Potential link between body dysmorphic disorder symptoms and alexithymia in an eating-disordered treatment-seeking sample

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A R T I C L E   I N F O

Article history:
Received 17 June 2010
Received in revised form 9 May 2011
Accepted 6 July 2011

Keywords:
Body dysmorphic disorder
Body image
Eating disorders
Affect regulation
Alexithymia
Psychopathology
Clinical psychology

A B S T R A C T

This study aimed to explore the manifestation of body dysmorphic disorder symptoms in a sample of people with eating disorders and to investigate possible associations between body dysmorphia and alexithymia. Forty patients currently seeking treatment for an eating disorder completed a battery of six measures assessing alexithymia, mood, eating behaviours, weight-related body image, body dysmorphism and non-weight related body image. Significant moderate positive correlations (Pearson’s r) between selected variables were found, suggesting that participants with high levels of dysmorphic concern (imagined ugliness) have more difficulty with the affective elements of alexithymia, that is, identifying and describing feelings. When depression, eating attitudes, and weight-related body image concerns were controlled for, significant moderate positive correlations between this alexithymia factor and dysmorphic concerns remained present. An independent-samples t-test between eating-disordered participants with and without symptoms of body dysmorphic disorder (BDD) revealed significant group differences in difficulties identifying feelings. This pattern of results was replicated when the groups were identified on the basis of dysmorphic concerns, as opposed to BDD symptoms. This study highlights the associations between alexithymia and body dysmorphism that have not previously been demonstrated.

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1. Introduction

Body dysmorphic disorder (BDD), previously known as dysmorphophobia, is an under-recognized psychiatric disorder (Phillips and Castle, 2001a, 2001b; Phillips, 2004). It is classified as a somatoform disorder in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) (DSM-IV) and is characterized by a distressing or impairing preoccupation with an imagined or slight defect in appearance. In spite of the classification of BDD under the somatoform umbrella, the DSM-IV also states that this grouping is based on the need to exclude medical causes for the bodily symptoms, rather than assumptions about shared etiology or mechanism. Indeed, BDD does not appear to fit well with the somatoform grouping. Thus, in an attempt to better understand the manner in which BDD develops, research has explored the relationship between BDD and psychological disorders with related symptomatology (Ruffolo et al., 2006). Connections have been made with disorders such as obsessive–compulsive disorder and depression (Allen and Hollander, 2004; Phillips, 2005; see also Ruffolo et al., 2006). Additionally, some experts have proposed a shared etiology with eating disorders (Phillips et al., 1995a, 1995b; Grant and Phillips, 2004; Phillips, 2005).

There is considerable overlap between eating disorders (EDs) and BDD, with major similarities including a high value being placed on appearance, body image disturbance, overlap in bodily areas of concern, obsessive thoughts, compulsive behaviours and avoidance, and similarities in onset and course (for example, see Allen and Hollander, 2004; Grant and Phillips, 2004; Phillips, 2005; Hrabosky et al., 2009). It should be noted that research looking at the relationship between BDD and EDs has not been consistent in terms of whether the sample has included only people with anorexia nervosa, people with bulimia nervosa, or both. That said, there is currently a move towards a ‘transdiagnostic’ approach to the theory and treatment of eating disorders (Fairburn et al., 2008). This approach recognizes that although anorexia nervosa and bulimia nervosa are separate disorders in the DSM-IV, many people with serious eating disorders do not fit neatly into either category and may change between categories over time (Fairburn et al., 2008). Thus the transdiagnostic approach is applicable to all eating disorders and there is more focus on attitudes and beliefs regarding shape and weight, rather than so much emphasis on the behavioural components of EDs (Fairburn et al., 2008). Comorbidity of EDs and BDD is high. For example, Grant et al. (2002) assessed a sample of patients with anorexia and found that 39% could be diagnosed with comorbid body dysmorphic disorder unrelated to weight concerns. Conversely, Ruffolo et al. (2006)
found that 32% of subjects with BDD had a comorbid lifetime eating disorder. Research suggests that body dysmorphic concerns are high amongst ED populations (Rosen et al., 1995; Gupta and Johnson, 2000; Grant et al., 2002; Dyl et al., 2006) and conversely that disordered eating is common amongst patients with BDD (Phillips, 2005; Ruffolo et al., 2006; Kittler et al., 2007). Indeed, although BDD is currently classified as a somatoform disorder, it has also been described as a body image disorder due to its parallels with EDs (Phillips et al., 1995b; Grant and Phillips, 2004).

To the authors’ knowledge, there have been no studies looking at BDD and alexithymia. Alexithymia is a multifaceted personality construct characterized by three main features, two of which are related to affective factors (i.e., difficulty identifying and describing feelings) whereas the last, which is related to cognitive features, manifests as concrete, Externally Oriented Thinking (Taylor et al., 1991, 1997; see also Zackheim, 2007). Given the well documented link between alexithymia and EDs (Bourke et al., 1992; Cochrane et al., 1993; deGroot et al., 1995; Taylor et al., 1996; Corcos et al., 2000; De Berardis et al., 2007; Speranza et al., 2007; Lawson et al., 2008a, 2008b), the more specific link between alexithymia and weight-related body image (De Berardis et al., 2005; Carano et al., 2006; De Berardis et al., 2007, 2009) and the vast research on alexithymia in somatoform conditions other than BDD (Sifneos, 1973; Warnes, 1985; Taylor et al., 1992; Bach and Bach, 1995; Taylor and Bagby, 2004; Zackheim, 2007), an investigation of a potential relationship between BDD and alexithymia may prove informative.

Whilst it is accepted that EDs and alexithymia are linked, and it is plausible that BDD and alexithymia are linked, it is important to consider the nature of these relationships. In the case of EDs and alexithymia, this relationship is not fully understood. Although findings from treatment evaluations (e.g., group therapy, individual therapy, and pharmacologic therapy) have varied, successfully treated ED patients may continue to feel much more than most people (Phillips, 2005) — difficult to describe. Total scores can range from 0 to 21 and a score greater than 11 indicates problematic dysmorphic concern. Oothuizen et al. (1998) report good internal consistency and face validity for the questionnaire and report that dysmorphic concern was not significantly influenced by the patient’s age, sex or diagnosis. Scores correlated with depressive cognitions, suggesting that dysmorphic concern may reflect the presence of a depressive cognitive set. In the current study, Cronbach's alpha coefficient was 0.87 for this measure.

2.4. Body Dysmorphic Disorder Questionnaire (BDDQ; Phillips et al., 1995a, cited in Phillips, 2005)

The BDDQ is a self-report questionnaire designed to screen individuals for BDD-related body image concerns that are not weight related. It is a reliable, semi-structured instrument based on DSM-IV criteria (Phillips et al., 1995a). It is made up of 11 items, with various response formats; yes or no, Likert scales, multiple choice and open-ended. The BDDQ is highly correlated with clinician diagnoses of BDD (Stewart et al., 2008). It has high levels of sensitivity and specificity (Phillips, 2005).

2.5. Zung Depression Rating Scale (ZDRS; Zung, 1965)

The ZDRS consists of 20 items presented in a 4-point Likert scale format. Several items are reverse scored. Raw scores are converted to Self-Rating Depression Scale (SDS) index, which equates to various categories indicating level of depression. It is a
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