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## Personality traits as vulnerability factors in body dysmorphic disorder

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## ABSTRACT

Cognitive behavioural models consider certain personality traits to be risk factors for the development of Body Dysmorphic Disorder (BDD). Research on personality traits in BDD is scarce, therefore this study examined perfectionism, aesthetic sensitivity and the behavioural inhibition system (BIS) in BDD. Furthermore, the association between these personality traits and the extent of dysmorphic concerns was investigated.

Individuals with BDD ( $n=58$ ) and a population based control sample ( $n=2071$ ), selected from a representative German population survey, completed self-report questionnaires assessing DSM-5 criteria of BDD, dysmorphic concerns, perfectionism, aesthetic sensitivity and BIS-reactivity.

Individuals with BDD reported significantly higher degrees of perfectionism as well as of BIS-reactivity compared to the population based control sample, whereas the groups did not differ significantly regarding aesthetic sensitivity. However, for the total sample, each of the personality traits was related dimensionally to dysmorphic concerns.

Current BDD models consider perfectionism and aesthetic sensitivity to be vulnerability factors. In addition to these concepts, the present study suggests that BIS-reactivity is related to BDD. Self-reported aesthetic sensitivity was not found to be specifically pronounced in BDD, but along with perfectionism and BIS-reactivity aesthetic sensitivity was generally associated with dysmorphic concerns.

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## 1. Introduction

Individuals with Body Dysmorphic Disorder (BDD) suffer from a preoccupation with defects or flaws in their physical appearance for which there is often no objective support. If a slight flaw does exist, then preoccupation with the defect is extremely exaggerated. The main focus of the appearance concerns are the nose, hair, or skin, but it is also possible for more than one body part to be included (Phillips et al., 2005). Individuals with BDD often perform repetitive and long lasting behaviour patterns, such as trying to camouflage their imagined defect using clothes or make up and frequently checking their appearance in mirrors and reflecting surfaces (Phillips et al., 2005). BDD is therefore a distressing condition that can lead to severe impairment in social and/or occupational functioning (APA, 2000).

The development of BDD is assumed to be multifactorially determined (Wilhelm, 2006), with a complex interaction occurring between previous life experiences (e.g. teasing or bullying), biological factors (e.g. genetics) and personality traits (e.g.

perfectionism). Cognitive behavioural models of BDD describe certain personality traits as risk factors that predispose an individual to BDD. Perfectionism is one of these personality traits, and in the models by Veale (2004) and Wilhelm (2006) it is considered to be an unspecific vulnerability factor for the development of BDD. Perfectionism leads to an individual setting high standards and to being extremely critical of themselves (Frost and Marten, 1990). Individuals with BDD are assumed to think and behave in a more perfectionistic way than other people, therefore it is speculated that they notice even minor flaws and intensify their focus on them, leading to bad feelings and distress when they are unable to tolerate their imperfections (Wilhelm, 2006). More recent research found that persons with BDD obtained higher scores for perfectionism than healthy controls (Buhlmann et al., 2008) and perfectionism was also found to be a relevant predictor for dysmorphic concerns in university students (Bartsch, 2007). However, research on perfectionism in BDD is scarce, with there only being two known studies that have investigated it in small and selected samples (Bartsch, 2007; Buhlmann et al., 2008).

In addition to perfectionism, Veale (2004) considers aesthetic sensitivity to be a further risk factor for BDD. According to his cognitive behavioural model, aesthetic sensitivity is a specific risk

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factor for the development of BDD. It may play an important role in the development of BDD, as being more aesthetically sensitive, individuals with BDD demonstrate greater aesthetic skills and set higher aesthetic standards (Veale et al., 2002). Aesthetic sensitivity is based on Harris' concept of "aestheticity" (Harris, 1982), which suggests that individuals differ in their view of beauty due to variability in the aesthetic sensitivity. The sense of "aestheticity" is presumed to be inborn and is comparable with musicality, a trait that also varies a lot between individuals. Individuals "with a highly developed sense of aestheticity are more self-conscious of abnormalities of appearance" (Harris, 1982, p. 284), which can lead to a permanent feeling of irritation and, by focusing on these symptoms, even BDD.

Lambrou et al. (2011) proposed an aesthetic sensitivity model that distinguishes three components: aesthetic perceptual sensitivity, aesthetic emotional sensitivity and aesthetic evaluations. When testing their model on individuals with BDD in comparison to controls, they found that the BDD group displayed a distorted emotional/evaluative processing, but showed a high perceptual sensitivity. Generally, individuals with BDD seemed to have a more critical eye and more appreciation of aesthetics than controls. Previous studies focusing on components of aesthetic perceptual sensitivity obtained mixed results. Stangier et al. (2008) found that individuals with BDD have a superior perception of aesthetic features, discriminating facial appearance stimuli more accurately than controls, whereas Reese et al. (2010) found no evidence for higher perceptual accuracy in the BDD group. Aesthetic sensitivity in BDD in all studies was examined using an experimental design focusing on a particular perceptual dimension, such as accuracy in perception (Stangier et al., 2008; Lambrou et al., 2011). However, aesthetic sensitivity as a characteristic of the BDD personality has not yet been directly examined. One way that aesthetic sensitivity could be assessed, which has currently not been done, is with the use of a self-report measure based on the aesthetic sensitivity model (Lambrou et al., 2011) with a focus on the component "aesthetic evaluations".

A further component of personality is the behavioural inhibition system (BIS) which is part of the behavioural inhibition/behavioural activation system proposed by Gray (1982). The two dimensions (BIS/BAS) are thought to be responsible for individual behaviour in emotional situations. The BIS in particular regulates aversive motivations, whereas the BAS regulates appetitive motivations. According to Gray, the BIS is sensitive to signals of punishment, nonreward and novel situations. It leads to raised attention, behavioural avoidance as well as behavioural inhibition. The extent of the behaviour is variable in accordance with individual levels of BIS reactivity that reflect individual anxiety proneness (Gray, 1982; Carver and White, 1994). Anxiety proneness is considered to be the cue factor that differentiates the BIS from neuroticism. A moderate correlation was found between BIS and neuroticism, but whereas neuroticism conceptualises negative emotionality, the BIS focuses on the sensitivities of anxiety proneness (Carver and White, 1994). In a longitudinal study the individual levels of BIS were found to be stable over time (Kasch et al., 2002). Johnson et al. (2003) confirmed in a population survey that extreme values of BIS were linked to a broad range of psychopathologies. In particular, individuals with a high BIS-reativity were found to be more vulnerable to depression and anxiety disorders. This result was also found in children. For example a 3-year-follow-up study found increased rates of childhood anxiety disorders among children who had been classified as behaviourally inhibited (Biederman et al., 1993). Behavioural inhibition seems to be a vulnerability factor that plays an important role in developing a psychopathological disturbance. Therefore, we speculate that the development of BDD is similarly influenced by behavioural inhibition as an unspecific risk factor.

Cohen et al. (2000) reported that patients with BDD showed a greater "personality impairment", which for example is reflected in less initiative or inhibition in self-organization. In another study patients with BDD showed higher values of harm avoidance (Mancuso et al., 2009), a personality trait which is associated with BIS (Carver and White, 1994). These findings indicate a presence of behavioural inhibition in individuals with BDD, but there has not been any study investigating directly BIS-reativity in individuals with BDD.

The aim of the study was therefore to examine specific and unspecific personality traits in individuals with BDD. To our knowledge research on personality factors in BDD is scarce. Findings of previous studies are based on selected or small clinical samples (Bartsch, 2007; Buhlmann et al., 2008). Personality factors have not yet been assessed in individuals with BDD recruited from a representative sample of the general population. This is the first study that employs a representative population sample with different age groups and socio-economic features to examine personality factors in BDD. A further advantage of the present research design is that it allows limiting the possible bias resulting from clinical samples. Based on cognitive behavioural models of BDD and previous findings, we hypothesised that there would be higher degrees of perfectionism and aesthetic sensitivity in individuals with BDD, in comparison to a population based control sample. We also expected higher degrees of behavioural inhibition in individuals with BDD. In addition, we wanted to assess the association between these personality traits and the extent of the dysmorphic concerns, predicting that higher values of personality traits would be accompanied with a greater extent of dysmorphic concerns.

## 2. Methods

### 2.1. Design and subjects

The University of Erlangen-Nuernberg initiated a cross-sectional self-report survey of a randomly selected sample of the German general population under the topic "Healthiness in Germany". It was conducted with the assistance of an independent demographic consulting agency (USUMA, Berlin, Germany). Subjects aged between 18 and 65 years from all over Germany were contacted from May to June 2011 and underwent a computer assisted telephone interview. To select the sample, a "mixed-mode-method" was used. First, a sample was selected using the ADM-mastersample. In a second step, a random sample of households was chosen proportionally to the population density in the region. Third, a target subject of the household was randomly identified with the Kish selection grid. Overall a total of 4212 persons were asked to complete the questionnaire either online or in written form. The recruited subjects corresponded similarly to the general German population with regard to age, gender and living area. Finally, 56% ( $n=2286$ ) of the selected sample agreed to participate in the study. Written informed consent was obtained from all participants. The population-based survey met the ethical guidelines of the International Code of Marketing and Social Research Practice by the International Chamber of Commerce and the European Society for Opinion and Marketing Research. Of the 2286 questionnaires, 157 had to be excluded from the analysis due to missing responses in the major instrument for BDD resulting in a total sample of 2129 participants. For the present study, the sample was further divided into two groups: subjects who met the criteria for BDD and those subjects who did not meet the criteria for BDD (assessment based on a self-report questionnaire). Fifty-eight subjects fulfilled the criteria of BDD (2.7%). The remaining 2071 subjects represented the population based control sample. The mean age of the BDD group was 42.7 years (S.D.=13.5), similar to the population based control sample which had a mean age of 45.3 years (S.D.=13.0). There was no significant difference between the groups for age. The groups differed significantly in gender distribution ( $\chi^2(1)=17.3, p<0.00$ ) and family status ( $\chi^2(2)=8.3, p<0.05$ ), with more BDD cases being female and single. Table 1 shows further clinical and demographic features of the two groups.

The BDD group showed a mean value of  $M=8.95$  (S.D.=3.99) for the Dysmorphic Concern Questionnaire, which differed significantly from the population based control sample. The main concerns of the BDD group were focused on the skin, stomach and hair, which are the typical body parts of concern in individuals with BDD (Phillips et al., 2005).

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