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The phenomenology of self-reported body dysmorphic disorder by proxy

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Abstract

Body dysmorphic disorder by proxy (BDDBP), a preoccupation with a perceived defect in *another* person's appearance may represent a variant of BDD. However, BDDBP has received little empirical attention. We present here the phenomenology of 11 individuals with self-reported BDDBP. Participants completed an internet-based survey that assessed symptoms, psychosocial impact, and treatment history. Participants (8 females, 3 males) reported preoccupation with a wide array of individuals (e.g., spouse, stranger). Body parts of concern most commonly involved the face and head. Most participants spent several (e.g., 3–8) hours per day preoccupied by perceived defects in the person of concern (POC). All participants engaged in rituals to try to alleviate distress or improve the POC's appearance. Most avoided social/occupational activities, including contact with the POC. The impact of BDDBP was profound, particularly on relationships. Findings may help elucidate diagnostic criteria, course, and treatment.

Keywords

Body dysmorphic disorder; Body dysmorphic disorder by proxy; Dysmorphophobia; Obsessive compulsive spectrum; BDD

Introduction

Body dysmorphic disorder (BDD), a severe disorder characterized by preoccupation with an imagined or slight defect in one's physical appearance, affects an estimated 1.8–2.4% of the population (Buhlmann et al., 2010; Koran, Abujaoude, Large, & Serpe, 2008). A variant of BDD has been documented in which the primary preoccupation involves perceived imperfections of another person who looks normal ("body dysmorphic disorder by proxy"); however, to our knowledge, only five published case reports of body dysmorphic disorder by proxy (BDDBP) exist to date (Atiullah & Phillips, 2001; Godden, 1999; Josephson & Hollander, 1997; Laugharne, Upex, & Palazidou, 1998; Phillips, 2005). For example, Phillips (2005) described a woman who worried excessively about her daughter's "crooked" nose and tried "pushing on it to make it straight" (p. 67). Atiullah and Phillips (2001)

reported on a 63-year-old male so distressed by the belief he had caused his daughter's hair to thin that he committed suicide. These case reports underscore the distressing, impairing, and potentially fatal nature of BDDBP and the need for empirical investigation of its phenomenology.

BDDBP is not recognized as a unique diagnostic entity in the Diagnostic and Statistical Manual IV-TR (APA, 2000), and thus, may be conceptualized as a variant of BDD under the current nomenclature. Prevalence studies on BDDBP have not yet been done, and the lack of validated diagnostic criteria and assessment tools thwart further research efforts. Therefore, the first step in establishing criteria is a systematic survey to explore phenomenology of the disorder. Understanding the clinical features of BDDBP will help to inform future research and clinical efforts. We present here the phenomenology of 11 individuals with self-reported BDDBP. Given the exploratory nature of the current internet-based study, no formal a priori hypotheses were made. Rather, the objective of the current study was to explore the phenomenology of BDDBP, including symptoms, impairment, associated features, and treatment history.

Method

Participants

The Institutional Review Board approved all recruitment and study procedures. Participants were recruited online (e.g., advertisements on internet search engines and support group forums [e.g., BDDCentral.com]) and through flyers posted in the community. Recruitment materials provided a link to the survey, which operated from March 2010 to November 2010. Participants were included if they were 18 years or older, proficient in English, and had self-reported BDDBP (as indicated by a score of ≥ 20) on the Yale Brown Obsessive-Compulsive Scale Modified for BDD by Proxy (BDDBP-YBOCS; description below). Of the 368 responses received, 357 were ineligible for the following reasons: insufficient data to determine eligibility ($n = 303$); under age 18 ($n = 14$); insufficient English proficiency ($n = 1$); appearance concerns not primary ($n = 2$); BDDBP total score < 20 ($n = 17$). These inclusion/exclusion criteria were informed by comparable studies in BDD (e.g., Marques et al., 2011). Surveys containing invalid data ($n = 20$; e.g., duplicate surveys containing identical information on all items) were excluded from analyses. Thus, the final sample included 11 subjects.

Participants ranged in age from 21 to 49 years ($M = 32.3$, $SD = 10.9$). The majority were female (72.7%, $n = 8$) and Caucasian (72.7%, $n = 8$). Almost three-quarters (72.7%; $n = 8$) were single/never married. Fewer than half (36.4%, $n = 4$) were employed full-time. The sample was highly educated: 18.2% ($n = 2$) graduated college and 36.4% ($n = 4$) had completed at least some graduate training.

Procedure

All measures were completed through an anonymous online survey supported by SurveyMonkey (<http://www.surveymonkey.com>). Upon entering the survey, participants were directed to an informed consent page. The survey took approximately 45 minutes to

complete. For their participation, individuals received either a \$10 gift certificate or a self-help book. To prevent duplicate responses, only one survey could be submitted per unique IP address.

BDDBP Symptom Measures

The Yale-Brown Obsessive Compulsive Scale Modified for BDDBP (BDDBP-YBOCS) is a 12-item self-administered scale that rates the severity of BDDBP symptoms over the past week. It was used to determine eligibility and severity of BDDBP symptoms. The BDDBP-YBOCS was modified from the BDD-YBOCS (Phillips, Hollander, Rasmussen, & Aronowitz, 1997) and from the self-report Y-BOCS (Baer, 1992; Goodman, Price, Rasmussen, Mazure, Fleischman, & Hill, 1989). Each item is scored along a Likert scale ranging from 0 (*least extreme*) to 4 (*most extreme*), with higher total scores indicating more severe BDDBP symptoms (range 0–48). A score of ≥ 20 on the BDDBP-YBOCS was used to determine eligibility and was selected based on the scale threshold of the BDD-YBOCS that corresponds to a diagnosis of BDD (score of 20; Deckersbach, Wilhelm, Otto, Savage, & Buhlmann, 1998). Internal consistency was adequate in the current sample ($\alpha = .74$).

To our knowledge, no measures to assess BDDBP existed at the time of the study. Thus, we developed questions to assess: (1) factors influencing BDDBP onset and maintenance; (2) persons of concern; (3) body parts of concern; (4) BDDBP-related thoughts, behaviors, and feelings; (5) impact of BDDBP on interpersonal relationships (e.g., isolation); and (6) treatment history. Questions contained a combination of forced-choice (e.g., *Has anyone ever told you that your preoccupation with another's appearance is excessive?*) and open-ended (e.g., *Please describe your specific concern for each body part checked*) items.

Psychosocial Functioning and Associated Symptom Measures

The Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear, & Greist, 2002) assessed impaired functioning. Internal consistency was good in the current sample ($\alpha = .81$).

The Quality of Life Enjoyment and Satisfaction Questionnaire –Short Form (Q-LES-Q – SF; Endicott, Nee, & Harrison, 1993) measured quality of life. Internal consistency was excellent ($\alpha = .91$).

The Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995) measured symptoms of depression, anxiety, and stress. Internal consistency was excellent ($\alpha = .96$ total; $\alpha = .75$ anxiety; $\alpha = .94$ depression; $\alpha = .92$ stress).

Results

Data are reported for the final sample of subjects who met the aforementioned study criteria ($n = 11$). Means and standard deviations were calculated. A missing BDDBP-YBOCS total score was imputed if one question (<10%) was unanswered, by assigning the missing item the overall mean score (Shrive, Stuart, Quan, & Ghali, 2006). All analyses were conducted using the Statistical Package for the Social Sciences (SPSS), version 17.0.

Descriptive Characteristics

Individuals' scores on the BDDBP-YBOCS ranged from 22 to 39, with a mean score of 28.1 ($SD = 5.8$), indicating moderate severity.

Body parts and persons of concern—The primary body area of concern (i.e., area that causes the greatest amount of preoccupation/distress) most commonly involved the face, hair, and stomach (see Table 1). However, 10 of 11 participants were concerned with multiple body parts; other concerns also involved the face and head, including eyebrows, mouth, teeth, hair (e.g., unruly), and skin (e.g., acne/scarring). The primary person of concern (POC; i.e., person whose perceived flaws causes the greatest amount of preoccupation/distress) also varied widely, but most often involved a significant other (e.g., spouse, partner) or a stranger. Other POCs included a child, parent, or sibling. Subjects who reported themselves as the POC ($n = 2$) appear to have BDD and were only included because they also reported preoccupation with others. Most reported preoccupation with multiple people ($M = 5.36$, $SD = 3.8$).

BDDBP related beliefs—Most participants ($n = 6$) reported spending several (e.g., 3–8) hours per day obsessing over others' appearance defects. Maladaptive beliefs were prominent. For example, participants endorsed beliefs about the importance of the POC's appearance in determining self-worth (e.g., "If his/her appearance is defective, he/she is worthless/unlovable"), selective attention (e.g., "The first thing people notice about him/her is what's wrong with his/her appearance"), and perfectionism (e.g., "He/she looks abnormal/defective"). Furthermore, participants described perceived defects in the POC relative to their own self-worth ("If his/her appearance is defective, I am worthless/unlovable") and happiness ("If he/she just looked the way I wish, I'd be much happier"). The majority (63.6–90.9%) reported ideas/delusions of reference, believing that others are noticing, staring at, or talking about the POC's appearance. More than 80% of participants expressed guilt or shame about their preoccupation with the POC's appearance, and worried about hurting the POC emotionally and/or revealing their concerns involuntarily (e.g., blurting them out).

BDDBP related rituals and avoidance—All participants performed rituals in an effort improve the POC's appearance or to reduce their own distress (see Table 1). All participants compared the primary POC's appearance to the appearance of others, and the majority provided reassurance to the POC about his/her appearance.

Onset and Course

The mean age of onset for BDDBP symptoms was 11.78 years ($SD = 7.1$, $n = 9$) and factors associated with onset included puberty, trauma (e.g., sexual abuse), and sociocultural factors (e.g., "unrealistic expectations of beauty").

Impact on Relationships

Most participants ended a relationship due to BDDBP symptoms (81.8%, $n = 9$) and worried that their significant other would end a relationship if s/he became aware of the BDDBP (81.8%, $n = 9$). Indeed, 81.8% avoided relationships due to BDDBP. BDDBP contributed to

feelings of isolation (81.8%, $n = 9$), and most (81.8%, $n = 9$) believed that their relationship with a person with an appearance defect would cause rejection by others.

Psychosocial Impairment

Participants reported markedly poor work and social functioning due to BDDBP symptoms. The mean impairment score on the WSAS (26.3, $SD = 6.8$) was higher than previously-cited WSAS scores among patients with depression (24.8, $SD = 7.3$; Mundt, Clarke, Burroughs, Brennenman, & Greist, 2001). A Pearson correlation revealed that WSAS impairment increased significantly with symptom severity ($r = .62$, $p = .04$, two-tailed).

Associated Symptoms

The majority of the participants had good to fair insight, indicated by Item #11 on the BDDBP-YBOCS ($M = 1.5$, $SD = 1.2$); 45.5% and reported a definite ($n = 3$) or probable ($n = 2$) psychological or psychiatric cause for their beliefs; 54.5% thought a psychological or psychiatric basis for their beliefs was possible ($n = 3$) or not probable ($n = 3$).

Participants reported significant anxious and depressive symptoms, as indicated by subscales of the DASS [DASS Anxiety $M = 21.5$ (9.1); DASS Depression $M = 26.2$ (12.7); DASS Stress $M = 25.5$ (10.0)]. Quality of life (percentage maximum of total score on the Q-LES-Q-SF) was poorer [$M = 44.0$ (18.4)] than has been reported in patients with BDD [$n = 126$, $M = 49.9$ (16.4)] and other psychiatric disorders (e.g., MDD, OCD, social phobia, panic disorder, PTSD; Phillips, Menard, Fay, & Pagano, 2005).

Treatment Utilization

On average, participants reported a gap of 9.6 years between the mean age of onset and seeking treatment. Of note, most (81.8%, $n = 9$) had sought treatment specifically for BDDBP symptoms. Most received talk therapy (72.7%, $n = 8$), and less than half received cognitive-behavioral therapy (45.5%, $n = 5$). One participant received eye movement desensitization and reprocessing. About one-quarter (27.3%; $n = 3$) never sought or received psychosocial treatment for BDDBP. More than half (55.6%) reported current treatment with medication (e.g., SRIs and benzodiazepines). Of those who sought treatment, participants first saw a psychiatrist (33.3%) or primary care physician (22.2%).

Discussion

To our knowledge, this is the first study to systematically evaluate the clinical picture of BDDBP. BDDBP appears to share core phenomenological features with BDD, including preoccupation with imagined or slight defects in physical appearance, rituals, and avoidance behavior. The most salient discriminating feature between BDD and BDDBP is the primary focus of preoccupation (i.e., oneself in BDD and another person in BDDBP).

Earlier reports described dysmorphic concern focused on the appearance of one's child (Atiullah & Phillips, 2001; Godden, 1999; Josephson & Hollander, 1997; Phillips, 2005) or significant other (Josephson & Hollander, 1997; Laugharne et al., 1998). Results from the current study suggest that BDDBP may be more heterogeneous. Our participants reported

concern with a wide array of individuals, and, on average, were concerned with at least five people. At least two participants reported current concern about their own appearance in addition to concerns about the appearance of others, which underscores the overlap in symptomatology between BDD and BDDBP. Similar to BDD (Phillips & Diaz, 1997; Phillips, Menard, Fay, & Weisberg, 2005), the most common areas of concern involved the skin and hair. The emergence of BDDBP in individuals previously concerned with his or her own appearance is consistent with some prior findings (Atiullah & Phillips, 2001; Josephson & Hollander, 1997) and raises the question of whether BDDBP may represent a variant of core BDD pathology (Josephson & Hollander, 1997). Interestingly, in the current study, the average age of onset [range: 4–25 years of age, $M = 11.8$ (7.1)] was earlier than has been reported in BDD [$M = 16.4$ (7.0); Phillips, Menard, Fay, et al., 2005; Phillips, Menard, Fay, et al., 2005]. However, further empirical investigation is needed to better understand the relationship of BDDBP to BDD and the obsessive compulsive spectrum.

In light of the study's conclusions, several methodological limitations must be considered. Internet studies have many strengths, including providing anonymity to a severely ill population who may avoid seeking treatment due to shame/embarrassment about the condition (Woods et al., 2006); however, the medium inherently excludes individuals without computer access. Also, despite the structured nature of the survey, the self-report method precludes confirmation of a diagnosis. Follow-up studies with an in-person interview are needed to better ascertain diagnostic criteria and comorbidity and to confirm whether the POC's physical defects actually exist. Poor insight is a common and often prominent feature of BDD, yet, the majority of participants in this exploratory study reported relatively good insight. There is much to be learned about the nature of insight in BDDBP; it is possible that the methodology used to assess insight (one-item from the self-report BDDYBOCS) was not sufficiently sensitive or reliable to adequately capture this complex construct. A multi-dimensional and/or clinician-administered interview may better assess insight.

Two participants reported themselves as the POC, and therefore might have had BDD; however, these participants also reported excessive concern with another's appearance, and thus also seemed to suffer from BDDBP. Given the paucity of research on BDDBP and the overlap in features between BDD and BDDBP, we retained these participants in the current analyses. However, future research must clarify the relationship between BDD and BDDBP. A better understanding of BDDBP's clinical features and treatment response could help to inform its conceptualization (i.e., as a unique diagnostic entity within the obsessive compulsive spectrum or as a variant of BDD) and identify steps for further research. The small sample size may limit generalizability and the power of statistical findings. However, to our knowledge this represents the largest systematic description of the phenomenology of BDDBP. A broad epidemiological study, utilizing standardized screening and diagnostic criteria, is needed to help determine the prevalence and phenomenology of BDDBP in the population.

The lack of standardized screening and diagnostic criteria for BDDBP has been a limiting factor in identifying its prevalence and phenomenology. Future research is needed to fully

understand the relationship of BDDBP to BDD and other OC spectrum disorders, and to establish standardized criteria for the assessment of BDDBP.

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Table 1

Clinical characteristics of BDDBP.

Variable	BDDBP (N = 11)	
	N	%
Primary parts of concern		
Face	2	18.2
Hair	2	18.2
Stomach	2	18.2
Feet	1	9.1
Hips	1	9.1
Nose	1	9.1
Skin	1	9.1
Teeth	1	9.1
Thighs	1	9.1
Common areas of concern ^a		
Teeth	10	90.9
Eyebrows	9	81.8
Mouth	9	81.8
Hair unruly	8	72.7
Hair not full enough	8	72.7
Hair thinning/balding	8	72.7
Skin (acne/scarring)	8	72.7
Skin (mark or blemish)	8	72.7
Person of greatest concern		
Significant other (e.g., spouse, partner)	3	27.3
Stranger	3	27.3
Self	2	18.2
Child	1	9.1
Parent	1	9.1
Sibling	1	9.1
Rituals – self-focused ^a		
Scrutinizing/comparing others' appearance	11	100
Other (e.g., checking body parts of concern)	11	100
Providing reassurance about how others look	8	72.7
Researching/reading about parts of concern	8	72.7
Taking others shopping for appearance-related items (e.g., makeup)	8	72.7
Telling others about your concerns with their appearance ^b	6	60.0
Rituals – other-focused ^{a,c}		
Grooming	10	90.9
Skin picking	3	27.3
Measuring body parts	6	60.0

Variable	BDDBP (<i>N</i> = 11)	
	<i>N</i>	%
Dieting	9	81.8
Changing clothing	10	90.9
Exercising/weightlifting	9	81.8
Tanning	3	27.3
Surgical procedures	6	60.0
Dermatological procedures	6	60.0
Dental procedures	7	63.6
Camouflaging/hiding body parts	8	72.7

^a Participants were able to check all that apply; therefore, responses exceed 100%.

^b *n* = 10 due to missing data.

^c Do you recommend that others engage in these behaviors due to your concerns about their appearance?