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Do obsessive beliefs predict body image disturbance?

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ABSTRACT

The controversial re-classification of body dysmorphic disorder with obsessive-compulsive disorder (OCD) in the Obsessive-Compulsive Related Disorders chapter of the latest diagnostic statistical manual was based primarily on neuropsychological research and theory. However, little research has examined the extent to which cognitive variables known to be important in the development and maintenance OCD (e.g., "obsessive beliefs") are related to body image disturbance (BID). The present study was designed to test the hypothesis that obsessive beliefs uniquely predict BID after controlling for other related variables. A total of 601 participants completed a battery of self-report measures of BID severity, obsessive beliefs, OCD symptoms, general distress, and pathological eating attitudes. As predicted, BID was positively correlated with all three obsessive belief domains. Contrary to hypotheses, only the need for perfectionism/certainty obsessive belief domain emerged as a significant unique predictor of BID. Limitations and potential implications for understanding, assessing, and treating BID-related conditions are discussed.

Body dysmorphic disorder (BDD) is a psychological condition that is characterized by excessive preoccupation with an imagined or slight defect in one's appearance that causes distress and functional impairment (American Psychiatric Association [APA], 2013). Common concerns include perceived flaws in the size, shape, or quality of one's skin, hair, muscles, face, thighs, or genitals. Such preoccupations are accompanied by anxiety or shame, as well as urges to perform certain "repetitive behaviors" such as mirror gazing (or mirror avoidance), excessive grooming or camouflaging the perceived defect, and seeking reassurance from others to alleviate distress (APA, 2013, p. 242). Although the prevalence of BDD is comparable among men and women (e.g., APA, 2013; Phillips & Castle, 2001; Phillips & Diaz, 1997), research indicates that there are gender-specific differences in appearance-related preoccupation (e.g., men are more likely to express concern about genitals and body build than are women; Phillips, Menard, Pagano, Fay, & Stout, 2006). Furthermore, some authors have argued that self-reporting of body image disturbance (BID) is more socially acceptable for women than for men, making it difficult to determine the gender distribution of BID-related conditions (e.g., Veale, Boocock, Gournay, & Dryden, 1996).

Historically, BDD has been difficult to classify within formal diagnostic systems because it shares a number of features with other conditions, including obsessive-compulsive disorder (OCD) and eating disorders (Cororve & Gleaves, 2001). In the most recent edition of the Diagnostic and Statistical Manual (DSM-5; APA, 2013), BDD has been re-categorized into the Obsessive-Compulsive and Related Disorders (OCRDs) chapter. Although not all experts agree with this reclassification (Mataix-Cols, Pertusa, & Leckman, 2007; Stein & Phillips, 2014), advocates for this change underscore shared factors in the etiology, course, and treatment of the two conditions as justification for their co-classification (e.g., Hollander, Friedberg, Wasserman, Yeh, & Iyengar, 2005). For instance, some researchers point to evidence suggesting common genetic vulnerability (e.g., Bienvenu, Samuels, Riddle, Hoehn-Saric, & Liang, 2000; Monzani et al., 2012) and neurocircuitry (Hollander, 2005) between OCD and BDD. Moreover, comparable prevalence rates (APA, 2013) and high comorbidity rates (as high as 30%; Gunstad & Phillips, 2003) between BDD and OCD provide additional support for their relatedness.

Critics (e.g., Abramowitz & Jacoby, 2015), however, argue that classification on the sole basis of putative biological similarities overlooks important empirically established characteristics of OCRDs. Accordingly, they assert that examining commonalities in psychological processes (e.g., dysfunctional beliefs; Beck, 1976) is a more clinically useful approach to understanding and treating OCRDs. Indeed, some researchers have observed similarities in the cardinal symptoms and cognitive processes thought to maintain BDD and OCD symptoms (e.g., Neziroglu, Wilhelm, & Knauz, 2001; Wilhelm & Neziroglu, 2002). For example, the subjective experience of preoccupation with imagined appearance defects in BDD has been likened to obsessional thoughts because appearance-related preoccupations (a) are experienced as

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uncontrollable and (b) have the ability to provoke distress and urges to avoid triggers and perform safety behaviors (e.g., Chosak et al., 2008), as is the case with OCD. Indeed, the DSM-5's definition of BDD-related "preoccupations"—intrusive, unwanted, time-consuming, and usually difficult to resist or control—is highly consistent with its description of an "obsession"—a recurrent and persistent thought, urge, or image that is experienced as intrusive or unwanted (APA, 2013). Nonetheless, despite the emerging evidence that BDD and OCD are related, few empirical studies have examined the extent to which they share cognitive vulnerabilities.

The importance of "obsessive beliefs" (i.e., dysfunctional appraisals about distressing thoughts) in the development and maintenance of OCD is well established (e.g., Wu & Carter, 2008). The Obsessive-Compulsive Cognitions Working Group (OCCWG, 1997, 2001, 2003, 2005) has emphasized three obsessive belief domains, including: (a) overestimating threat/responsibility for harm, (b) the importance of/need to control thoughts, and (c) the need for perfectionism/certainty. Consider a man with OCD who experiences obsessive doubts and checking rituals related to turning off household appliances. He might (a) overestimate the likelihood that he will forget to turn off the stove and cause a house fire, (b) interpret his obsessive doubts as "proof" that he lacks mental control, and (c) insist that the stove must be turned off in the "right way" to prevent harm. If BDD shares dysfunctional beliefs with OCD, this condition should also be associated with the aforementioned obsessive beliefs specifically related to appearance. To illustrate, a woman preoccupied with the shape of her lips might (a) overestimate the likelihood that someone will notice her perceived defect, (b) believe she should be able to control her preoccupation with her appearance, and (c) insist on grooming and camouflaging until her appearance is "just right."

As previously mentioned, research testing the hypothesis that individuals with OCD symptoms and BID exhibit common cognitive vulnerability factors is scant; moreover, studies directly testing the importance of obsessive beliefs in BID are limited to perfectionism—which does appear to be a cognitive process important to BID[1] (Hartmann, Thomas, Greenberg, Matheny, & Wilhelm, 2014; Schieber, Kollei, de Zwaan, Müller, & Martin, 2013). To illustrate, someone with BID might be prone to idealize the "perfect" appearance (i.e., over-value physical appearance and self-scrutinize perceived body defects). Supporting the notion that BDD and OCD share this cognitive vulnerability, research suggests that relative to community controls, OCD and BDD patients score higher on measures of perfectionism; yet these patient groups do not differ from each other in their level of perfectionism (Buhlmann, Etcoff, & Wilhelm, 2008). Similarly, the distress associated with perceived physical asymmetry in BDD (e.g., "uneven" eyebrows) resembles the anxiety provoked by asymmetry among those with OCD (e.g., touching something with the right hand, but not the left). Experimental research provides mixed support for this parallel. In one study, over 25% of BDD patients reported symmetry-related preoccupations, and these patients were more likely to have a lifetime diagnosis of OCD than were BDD patients without symmetry concerns (Hart & Phillips, 2013). In another study, however, symmetry detection ability and preference were equivalent among BDD patients, OCD patients, and healthy individuals (Reese, McNally, & Wilhelm, 2010).

No work to date, however, has investigated the relationship between BID and other obsessive belief domains such as threat overestimation/responsibility and the importance of/need to control thoughts. The present study was therefore designed to examine the degree to which obsessive beliefs predict BID after controlling for OCD symptoms and established BID-related cognitive factors; namely, general distress and eating attitudes (e.g., Feusner, Neziroglu, Wilhelm, Mancusi, & Bohond, 2010). In light of inconsistent findings related to BID gender distribution and gender-specific symptom presentation (e.g., Veale et al., 1996), we also controlled for gender. On the basis of growing research suggesting that BDD and OCD are closely related, we predicted positive associations between BID and all three obsessive belief domains. In light of work demonstrating a relationship between perfectionism and BDD, we further predicted that among the three obsessive belief domains, perfectionism/certainty would account for the greatest amount of unique variance in BID.

1. Method

1.1. Participants

We tested our hypotheses using a nonclinical sample given the dimensional structure of BID (e.g., Cash, Phillips, Santos, & Hrabosky, 2004), obsessive beliefs and OCD symptoms (Abramowitz et al., 2014), and dietary restraint (e.g., Holm-Denoma, Richey, & Joiner, 2010). A total of 601 undergraduate students at a large university in the southeastern United States participated in this study for course credit. Participation was open to all undergraduates enrolled in introductory psychology courses at the university during the data collection period. Approximately 1,800 undergraduate students may have been enrolled in introductory courses at the research site during this study period. Slightly more than half of the sample identified as female (n=331; 55.5%) with a mean age of 19.97 years old (SD=1.20, range 18–32). The majority of participants identified as white (n=429; 71.9%), with 10.9% (n=65) identifying as black, 9.2% (n=55) identifying as Asian, 5.2% (n=31) identifying as Hispanic/Latino, and 2.8% (n=17) identifying with another racial/ethnic group. Fifteen (2.5%) participants had a lifetime diagnosis of an eating disorder (nine [1.5%] reported a lifetime anorexia nervosa diagnosis, six [1%] reported a lifetime bulimia nervosa diagnosis, and two [< 1%] reported a lifetime binge eating disorder diagnosis; two [< 1%] participants reported a lifetime comorbidity of anorexia nervosa and bulimia nervosa).

1.2. Procedure

Upon electronically consenting to participate, respondents were directed to a survey link hosted by Qualtrics, a secure online survey development tool. Participants completed the measures described below in addition to a demographics questionnaire. This study was approved by the university's Institutional Review Board.

1.3. Measures

1.3.1. Body Image Disturbance Questionnaire (BIDQ; Cash et al., 2004)

The BIDQ is widely-used 7-item self-report BID screening measure derived from the validated Body Dysmorphic Disorder Questionnaire (Dufresne et al., 2001; Phillips, 2005). Participants rate the strength of their concerns and preoccupations with physical appearance, appearance-related distress, the effects of body image concerns on multiple aspects of functioning, and appearance-related avoidance behavior on a 1 (*not at all*) to 5 (*extremely*) scale. Higher scores indicate greater overall BID. Although the BIDQ has not been validated for use in BDD samples, it has demonstrated strong reliability and validity in nonclinical samples endorsing variable levels of BID (Cash et al., 2004). We therefore elected to use the BIDQ as our outcome measure given our use of a nonclinical sample in the present study. The BIDQ displayed good internal consistency in this sample (α=.89).

1.3.2. Obsessive Beliefs Questionnaire (OBQ-44; Obsessive Compulsive Cognitions Working Group [OCCWG], 2005)

The OBQ-44 is a 44-item self-report instrument that assesses

[1] Although not discussed here, research implicates several additional cognitive factors in the maintenance of BID other than obsessive beliefs, including information processing biases, rumination, and delusional beliefs (e.g., Buhlmann & Wilhelm, 2004; Veale, 2004)