as well as physical and emotional neglect. The effect of childhood experiences on adult individuals diagnosed with BDD can also be seen in Osman et al.'s (2004) study, which found that many adults with BDD had spontaneous images which were related to negative memories of bullying and teasing. Social impairment seems to be universal in BDD, and individuals diagnosed with BDD are often single, avoid dating, and have high levels of social isolation (Didie, Tortolani, Menard, Fay, & Phillips, 2006; Phillips, 2000, 2004). However, what these studies do not indicate are the specific beliefs that serve to maintain perceptions of self in the present, and why negative appraisals of self are necessarily linked to appearance and/or physical defects.

The self within a present internal construct: cognitive research.

Cognitive research has long placed emphasis on the internal and current cognitive mechanisms and behaviours that serve to maintain negative thought cycles argued to be associated with negative ways of perceiving appearance in BDD. According to this view, Veale (2001, 2004a) has proposed a cognitive behavioural model of BDD. It is thought that the cycle is triggered by a negative thought, a threatening social situation or when an actual or mental image of the person's appearance is viewed. A mental image is defined as 'contents of consciousness that possess sensory qualities, as opposed to those that are purely verbal or abstract' (Horowitz, 1970, cited in Veale, 2004a, p. 115). This mental image is considered to be distorted. Whereas individuals diagnosed with BDD tend to assume that 'what you see is what you get' in front of the mirror, Veale and Riley (2001) show that 'what you see is what you construct', as the perceived image is dependent upon the value that is put on appearance, the desired ideal image, and mood. Furthermore, this image is then scrutinised intensively by the individual for defects. The longer that the person looks in a mirror, the more self conscious s/he becomes, and the more that the negative image is reinforced. The negative appraisals that patients have produce negative feedback, which lead to self-focused attention on their image. Veale (2004a) shows how comparing the self with other people continues to reinforce feelings of shame, disgust and hopelessness. To reduce scrutiny patients engage in safety behaviours such as camouflage and avoidance (Veale, 2004a); Veale & Riley, 2001. Although such behaviours might decrease anxiety in the short term, in the long term they serve to increase anxiety and continue the BDD cycle (Veale, 2001, 2004a).

Whilst this cognitive model can explain the maintenance of BDD, cognitive models of mental distress require further development to include the emotional, cultural and interpersonal factors that influence people's lives (Kendall, 2000). In other words, cognitive models may need to further explore how and where negative thought patterns arise, and how they are maintained by the individual's relationships with intimate others and the more macro-cultural emphasis on appearance more generally. Furthermore, perhaps what cognitive models miss is an understanding of self as fully immersed in the context of an entire life history, which includes an acknowledgement of the different meanings associated with appearance at different developmental stages. Rather than examining cognitive constructs of self in the present only, it is perhaps more valid to examine experiential, holistic driven accounts that can fully embrace the variety and depth of an individual's life story, with all its contextual richness. In brief, an examination of life narratives in the form of qualitative data may succeed in achieving contextual richness, as cognitions, emotions and behaviours are treated as thoroughly grounded in the complexities of people's relationships and changing engagement with the world across time.

Although studies on BDD have increased knowledge of the clinical features and treatments for BDD, many of these studies have used methodologies that rely on quantitative measures (of isolated cognitions) rather than studies rich in contextual detail (e.g. Cororve & Gleaves, 2001; Rosen, 1995). Notwithstanding one paper by da Costa, Nelson, and Rudes (2007) that suggests narrative therapy as a *treatment* for BDD, there have been no empirical narrative analytic studies of people with BDD to our knowledge to date. Our aim in this paper is to provide an analysis that reports some commonalities in individuals with BDD over a life time.

From cognitions to narratives: the self evolving across time

Reissman (1993) defines a personal narrative as 'talk organised around consequential events. A teller in a conversation takes a listener into a past time or world and remembers what happened to them to make a point, often moral' (p. 3). A narrative analytic approach looks at the story being told by the teller and fully acknowledges that individuals construct the self, both past and present, through narrative. This often involves a description of an event or action and an analysis of its meaning which provides insight into the narrator's sense of self (Frost, 2007).

Bruner (1990) argues that personal stories are often recited when people have a discrepancy between the perceived actual and perceived ideal self and society. Given that there is a large difference between the perceived ideal and perceived real in people with BDD (Veale, Kinderman, Riley, & Lambrou, 2003), it is considered that participants will have personal and often dramatic stories to tell. Broyard (1992) suggests a possible reason for this: 'always in emergencies we invent narratives. We describe what is happening as if to confine the catastrophe (sic). Storytelling…seems to be a natural reaction to illness' (p. 21). This approach must of course acknowledge the cultural landscape that gives rise to the link between stories of BDD and wider cultural discourses on aesthetic perfection and self-worth.

Narratives of cosmetic surgery and other bodily transformations, for example, have been explored in order to uncover the choices individuals make in order to alter their appearance. Gimlin (2000) interviewed 20 female clients of a plastic surgeon based in New York, in order to find out more about the women's experiences of bodily/aesthetic discomfort and reasons for choosing surgery. Many of the women were at pains to justify their reasons for and entitlement to surgery by stating that they had tried dieting and exercising before resorting to surgery, which required both physical and financial sacrifices. Participants were aware of the negativity that surrounds such surgery, and the need to justify such practices. The women stressed that their bodily 'defects' were a result of factors outside of their control, such as aging and genetics, and that their flawed bodies were actually incorrect indicators of character. The goal of surgery was thus to remove or change one physical feature to create a 'normal' appearance. Whereas some wanted to construct or regain a youthful appearance, other women had surgery to remove the physical markers of ethnicity and to have an appearance that