



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

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ABSTRACT

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 dysmorphia 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 dysmorphia 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)

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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 score highly on alexithymia measures (Iancu et al., 2006; cf Becker-Stoll and Gerlinghoff, 2004). Further, the possibility that the relationship between EDs and alexithymia is mediated by a third 'general distress' factor has also been raised (Hund and Espelage, 2006). Such findings, together with research that suggests a strong association between EDs, alexithymia, and affective disorders (Sexton et al., 1998; Eizaguirre, et al., 2004; Speranza et al., 2005), has led to the suggestion that there may be various types of clinical profiles, with the different aspects of alexithymia being related to various aspects of eating pathology and depression or anxiety (Quinton and Wagner, 2005; Speranza et al., 2005; Kiyotaki and Yokoyama, 2006; Speranza et al., 2007). A closer investigation of whether specific elements of alexithymia, namely affective components, are more strongly related to EDs than other components (e.g., cognitive elements), shows support for this contention (Speranza et al., 2007; Lawson et al., 2008a, 2008b; De Berardis et al., 2009). Further, the cognitive component of alexithymia — Externally Oriented Thinking — does not appear to be related to EDs (Troop et al., 1995; Taylor et al., 1996). As with EDs, there is also a selective association between the affective components of alexithymia and somatoform disorders (Bankier et al., 2001; Waller and Scheidt, 2004). Thus, based on these findings (with EDs and somatoform conditions), one might expect that BDD and the affective components of alexithymia will be most strongly related. It could also be hypothesized that a global emotion-processing deficit (as reflected in the affective elements of alexithymia) could partially underlie a shared etiology between EDs and BDD.

The aim of this study was to assess the relationship between alexithymia and body dysmorphic concerns in ED patients. It was hypothesized that there would be a difference between ED patients with and without significant body dysmorphic concerns in terms of alexithymia. Furthermore, it was expected that the relationship between BDD symptoms and alexithymia would be partially accounted for by levels of depression, but that alexithymia would still have an independent relationship with BDD.

2. Method

2.1. Participants

The participants comprised 40 females seeking treatment for an ED. Participants were aged between 14 and 69 years old ($M = 29$ years; $S.D. = 11.61$). Participants' Body Mass Index (BMI) ranged from 11.53 to 36.24 ($M = 18.43$; $S.D. = 4.34$). Ninety percent of subjects were Caucasian Australians. Questionnaires were distributed by psychiatrists and psychologists at a private psychiatric clinic in Brisbane, as well as by local private practitioners and the Eating Disorders Association. Participation was voluntary and did not affect treatment in any way.

It should be noted that the participants included both those with anorexia nervosa, bulimia nervosa and possibly some with Eating Disorder Not Otherwise Specified (EDNOS) diagnosed by a psychologist or psychiatrist using standard DSM-IV criteria. This approach was taken because the core body image disturbance is similar in these groups (Gupta and Johnson, 2000). The study sample was one of convenience, in that doctors and psychologists approached all patients who were in their care (at the private psychiatric clinic, through private practitioners in the community or through a community support group). Thus, the sample comprised both inpatients and outpatients. However, due to the data collection method used (anonymous drop-off boxes or reply paid envelopes) it was not possible to determine how many were inpatients versus outpatients. To be included in the study, participants had to be seeking treatment for a diagnosed eating disorder and provide a written informed consent. There were no exclusion criteria, other than if clinicians judged that patients were too critically unwell to participate or if questionnaires were returned with excessive missing data.

2.2. Measures

A battery of six established measures, which were part of larger suite of tests, was administered for this study. These standardized measures comprised questions about eating behaviours, weight-related body image, body dysmorphia and non-weight related body image, mood, and alexithymia. They were selected for this study because of their previous use in research or clinical applications involving EDs, BDD, or mood disorders.

2.2.1. Eating Attitudes Test (EAT; Garner et al., 1982)

The EAT is a well-established self-report measure of disordered eating patterns, which can be divided into three factors; 'dieting', 'bulimia and food preoccupation', and 'oral control'. The EAT-26 is an objective, valid and reliable measure of ED symptomatology (Garner et al., 1982). The EAT consists of 26 Likert items that are scaled on a 6-point response continuum (never, rarely, sometimes, often, very often and always). Total scores can range from 0 to 78. A higher score reflects a greater degree of eating pathology, with a score over 20 (cut-off) indicating an eating problem. Garner et al. (1982) originally reported a Cronbach's alpha of 0.83 (in a sample of female undergraduates). Other evidence of the reliability and validity of this scale can be found in the literature (for example, see Ratte et al., 1989; Nakai and Seishin, 2003). In the current study, Cronbach's alpha coefficient for this scale was 0.87.

2.2.2. Body Shape Questionnaire (BSQ; Cooper et al., 1987)

The BSQ is a 34 item scale, designed to assess weight and shape related body image concerns. Each item is set out in a Likert format, with never, rarely, sometimes, often, very often and always as possible answers. Scores can range between 34 and 204, with a cut point of 129 indicating a distorted concern with weight and shape. The BSQ is a valid and reliable measure of body image (Cooper et al., 1987; Rosen et al., 1996; Pook and Tuschen-Caffier, 2003). Cronbach's alpha coefficient for the current study was 0.96.

2.2.3. Dysmorphic Concern Questionnaire (DCQ; Oosthuizen et al., 1998)

The DCQ is designed to assess dysmorphic concern. It consists of 7 questions, each with 4 possible responses: 'not at all', 'same as most people', 'more than most people', and 'much more than most people'. Scores range from 0 to 21 and a score greater than 11 indicates problematic dysmorphic concern. Oosthuizen 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, the Cronbach's alpha coefficient was 0.87 for this measure.

2.2.4. 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/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).

2.2.5. 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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