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Short communication

Relative relationships of general shame and body shame with body dysmorphic phenomenology and psychosocial outcomes

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ABSTRACT

Body Dysmorphic Disorder (BDD) is characterized by a preoccupation with a perceived flaw in appearance and repetitive avoidance behaviors. BDD involves severe psychosocial outcomes (e.g., depression, suicidality, functional impairment). Identifying correlates of BDD symptoms and outcomes can inform treatment. Shame, a painful emotion felt in response to critical self-judgment, may be one key correlate. However, research on shame in BDD is scarce and previous studies have not distinguished general shame from body shame. This study examines the relative relationships between body shame and general shame with body dysmorphic phenomenology and psychosocial outcomes. Participants (N = 184) were recruited online via BDD organizations and completed a survey. Path analysis was used to examine associations between body and general shame with 1) body dysmorphic phenomenology and 2) depression severity, suicide risk, and functional impairment. Both types of shame were differentially related to outcomes. Body shame was more strongly related to phenomenology, whereas general shame was more strongly related to psychosocial outcomes. Thus, it may be important for BDD treatment to focus on reducing both general and body shame. Further research should evaluate whether current treatments adequately address and reduce general and body shame, and whether addressing shame promotes better treatment outcomes.

1. Introduction

Body dysmorphic disorder (BDD) is a psychiatric disorder that involves a distressing preoccupation with an imagined or slight defect in one's physical appearance, accompanied by time-consuming rituals and impairing avoidance behaviors (American Psychiatric Association, 2013). BDD typically involves the experience of exaggerated appearance-related cognitions, such as the belief that "The first thing people notice about me is what's wrong with my appearance" (Wilhelm, Greenberg, Rosenfield, Kasarskis, & Blashill, 2016). Moreover, BDD often presents with severe psychosocial correlates. Comorbid major depressive disorder (MDD) occurs in 55–83% of individuals with BDD (Phillips et al., 2006; Phillips, Menard, Fay, & Weisberg, 2005). The majority (80%) of patients report lifetime suicidal ideation, and approximately one quarter of patients (24–28%) have made a suicide attempt (Phillips, 2007; Phillips et al., 2005, 2006; Veale et al., 1996). BDD patients also experience functional impairment, including social dysfunction in nearly all patients (Phillips, & Diaz, 1997; Phillips et al., 2006), unemployment rates (39–53%) that surpass those documented in patients with MDD or obsessive compulsive disorder (OCD) (Birnbaum et al., 2010; Didie, Menard, Stern, & Phillips, 2008; Frare, Perugi, Ruffolo, & Toni, 2004; Perugi et al., 1997; Veale et al., 1996), and lifetime housebound rates of 30% (Phillips et al., 2006).

To best understand and treat BDD, it is important to conduct research that focuses on identifying risk factors and correlates to body dysmorphic phenomenology and psychosocial outcomes. Clinical conceptualizations of BDD recognize shame as central to the disorder and its adverse outcomes (e.g., see review by Weingarden & Renshaw, 2015). In its earliest clinical documentation, BDD was described as "an obsession with shame of the body" (Janet, 1903). Research on the etiology of BDD points to childhood and adolescent factors that may engender elevated levels of shame in this population. In particular, individuals with BDD report more frequent childhood abuse (Didie et al., 2006; Neziroglu, Khemlani-Patel, & Yaryura-Tobias, 2006; Veale et al., 2015), as well as more frequent experiences of bullying (Buhlmann, Cook, Fama, & Wilhelm, 2007; Veale et al., 2015) compared to healthy control and clinical comparison groups. These stressful developmental events may increase risk for BDD and heightened shame-proneness.

Shame is a painful self-conscious emotion that is felt in response to

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critically judging oneself as worthless or bad (Tangney & Dearing, 2002). Cognitive behavioral models suggest that processing biases (e.g., selective attention to perceived flaws) and cognitive distortions (e.g., "if I do not look perfect, I will be rejected") common to BDD may elicit shame (Weingarden & Renshaw, 2015). In response to distressing feelings of shame, individuals with BDD may avoid situations that draw attention to the perceived flaw and engage in rituals like camouflaging body parts of concern. Shame also acts as a barrier that prevents individuals from seeking treatment for their BDD symptoms. Each of these maladaptive behavioral responses likely contributes to maintenance of BDD symptoms, as well as development and maintenance of depression, suicidal thoughts, and functional impairment. Over time, shame-driven core beliefs may also develop, such as "I am bad," and "I am worthless" (Tangney & Dearing, 2002), which serve to further maintain body dysmorphic symptoms and related impairment. Taken together, cognitive behavioral models suggest that shame may be a key risk factor for the severe presentation and psychosocial outcomes observed in BDD (Weingarden & Renshaw, 2015).

To date, however, the empirical literature on shame in BDD is scarce. One recent study demonstrated that individuals with BDD symptoms have higher levels of general shame-proneness compared to healthy controls, and that general shame predicts depressive severity and suicide risk, above and beyond anxiety severity (Weingarden et al., 2016). The existing research on shame in BDD has focused primarily on general shame, felt when one judges his or her whole self as broadly defective, bad, or worthless. However, shame is a multifaceted emotion, and our understanding of BDD and its treatment would be enhanced through information about which types of shame are most strongly related to body dysmorphic phenomenology and outcomes. Other types of shame implicated in BDD include body shame, shame about having a mental illness, and shame about specific symptoms (e.g., the need to perform "embarrassing" appearance rituals) (for a review of shame in BDD, see Weingarden & Renshaw, 2015). Body shame, which is an evaluation of oneself as bad or worthless because one's body is judged to be defective, bad, or worthless, is particularly likely to be central in BDD (Weingarden & Renshaw, 2015). However, to date little is known about the role of body shame, compared to general shame, in BDD. The present study aims to extend our knowledge of the relative relationships of body shame and general shame with body dysmorphic phenomenology (i.e., symptom severity and cognitions) (Aim 1) and adverse psychosocial outcomes (i.e., depressive severity, suicide risk, functional impairment) (Aim 2). Enhancing our understanding of the specific types of shame that are related to body dysmorphic phenomenology and outcomes may inform clinicians as to which shame experiences, specifically, should be targeted in psychological interventions for BDD.

2. Method

2.1. Participants

Adults with elevated body dysmorphic concerns were recruited through BDD organization websites (e.g., Massachusetts General Hospital BDD Clinical Research Program, International OCD Foundation). See Table 1 for the sample's demographic and descriptive characteristics. Inclusion criteria required participants to be at least 18 years old and meet self-reported diagnostic criteria for BDD on the Body Dysmorphic Disorder Questionnaire (BDDQ). Participants were excluded if they did not accurately answer two screening items designed to detect low data quality (see Procedures for more detail), or if they did not complete the primary study measures. Initially, 1399 people clicked the link to the survey. Of those, 1186 agreed to the Informed Consent and had only a single survey entry. Participants who were under age 18 or did not correctly answer two quality screening items (n = 234) were removed. Participants who did not meet inclusion criteria for the present study (n = 768) were also removed. Of note, the number of participants excluded in this step reflects that the broader data collected for the primary study (citation removed for blind review) recruited healthy control participants and participants with OCD symptoms in addition to those with body dysmorphic concerns. A final sample of 184 participants was obtained.

Table 1
Demographics and means (SDs) of primary variables.

Variable	%/ M (*SD*)
Age M (*SD*)	29.68 (*10.14*)
Gender (% female)	92.4
Relationship status:	
% Single, divorced, widowed	37.5
% Dating, cohabiting (unmarried)	39.7
% Married	22.8
Race	
% Caucasian	80.4
% African American/Black	2.7
% Asian	6.0
% Hispanic/Latino	6.5
% Another race	4.3
BDD-YBOCS M (*SD*)	22.75 (*5.85*)
SDS M (*SD*)	17.77 (*8.53*)
SBQ-R M (*SD*)	9.69 (*4.25*)
DASS-21 Depression M (*SD*)	24.33 (*11.86*)
DASS-21 Anxiety M (*SD*)	15.98 (*10.02*)

Note: BDD-YBOCS = Self-report (10-item) Yale-Brown Obsessive Compulsive Scale Modified for BDD; SDS = Sheehan Disability Scale; DASS-21 Depression = Depression Anxiety Stress Scale-21 depression subscale; SBQ-R = Suicide Behaviors Questionnaire-Revised.

2.2. Measures

2.2.1. BDDQ (Phillips, 1996)

The BDDQ is a dichotomous diagnostic measure for BDD, based on DSM-IV criteria. The BDDQ shows 100% sensitivity and 89% specificity in identifying BDD diagnoses in a clinical sample (Phillips, 1996). A qualitative item prompts participants for a description of their appearance concerns, which the first author used to exclude participants whose sole concerns were weight-based (i.e., potentially better accounted for by an eating disorder) or related to trichotillomania or skin picking disorder. A second coder (M.A.-level clinical psychology doctoral student) independently scored this item for inter-rater reliability, which indicated adequate agreement (κ = .68; Landis & Koch, 1977). The two coders discussed and resolved cases on which their ratings were discrepant, and the agreed-upon score was used.

2.2.2. Body Dysmorphic Disorder Symptom Scale (BDD-SS; Wilhelm et al., 2016)

The BDD-SS measures severity of BDD symptoms and phenomenology. In the present study, the cognitions subscale was used as a measure of severity of appearance-related distorted beliefs. The BDD-SS demonstrates strong psychometric properties (Wilhelm et al., 2016), and in the present study, internal consistency was strong (α = .95).

2.2.3. Test of Self-Conscious Affect-4 (TOSCA-4; Tangney et al., 2008)

The TOSCA-4 total shame score was used to measure proneness to general shame. The TOSCA-4 is a scenario-based self-report measure that describes 15 situations likely to evoke moral emotions (i.e., shame, guilt, externalization). Participants rate their likelihood of responding to the scenario in a number of ways (i.e., shame-driven, guilt-driven, externalization of blame-driven responses). Items do not name the emotion being assessed. Higher scores indicate greater general shame-proneness. Strong psychometric properties are reported for the TOSCA scales (Rusch et al., 2007; Woien, Ernst, Patock-Peckham, & Nagoshi, 2003), and the total shame scale demonstrated strong internal consistency in the present sample (α = .95).