



Body image, emotions and thought control strategies in body dysmorphic disorder compared to eating disorders and healthy controls

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ABSTRACT

Objective: A disordered body image, emotions such as shame and disgust, and intrusive thoughts are described as important and interdependent features of body dysmorphic disorder (BDD). However, research in this field is scarce and knowledge is often based on clinical observation.

Methods: The present study examined body image dimensions, emotions, and thought control strategies in individuals with: BDD ($n = 31$), anorexia nervosa ($n = 32$), bulimia nervosa ($n = 34$), and healthy controls ($n = 33$). Assessment was based on structured diagnostic interviews and self-report questionnaires.

Results: Individuals with BDD scored higher on psychosocial and appearance manipulation dimensions of body image compared to healthy controls. Furthermore, they reported higher psychosocial impairment due to appearance than both eating disorder groups. In terms of emotions, BDD subjects reported a higher degree of negative emotions compared to healthy controls, whereas no differences were found in comparison to eating-disordered patients. Individuals with BDD reported using maladaptive strategies such as worrying and confrontation more often than healthy controls, when encountering intrusive and unwanted thoughts.

Conclusion: The results indicate that individuals with BDD experience substantial psychosocial impairment due to appearance, high levels of various negative emotions and frequently use maladaptive thought control strategies.

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Introduction

Individuals with body dysmorphic disorder (BDD) have a preoccupation with perceived defects or flaws in their physical appearance. These defects or flaws are either not observable by others or appear to be only slight [1]. The most common body parts of concern are the skin, hair, or nose, but any part of the body may be included and often the preoccupation involves several body parts. Individuals with BDD frequently perform repetitive behaviors such as camouflaging their appearance, mirror checking or reassurance seeking. Distressing, recurrent and intrusive thoughts related to their appearance are reported to be common in BDD as well as feelings of shame, anxiety and hopelessness [2]. As a consequence individuals with BDD suffer from severe distress and substantial impairment in psychosocial functioning [3]. BDD is still an underrecognized disorder and only a small percentage of individuals with BDD is reported to receive empirically supported psychotherapy [4].

Several cognitive-behavioral models of BDD have been developed and evidence has been found of attentional and interpretative biases [5,6], as well as abnormal visual processing [7]. According to these models a disordered body image is a core feature of BDD. Emotions such as hopelessness or shame, and processes such as rumination or intrusive thoughts have also been described as important features. It is assumed that a negative appraisal of body image fosters feelings of shame, disgust, as well as depression and may also elicit intrusive thoughts about one's appearance [8]. However, very little research has been carried out on body image and even less research has been done on emotions and the types of thoughts that contribute to the preoccupation of individuals with BDD. Knowledge, especially in the latter two fields is often based solely on clinical observation. The aim of the present study was therefore to extend the body of knowledge on BDD by examining body image dimensions, emotions and thought control strategies in a sample of individuals with BDD, as compared to samples of clinical and healthy controls.

The few studies that have directly examined body image dimensions of individuals with BDD in comparison to healthy controls found that BDD subjects evaluated their appearance more negatively, were less satisfied with it and attached more importance to it [9,10]. Compared with eating-disordered subjects, individuals with BDD showed comparably high levels of negative body evaluation and

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body dissatisfaction, but reported more appearance overvaluation than eating-disordered subjects [10,11]. One study compared individuals with BDD to individuals with anorexia nervosa (AN) and bulimia nervosa (BN), separately [11]. Individuals with BDD reported more appearance-managing investment and appearance fixing than individuals with AN. In comparison to both eating disorder groups, BDD subjects reported a higher degree of psychosocial impairment due to their appearance concerns. Existing studies indicate that individuals with BDD are characterized by a disordered body image, which severely impairs their level of functioning. Similarities between BDD and eating disorders are apparent in terms of body dissatisfaction and negative body evaluation, whereas differences appear to exist in the level of psychosocial impairment resulting from a disordered body image.

Feelings of shame, depression, hopelessness, anger, and guilt are described as common phenomena in individuals with BDD [2], but distinct emotions in BDD have rarely been studied. Lambrou (2006) found higher levels of shame in individuals with BDD compared to healthy controls [12]. Neziroglu et al. (2010) assessed disgust reactivity across repeated mirror exposures [13]. The BDD group showed a higher baseline disgust reactivity and a significant decrease in disgust after repeated mirror exposure, compared to healthy controls. These findings indicate a higher level of shame in individuals with BDD and provide preliminary evidence of a higher level of disgust reactivity.

Individuals with BDD experience aversive thoughts and images relating to their appearance. Veale and Neziroglu (2010) consider cognitive processes such as rumination, worrying, mental planning, comparing, self-assurance and self-attacking as efforts to control aversive thoughts and images [14]. However, empirical evidence in this area is lacking as there have not yet been any studies carried out in relation to thought control strategies in individuals with BDD.

In the current study we examined body image dimensions, the intensity of ten different fundamental emotions and the frequency of various thought control strategies in individuals with BDD. To investigate whether these phenomena were specific to BDD or also characteristic of other mental disorders, we included individuals with eating disorders as the clinical control group. As there is evidence that individuals with AN and BN differ on certain body image dimensions such as global body dissatisfaction [15], we included them as separate groups.

Based on existing knowledge we hypothesized: a) that individuals with BDD would score higher on dimensions of a disturbed body image than healthy controls, b) that individuals with BDD would suffer from higher impairment in functioning due to their appearance concerns than individuals with an eating disorder, c) that individuals with BDD would experience a higher intensity of negative emotions than healthy controls and d) that individuals with BDD would use more maladaptive strategies in order to control aversive thoughts and images than healthy controls.

Method

Participants

We recruited 31 subjects with a diagnosis of BDD. Twenty consecutive inpatients with BDD were recruited from two psychosomatic inpatient settings. Eleven subjects with BDD were recruited via flyers and an advertisement on a website run by an internet-based self-help group for BDD. We recruited 32 consecutive inpatients with a diagnosis of AN and 34 consecutive inpatients with a diagnosis of BN. We recruited 33 healthy controls from the community via flyers and by personal contact.

Individuals were eligible for the BDD group if they met DSM-IV criteria for current BDD. Exclusion criterion for the BDD group was a current or lifetime diagnosis of an eating disorder. Clinical control subjects needed to fulfill the DSM-IV criteria for current AN or BN.

Exclusion criterion for the AN or BN group was a current or lifetime diagnosis of BDD. Individuals were eligible for the healthy control group if they did not meet the criteria of any current axis I mental disorder according to DSM-IV. Participants had to be at least 16 years of age. General exclusion criteria for all groups were inability to read and understand the information brochure and consent form and inability to take part in the study consciously.

Forty-three individuals were assessed for eligibility for the BDD group. Seven BDD subjects were excluded due to a current or lifetime diagnosis of an eating disorder and five individuals did not meet full BDD diagnostic criteria. Eighty-six individuals were assessed for the eating disorder group. Ten individuals were excluded due to a current or lifetime diagnosis of BDD, nine individuals refused to participate and one individual did not have sufficient German skills to participate. In total, 130 individuals provided written informed consent to participate in the study.

Participants with BDD did not differ from healthy controls in gender ratio, age and education. However, they differed from healthy controls in relationship status. The BDD group did not differ from the AN and BN groups in age and relationship status. However, the BDD group differed from the AN and BN groups in gender ratio and it differed from the AN group but not from the BN group in education (cf. Table 1).

Procedure

The study design was reviewed and approved by the local institutional ethics committee. Informed consent was obtained after the nature of the procedures has been fully explained. A structured diagnostic interview assessing axis I mental disorders (Mini-DIPS) [16] and the SCID-modules for BDD and eating disorders [17] were administered to all participants. BDD symptom severity was assessed with the Yale-Brown Obsessive-Compulsive Scale, modified for body dysmorphic disorder (BDD-YBOCS) [18]. Eating disorder symptom severity was assessed with an adaptation of the BDD-YBOCS for eating disorders. Following the interview participants filled out self-report questionnaires.

Measures

Structured diagnostic interview: Mini-DIPS

The Mini-DIPS [16] is a structured diagnostic interview based on DSM-IV to assess the most frequent clinical disorders. Interrater reliability (Cohen's κ) ranges between .84 and 1.0 [16]. As the Mini-DIPS does not assess BDD and eating disorders not otherwise specified we additionally used the SCID-I research version modules for BDD and eating disorders.

SCID-I (for DSM-IV, research version) modules for BDD and eating disorders

The SCID-I for DSM-IV disorders [17] is a widely used structured interview to assess axis I mental disorders. Fair agreement has been reported for the assessment of eating disorders (Cohen's $\kappa = .61$ to $.77$) [19,20]. The SCID-I module for BDD is often used to assess DSM-IV BDD diagnostic criteria; however, interrater reliability still needs to be determined.

Yale-Brown obsessive compulsive scale, modified for Body Dysmorphic Disorder

The BDD-YBOCS [18,21] is a widely used measure to assess BDD symptom severity. It consists of 12 items. Each item is rated by the clinician on a scale from 0 to 4. The total score ranges from 0 up to 48 with higher scores implying a higher degree of symptom severity.

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