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Escalation from normal appearance related intrusive cognitions to clinical preoccupations in Body Dysmorphic Disorder: A cross-sectional study

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ABSTRACT

Current cognitive approaches to Body Dysmorphic Disorder (BDD) assume that appearance-related intrusive cognitions and their functional consequences characterize the disorder, in a similar way that obsessive intrusive thoughts characterize the Obsessive-Compulsive Disorder (OCD). This study explores whether normal but unwanted appearance-related intrusive thoughts (AITs), escalate to clinical AITs when they are dysfunctionally appraised and instigate counterproductive neutralizing strategies. From a sample of 344 non-clinical individuals who reported a highly upsetting AIT during the past three months two subgroups were extracted according to their high (n = 68) and low (n = 276) vulnerability to BDD. The subjects in the high-risk group obtained significantly higher scores on the frequency of the most disturbing AIT and its emotional impact, interference, and appraisals evaluated with the Appearance Intrusions Questionnaire (AIQ). Additionally, two subgroups of 15 subjects each, with high and low risk to BDD, were formed and their scores were compared to 10 patients with BDD. The AIT had a greater emotional negative impact and more severe consequences on individuals with BDD compared to individuals at high-risk of BDD, which in turn, reported worse consequences of the AIT than those at low-risk. These results empirically support the similarities between BDD and OCD regarding their functional and phenomenological characteristics.

1. Introduction

Body Dysmorphic Disorder (BDD) is still an under-recognized and silent disorder (Fang and Wilhelm, 2015) characterized by excessive preoccupation about a perceived or slight defect in one's appearance. The preoccupations can be about any particular area of the body, although over the course of the disorder some patients may be concerned with everybody area (Wilhelm et al., 2013), whereas other patients may feel that their general physical appearance is "ugly" or deformed. Appearance preoccupations are not usually based on genuine or real defects, and if the defect does exist, it would not be especially noticeable to others. Patients are reluctant to discuss their appearance concerns, and this difficults to estimate its prevalence, since the rates range between 1.9% and 20.1%, depending on the context studied (Veale et al., 2016). Although patients may seek treatment for comorbid disorders, they tend to conceal their BDD symptoms, even to clinicians (Bjornsson et al., 2010; Wilhelm et al., 2010).

The preoccupations about physical appearance defects cause significant distress and impairment, are accompanied by feelings of shame and anxiety (Weingarden and Renshaw, 2015), and lead the individual to perform time-consuming and counterproductive behaviors that are usually repetitive, such as appearance checking and reassurance seeking (Eisen et al., 2004), in order to reduce anxiety and control the distressing preoccupations (Veale and Neziroglu, 2010). These characteristics of BDD parallel the symptoms of Obsessive Compulsive Disorder (OCD): obsessions, compulsions, and the functional relationship between them (Bjornsson et al., 2010). These similarities between the two disorders, along with others, such as comorbidity, course, and age of onset (e.g., Frare et al., 2004; Phillips et al., 2007), support the current inclusion of BDD within the obsessive compulsive and related disorders section of the Diagnostic and Statistical Manual of mental disorders, 5th Edition (DSM-5; American Psychiatric Association, 2013).

According to the cognitive model of OCD, obsessions arise from attaching personal significance to intrusive cognitions, defined as "repetitive, upsetting and unwanted thoughts, images or impulses that suddenly appear in consciousness and are considered irrational, unrealistic, foreign to one's character, and difficult to control" (Purdon and Clark, 1993, p. 715). BDD preoccupations have also been described as repetitive, excessive, intrusive, distressing, and difficult to

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resist and keep under control (e.g., Eisen et al., 2004; Lavell et al., 2014; Wilhelm et al., 2013). The cognitive model of OCD postulates that the occurrence of these intrusive cognitions could initiate a process of faulty appraisals, followed by neutralizing efforts, which in turn could spiral into the development of clinical obsessions. In fact, the differences between normal, although unwanted, intrusive thoughts with obsessional contents and clinical obsessions lie in the way people appraise the thoughts and react to them, but not in the mere experience of those intrusions and their contents (e.g., Clark, 2005; Rachman, 1997; Salkovskis, 1989). From a similar perspective, Wilhelm and Neziroglu (2002) argued that what distinguishes BDD patients from non-patients are not the thoughts about perceived appearance defects, or even the defects themselves, but the way patients react to them. Additionally, as Lavell et al. (2014) stated, BDD symptoms may be considered as dimensional rather than categorical, which also support the similarities between OCD and BDD regarding the escalation from normal intrusive cognitions and their associated consequences to clinical symptoms.

To date, several studies have examined some of these assumptions about BDD. For example, Onden-Lim and Grisham (2013) found that intrusive appearance-related images were common in non-clinical undergraduates, and that attempts to suppress them predicted dysmorphic concern. Giraldo-O'Meara and Belloch (2017a, b) reported that, as with intrusive thoughts with obsessional contents, preoccupations about perceived appearance defects have an intrusive nature, are nearly universal, and their frequency has a continuous or dimensional nature that ranges from normalcy to subthreshold BDD. Kollei and Martin (2014) found that individuals with BDD reported high levels of negative emotions in response to body-related cognitions. Lavell et al. (2014) examined, in undergraduate students, the role that dysfunctional beliefs that maintain OCD (e.g., OCCWG, 2001, 2005) play in BDD symptomatology. The authors found that BDD symptoms correlated with scores on intolerance to uncertainty and thought control beliefs. Regarding the neutralizing strategies, Hartmann et al. (2015) explored their role in participants with Anorexia Nervosa, BDD, and healthy controls, and they found that the clinical groups reported a stronger urge to do something about their thoughts and preoccupations about topics related to their respective disorder than non-clinical controls.

The studies described above support the similarities between OCD and BDD upsetting intrusive thoughts and their consequences, and partially underpin a link between appearance-related thoughts and the urge to engage in repetitive and time-consuming rituals to correct, fix, or hide the body parts that are the focus of preoccupation. However, as far as we know, none of those studies have examined whether the proposed cognitive model of BDD phenomenology actually parallels the OCD cognitive model. As said before, following the OCD cognitive proposals, the escalation from normal but unwanted obsessional intrusive thoughts into clinical obsessions is caused by the dysfunctional meaning that individuals ascribe to these intrusions, and then, the counterproductive neutralizing strategies aimed to keep them under control. Recently, Fang and Wilhelm (2015) presented a cognitive-behavioral model of BDD proposing that what distinguishes people with a normal body image from patients with BDD is the way patients respond to their negative thoughts about their appearance defects. This study aims to present data about this proposal, trying to examine if OCD and BDD share the same phenomenology. Therefore, we aimed to explore whether normal but unwanted appearance-related intrusive thoughts (AITs), defined as "repetitive and upsetting thoughts, images, impulses or feelings", escalate to BDD clinical AITs when they are dysfunctionally appraised and instigate neutralizing and/or control strategies to keep them under control. From this, we hypothesized that a highly upsetting AIT would have a lower impact (frequency, emotional distress, interference, faulty appraisals, and neutralizing strategies) in non-clinical individuals with low-risk of BDD compared to individuals at high-risk of and patients with BDD, which in turn, will show a higher impact regarding their AITs than those at high-risk of BDD individuals. Finding out data supporting this hypothesis might also confirm the dimensionality of BDD symptoms (Lavell et al., 2014), which makes non-clinical populations adequate to advance in the understanding of an underdiagnosed disorder as the BDD.

2. Method

2.1. Participants

Two different samples participated in the study: a non-clinical sample, and a group of patients with BDD. The initial non-clinical sample consisted of 583 participants (71.6% women; mean age = 29.80, *SD* = 13.23 years; range = 18–60 years). The majority were single (64.5%) and had a medium (67.1%) socioeconomic level. Regarding education, 25.7% had completed high school (14 years of education), 45% were undergraduate University students, and 29.3% had completed University studies. From this initial sample, 344 (59.10%) participants (76.5% women; mean age = 27.05 *SD* = 11.01 years) reported having experienced a highly upsetting AIT during the past three months. Therefore, only the data from those subjects were considered for analyses to minimize response biases given the retrospective nature of the study. In this group 68 (19.76%) individuals (55 women; mean age = 22.68, *SD* = 5.63 years) met the Body Dysmorphic Disorder Questionnaire (BDDQ; Phillips et al., 1995) criteria for BDD. The BDDQ, which is described below, has been used as a screening instrument in other studies with non-clinical samples (e.g., Phillips et al., 2000; Schneider et al., 2017).

The clinical sample consisted of 10 subjects (5 females) with a primary diagnosis of BDD according to the DSM-5 (American Psychiatric Association, 2013), which were recruited from two outpatient mental-health settings. Before being included in the study, all potential participants were individually screened by full history and examination by one of the authors with doctoral level clinical psychology (AB), who decided to include the patient in the study on the basis of the following criteria: (a) to have a main diagnosis of BDD without current co-morbid conditions (DSM-5 criteria); (b) age range from 18 to 65 years; (c) not to have past or current history of psychotic and/or alcohol/drugs-related disorders; (d) to have an adequate level of reading ability; e) not to have received psychological treatment or pharmacotherapy for their disorder in the past year. The diagnoses were confirmed by the structured clinical interview for DSM-IV (SCID; First et al., 1995). The severity of BDD was between moderate and high following the Yale-Brown Obsessive-Compulsive Scale modified for body dysmorphic disorder (BDD-YBOCS) (Phillips et al., 1997): Mean = 29.11 (*SD* = 4.67). The mean duration of their disorder was 6.38 (*SD* = 2.06) years, and the mean age of onset was 18.72 (*SD* = 3.21) years.

In order to test our hypothesis, a subgroup of 30 subjects from the non-clinical sample who had experience a highly upsetting AIT during the past three months (n = 340) was extracted, following a simple random sampling strategy. Fifteen were from the 276 individuals at low-risk of BDD and 15 were from the 68 subjects at high-risk of the disorder. The three stablished groups (i.e., 15 subjects at low-risk of BDD, 15 subjects at high-risk of BDD, and 10 patients with BDD) did not differ on socio-demographic variables, with the only exception of socioeconomic level, where all the non-clinical subjects reported a medium socioeconomic level. Table 1 shows the main socio-demographic characteristics of the three groups and the differences among them.

2.2. Procedures

Non-clinical participants were recruited through advertisements at the University Campus requesting voluntarily participation in a study on beliefs and values about physical appearance. Potential participants