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Appearance concerns comparisons among persons with body dysmorphic disorder and nonclinical controls with and without aesthetic training☆

Christina Lambrou*, David Veale[1], Glenn Wilson[2]

Department of Psychology, Institute of Psychiatry, King's College London, London, United Kingdom

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ABSTRACT

Body dysmorphic disorder (BDD) concerns may be on a continuum with normal appearance concerns, differing only quantitatively. As emerging evidence suggests that an increased aesthetic sensitivity plays a role in BDD, individuals with BDD ($n = 50$) were compared with a control group of individuals with an education or employment in art and design related fields ($n = 50$) and a control group of individuals without aesthetic training ($n = 50$). Participants completed a demographic questionnaire and a series of measures for depression, BDD symptomatology, and body image. Most controls (with and without aesthetic training) reported appearance concerns and expressed comparable ideals to those with BDD. However, BDD participants differed by using negative, emotive, and morally based descriptions for their defect(s), spending a greater time preoccupied with their defect(s) causing increased interference with functioning, performing appearance-related behaviors more frequently, and experiencing greater distress when performing those behaviors.

Introduction

For those with body dysmorphic disorder (BDD), the concern with an imagined or slight defect in their appearance is excessive, causing them significant distress and/or impairment in their social and/or occupational functioning. BDD concerns may be on a continuum with normal appearance concerns, differing quantitatively as a more severe version.

The preoccupation in BDD typically focuses on one aspect of the body, which can shift during the course of the disorder, especially following surgical treatment (Tignol, Biraben-Gotzamanis, Martin-Guehl, Garbot, & Aouizerate, 2007; Veale, 2000). Some sufferers are preoccupied with several body parts simultaneously (Phillips, Menard, Fay, & Weisberg, 2005). Any body part may be the focus in BDD. Complaints about skin, hair, and the size, shape, or symmetry of facial features however, are the most common (Phillips, McElroy, Keck, Pope, & Hudson, 1993; Phillips, Menard, & Fay, 2006; Phillips et al., 2005; Veale et al., 1996).

Individuals with BDD resemble those with an eating disorder in their overall body dissatisfaction; but they report greater self-evaluative and appearance-managing investment, as well as greater overall body image disturbance and a more detrimental impact of body image on quality of life than those with an eating disorder (Hrabosky et al., 2009). Unlike other body image disorders, BDD affects approximately an equal proportion of men and women (Phillips & Diaz, 1997). Gender may differentially influence localisation of the preoccupations in BDD (Phillips & Diaz, 1997; Phillips et al., 2006). Some of these gender differences may reflect the trends in the general population (Harris & Carr, 2001), suggesting that BDD concerns represent an extreme version of normal appearance concerns.

Many in the general population express dissatisfaction, to some degree, with at least one facet of their appearance (Harris & Carr, 2001). Paralleling trends observed in those with BDD (Phillips et al., 2006), concerns about the nose, skin, and weight are reported most frequently by both men and women in the general population (Harris & Carr, 2001). Women are twice more likely than men to have an appearance concern; interestingly, among women the prevalence of concern peaks during the late teens and late twenties and remains high through to age 60 years, whereas among males it peaks during the late teens and early twenties and decreases progressively with age (Harris & Carr, 2001).

Individuals with BDD appear to appreciate art and beauty to a greater degree than comparative psychiatric groups, as evidenced by their choice of occupation and/or education (Veale, Ennis, & Lambrou, 2002). This raises an interesting question about the

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* Corresponding author at: Department of Psychology, Box PO77, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, United Kingdom.
E-mail address: christina.lambrou@kcl.ac.uk (C. Lambrou).
[1] Current address: NIHR Specialist Biomedical Research Centre for Mental Health, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry, King's College London, United Kingdom.
[2] Current address: Gresham College, London, United Kingdom.

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definition of BDD as a preoccupation with an imagined defect or a minor physical anomaly. Perhaps those with BDD are more aesthetically sensitive than the mental health professionals who diagnose them and who are therefore unable to appreciate art and beauty to the same degree (Veale & Lambrou, 2002). A high aesthetic sensitivity would augment a person's self-consciousness and distress over any appearance defect (Harris, 1982). Preliminary evidence suggests that a higher aesthetic sensitivity may partly explain why a small defect in their appearance severely disturbs those with BDD (Lambrou, Veale, & Wilson, 2011; Stangier, Adam-Schwebe, Müller, & Wolter, 2008). Akin to the perceptual and affective/attitudinal components of body image, aesthetic sensitivity has a perceptual, emotional, and evaluative component (see Lambrou et al., 2011, for the aesthetic sensitivity model). Rather than suffering from a perceptual deficit, individuals with BDD have a superior accuracy in their self-actual estimation; instead, they resemble nonclinical individuals with an education or employment in art and design related fields in their increased understanding of aesthetic proportions (Lambrou et al., 2011). The source of their disturbance is in their emotional/evaluative processing of their self-image, where they display a negative emotional bias and a discrepancy between their self-actual and self-ideal, because of an absent self-serving bias in their self-actual; they also overvalue the importance of appearance and self-objectify.

Since appearance concerns are the norm in our culture, it is important to distinguish the traits that typically define those with BDD, and how they are distinguished from the general population; particularly from those with an art and design education and/or occupation as emerging evidence suggests that an increased aesthetic sensitivity plays a role in BDD. Previous surveys have assessed the demographic and clinical characteristics of those with BDD (e.g., Phillips et al., 2005; Veale et al., 1996), but comparative control surveys are sparse.

The aims of the present study were two-fold: (a) to report the demographic characteristics of a sample comprising individuals with BDD and healthy controls (with and without aesthetic training) and (b) to explore how those with BDD compare with healthy controls (with and without aesthetic training) in their clinical characteristics including their depressive symptomatology, as well as the nature and extent of their appearance concerns.

Method

Participants

The study sample comprised 150 participants in three groups: (a) 50 individuals with BDD, (b) 50 nonclinical controls with aesthetic training, and (c) 50 nonclinical controls without aesthetic training. Male and female adults aged 18 through 40 were recruited. This age group was selected because it is representative of the time when individuals are more commonly and most affected by BDD. The groups were age and gender matched.

The inclusion criteria for the BDD group were (a) a primary DSM-IV diagnosis of BDD based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994) and (b) a total score of at least 20 on the Yale-Brown Obsessive–Compulsive Scale modified for BDD (BDD-YBOCS; Phillips, Hollander, Rasmussen, Aronowitz, DeCaria, & Goodman, 1997), including a score of at least 2 on Item 1 (1–3 h per day of preoccupation with the perceived defect). The BDD cohort formed part of a larger study, which had pre-selected the BDD participants for their predominant facial concerns (see Lambrou et al., 2011). Aside from their primary BDD diagnosis, as confirmed by the Structured Clinical Interview for *DSM-IV* (SCID; First, Spitzer, Gibbon, & Williams, 1997), their comorbid disorders were major depression ($n = 21$), delusional disorder ($n = 19$), social phobia ($n = 5$), obsessive–compulsive disorder ($n = 4$), alcohol misuse ($n = 2$), adjustment disorder ($n = 1$), and bulimia nervosa ($n = 1$). Participants with BDD were either individuals receiving treatment at the Priory Hospital North London or individuals who had contacted a BDD support group. They underwent the SCID as part of their assessment for treatment; at the end of this clinical session, they were recruited to the study. The BDD group comprised 4 inpatients, 36 current outpatients, and 10 newly assessed outpatients.

The two nonclinical control groups excluded (a) those who responded *yes* to "Have you ever been diagnosed with a psychiatric disorder?" and/or "Are you currently suffering with a psychiatric disorder?" and (b) those who had excessive appearance concerns defined by a total score of 20 or above on the BDD-YBOCS, including a score of at least 2 on Item 1. The only difference between the control groups was the additional inclusion criterion of an education or occupation in art and design, necessary for the art and design group. This included a current or completed education (at least advanced level) or training in art, fine art, art history, architecture, or design or an occupation as an artist, an art teacher, an architect, or a graphics, fashion, or textile designer. To classify a participant, both current and past occupation, training, and education in art and design were used. For instance, a participant with an art degree but working as a waiter qualified for the art and design group. The two control groups were recruited by (a) advertisements in a local newspaper, (b) email circulars in 11 universities and colleges, (c) leaflets delivered to 1,000 homes, and (d) snowball sampling. The ethics committees of the Institute of Psychiatry and the Priory Hospital North London approved the study protocol.

Assessments

Demographic characteristics. A self-report questionnaire was used to gather information about age, gender, marital status, employment status, educational success, ethnic origin, and sexual orientation.

Clinical characteristics. The clinical characteristics divided into four categories: (a) depression, (b) description of appearance concerns and ideal, (c) BDD severity, and (d) frequency and distress of appearance-related compulsive behaviors.

Beck Depression Inventory (BDI). The BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a 21-item self-report inventory, was used to assess the presence and severity of symptoms related to depression. Total scores range from 0 to 63 (none or minimal: <10; mild to moderate: 10–18; moderate to severe: 19–29; severe: 30–63). Internal consistency was high in the present sample as a whole (Cronbach's $\alpha = .948$) and good in each group (BDD: $\alpha = .899$; with aesthetic training: $\alpha = .860$; without aesthetic training: $\alpha = .876$)

Body Dissatisfaction Checklist. The Body Dissatisfaction Checklist, a modified version of Part 1 of the Body Dysmorphic Disorder Examination Self-Report (Rosen & Reiter, 1994), was used to explore the nature of the appearance concerns and the ideal standard. The checklist consists of 30 facial and nonfacial body features. Respondents are required to select any features that they had felt to be defective or had disliked in the past week and describe what they perceive as defective about the feature(s) and how they believe the feature(s) must be in order to be happy (ideal).

BDD-YBOCS. The BDD-YBOCS (Phillips et al., 1997), a 12-item semistructured interview was administered to assess the severity of BDD symptoms during the past week. Total scores range from 0