



# 'Not just right' experiences and incompleteness in body dysmorphic disorder



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## ABSTRACT

The current studies examined the role of 'not just right' experiences (NJREs) and incompleteness (INC) in body dysmorphic disorder (BDD). In Study 1, a clinical BDD sample endorsed more severe NJREs than healthy controls, when controlling co-occurring symptoms of depression and anxiety. In Study 2, INC predicted reactivity to an *in vivo* task designed to evoke BDD-related concerns in an unselected sample. Study 3 demonstrated a positive relationship between INC and BDD symptom severity in a community sample. Study 4 examined *in vivo* sensory NJRE tasks and INC in a sample high and low in BDD symptoms. The high symptom group reported greater INC and reactivity to a visual NJRE task than their low symptom counterparts, when controlling for co-occurring symptoms of depression, anxiety, and OC symptoms. No group differences were observed for tasks assessing auditory and tactile NJREs. These studies demonstrate a unique relationship between INC/NJREs and BDD.

## 1. Introduction

'Not just right' experiences (NJREs) and feelings of incompleteness (INC) are sensory-perceptual disturbances which have been defined as uncomfortable sensations of imperfection, or perceptions that the environment (internal or external) is not as it *should* be (e.g., Coles et al., 2003; Rasmussen and Eisen, 1992; Summerfeldt, 2004). These two constructs are closely tied and often discussed interchangeably in the literature. However, some researchers have recently argued that NJREs refer to an induced *state* (i.e., internal sensation/discomfort), while INC reflects a more stable motivational *trait* involving tendencies to engage in repetitive/idiosyncratic behavior aimed to reduce or counteract feelings of imperfection (Belloch et al., 2016). As such, the two constructs largely differ in the way in which they are assessed, as NJRE measures such as the Not Just Right Experiences-Questionnaire-Revised (NJRE-Q-R; Coles et al., 2005) typically tap sensations evoked by these experiences, while INC measures such as the Obsessive-Compulsive Core Dimensions Questionnaire (OC-CDQ; Summerfeldt et al., 2014) target actions motivated by these experiences. Extant research suggests that these phenomena can be experienced across separate sensory modalities (e.g., looking, feeling, sounding 'right'; Rosário et al., 2009; Summerfeldt, 2004; Summers et al., 2014) and may be indicative of dysfunction of the sensory-affective system (Summerfeldt, 2004).

NJRE's and INC are generally thought to be vulnerability markers

that contribute to obsessive-compulsive disorder (OCD) symptomatology (Belloch et al., 2016) and are perhaps most commonly linked to ordering and arranging symptoms. The recently developed Dimensional Obsessive Compulsive Scale includes an assessment category that examines these constructs in tandem (i.e., "Concerns about Symmetry, Completeness, and the Need for Things to be 'Just Right'"; Abramowitz et al., 2010). INC/NJREs are also strongly related to other OC symptom clusters, including checking, washing, and obsessing (see Taylor et al., 2014, for a meta-analysis). Research further suggests that INC/NJREs are more strongly related to OCD features than symptoms of anxiety disorders or depression (Coles et al., 2003, 2005; Ghisi et al., 2010). For example, one recent study examined NJRE severity across disorders thought to share possible phenomenological, psychiatric comorbidity, and neurobiological features with OCD (i.e., hair-pulling disorder (HPD), eating disorders (ED), gambling disorder (GD); Sica et al., 2015). Across these groups, NJREs consistently showed positive associations with OC symptoms, with patterns of associations consistent with the primary clinical features of each respective disorder (i.e., mental neutralizing in OCD, obsessions in ED and GD, and checking in HPD).

Given the relationship between INC/NJREs and disorders closely related to OCD, it is also possible that these phenomena are relevant to body dysmorphic disorder (BDD). BDD is a disturbance of body image characterized by a distressing and/or impairing preoccupation with a perceived anomaly in one's physical appearance; these individuals

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engage in time consuming compulsive behaviors or mental acts in response to intrusive appearance-related thoughts (e.g., excessive grooming, mirror checking, camouflaging, skin picking, comparing with others; APA, 2013). The disorder is characterized by perceptual sensitivity to symmetry (Veale and Lambrou, 2002) and individuals with BDD commonly endorse appearance-related symmetry obsessions, such as concern about the symmetry of particular body parts (e.g., hair, breasts, eyes, face shape; Hart and Phillips, 2013). Of note, the extant OC literature has linked heightened preferences for visual symmetry to high trait INC (Summerfeldt et al., 2015). Clinical observations of these individuals also cite concerns with their appearance being ‘not right’ (Phillips, 2005, 2009) and suggest that BDD-related compulsions may be repetitively performed until the target aspect of their appearance is perceived as ‘right’ (e.g., excessively grooming hair or changing outfits until the ‘right’ look or feel is achieved; Baldock et al., 2010).

Individuals with BDD also tend to exhibit irregular visual processing styles that extend beyond symptom-relevant stimuli, showing preferences for localized/detail-oriented processing (e.g., attending to features of a face or object) over global processing (e.g., viewing the face or object as a whole; Feusner et al., 2010; Kerwin et al., 2014; Stangier et al., 2008). Thus, given the visual nature of the disorder and these individual’s sensitivity to symmetry, it seems that visual NJREs (i.e., things not *looking* ‘right’; e.g., disorganization or asymmetry) may be especially relevant to BDD. It is also possible that tactile NJREs (i.e., things not *feeling* ‘right’; e.g., certain textures) motivate compulsions in BDD.

Despite the potential relationship between INC/NJREs and BDD-related obsessions and rituals, the relevance of these phenomena to BDD symptoms has not yet received empirical attention. Thus, the purpose of the present studies was to examine this. In addition to utilizing traditional self-report measures, we sought to incorporate behavioral tasks, as retrospective self-report measures can be imprecise and reliance on relationships between multiple self-report assessments raises concerns related to common-method variance. Further, we included depression and trait anxiety as covariates in our analyses, as this would provide information about the specificity of these phenomena to BDD beyond negative affectivity.

Four studies were conducted. Study 1 aimed to compare self-reported NJREs between a clinical BDD sample and healthy controls; we predicted that the clinical BDD group would report greater tendencies to experience NJREs than their healthy control counterparts. Study 2 aimed to examine the relationship between INC and reactivity to an *in vivo* appearance-related stressor designed to evoke BDD-related concerns (having their picture taken from different angles) in an unselected sample; we hypothesized that INC would predict reactivity to this task. Study 3 aimed to examine the relationship between self-reported INC and BDD symptoms in a community sample; we predicted a positive relationship between these variables. Finally, Study 4 aimed to compare self-reported INC and reactivity to four *in vivo* tasks designed to elicit NJREs specific to certain sensory modalities (i.e., visual, tactile, auditory) between students low versus high in BDD symptoms. We predicted that the high symptom group would endorse greater INC and visual NJREs than their low symptom counterparts; in this study, we also considered whether co-occurring non-symmetry OC symptoms would explain these relationships. Use of varied samples (unselected, community, clinical) and assessment approaches (dispositional, *in vivo* reactivity) allows for replication of effects and could provide stronger evidence for the consistency of observed relationships.

## 2. Study 1

### 2.1. 1. Methods

#### 2.1.1. Participants and procedure

Participants were recruited via undergraduate psychology courses at a large university in the southeastern United States. Informed consent was obtained from all study participants before completing clinical interviews and questionnaires.

The clinical BDD group ( $N=28$ ) was recruited as part of a larger randomized control trial; current study measures were administered prior to these participants beginning treatment. Prospective clinical participants completed an online screener composed of the first three questions of the Yale Brown Obsessive-Compulsive Scale Modified for BDD (BDD-YBOCS; Phillips et al., 1997). These questions map on to the DSM-IV-TR diagnostic criteria; individuals who reported spending at least one hour a day thinking about a perceived physical flaw *and* endorsed at least a “moderate” level of interference *or* disturbance resulting from these thoughts were invited to complete a lab assessment. These individuals were interviewed using the BDD module of the Structured Clinical Interview for DSM-IV–Inpatient Edition (SCID-I/P; First et al., 1995) to confirm BDD diagnosis and the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 2006) to assess for the presence of comorbid diagnoses. Clinical interviews were conducted by the principal investigator (first author) and audio recorded; the interviewer was trained in diagnostics and attended BDD workshops prior to beginning the project. An advanced graduate student independently reviewed a random selection of the interviews ( $N=8$ ); average percentage agreement was 96.9%, and average Kappa was .90 (range of Kappas was .60–1).

The clinical group was composed of individuals who met criteria for a diagnosis of BDD, as assessed by the SCID DSM-IV edition, and also endorsed engaging in compulsive behaviors (e.g., excessive grooming, mirror checking) or mental acts (e.g., comparing self to others) related to their appearance concerns (corresponding to DSM-5 criteria; APA, 2013). Further, to be included in the clinical group, participants also needed a score of 16 or higher on the 10-item BDD-YBOCS-SR (consistent with widely used cut point of 16 on the YBOCS to determine the presence of OCD). Of note, all of the participants in the clinical group scored well above this cutoff ( $range=20–33$ ). For descriptive purposes, the clinical sample was also administered the additional two items of the BDD-YBOCS assessing insight and appearance-related avoidance; scores on the full 12-item BDD-YBOCS revealed moderate to severe symptoms ( $M=28.50$ ;  $SD=4.30$ ;  $range=22–40$ ). The clinical sample was 71.4% female with ages ranging from 18 to 26 ( $M=19.21$ ,  $SD=1.85$ ); the ethnic make-up was: 64.3% Caucasian, 14.3% Hispanic, 14.3% African-American, and 7.1% Asian or Pacific Islander. Comorbidity percentages and primary body area of concern are presented in Table 1.

The non-clinical healthy control group ( $N=26$ ) completed questionnaires as part of a separate investigation examining correlates and maintaining factors of mood and anxiety disorders. They were also administered the BDD module of the SCID; however, they only completed screener items of the MINI. They were identified as “healthy” if they did not endorse symptoms of BDD or any of the MINI screener items. The healthy sample was 80.8% female with ages ranging from 18 to 22 ( $M=19.08$ ,  $SD=1.06$ ); the ethnic make-up was: 80.8% Caucasian, 7.7% Hispanic, 7.7% Asian or Pacific Islander, and 3.8% other.

#### 2.1.2. Self-report measures

2.1.2.1. *Yale-Brown Obsessive Compulsive Scale modified for BDD-Self Report (BDD-YBOCS-SR; adapted from Phillips et al., 1997)*. The BDD-YBOCS is a modified version of the Yale-Brown Obsessive-Compulsive Scale (Goodman et al., 1989) that assesses the severity of

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