

REVIEW ARTICLE

Body Image and Body Dysmorphic Concerns

Lucia TOMAS-ARAGONES and Servando E. MARRON

University of Zaragoza and Aragon Health Sciences Institute, Zaragoza, Spain

Most people would like to change something about their bodies and the way that they look, but for some it becomes an obsession. A healthy skin plays an important role in a person's physical and mental wellbeing, whereas a disfiguring appearance is associated with body image concerns. Skin diseases such as acne, psoriasis and vitiligo produce cosmetic disfigurement and patients suffering these and other visible skin conditions have an increased risk of depression, anxiety, feelings of stigmatization and self-harm ideation. Body image affects our emotions, thoughts, and behaviours in everyday life, but, above all, it influences our relationships. Furthermore, it has the potential to influence our quality of life. Promotion of positive body image is highly recommended, as it is important in improving people's quality of life, physical health, and health-related behaviours. Dermatologists have a key role in identifying body image concerns and offering patients possible treatment options. *Key words: body image; skin; body dysmorphic concerns; body dysmorphic disorder; appearance; self-esteem.*

Accepted Feb 16, 2016; Epub ahead of print Jun 9, 2016

Acta Derm Venereol 2016; Suppl 217: 47–50.

Lucia Tomas-Aragones, Faculty of Education, Calle Pedro Cerbuna 12, ES-50009 Zaragoza, Spain. E-mail: luciatomas@cop.es

Interest in body image (BI) has increased in recent years, and researchers from different disciplines have started studying factors that affect people's experiences of embodiment, as well as the impact of BI on behaviour.

There is no simple link between people's subjective experience of their bodies and what the outside observer perceives. The image the individual has of his or her body is largely determined by social experience. Research has suggested that most people have key reference groups that furnish social information relevant to BI (friends, family, media). Hence, as BI is socially constructed, it must be investigated and analyzed within its cultural context (1).

Most people wish to change something about their bodies and the way they look, but for some people it becomes an obsession. A freckle, a mole, the size of their nose, the symmetry of their ears, the size of their breasts, whatever the flaw or flaws, major or minor, real or misperceived, noticeable or not, they are life-consuming for people with body dysmorphic disorder (BDD) (2).

Where does normal stop and abnormal begin? Is there a normal? Ancient Mayans flattened infants' foreheads to make them prettier. In parts of China foot binding was practiced for almost a thousand years. For ages some cultures have valued stretched earlobes and necks. Not so long ago women permanently modified their waistlines and ribcages with corsets.

BI is something that impacts everyone's daily lives, whether in extreme ways, like those who have BDD, or in more subtle ways. BI is the subjective evaluation of one's appearance, and BI disturbance is an umbrella term that consists of several dimensions, including affective, cognitive, behavioural, and perceptual components. The ideal self-image may be considered as either an internal ideal or a social ideal, resulting from the dictates of the surrounding cultural and social environment as to what constitutes the perfect body (2).

THE SKIN

The skin is the largest organ of the body and serves as an important function in communicating with the world throughout the lifespan: attachment in the first years of life, self-image and self-esteem as we grow into adolescents and accepting its aging process as we get older. All these functions are highly influenced by emotional, social and psychological issues.

Metaphorically speaking, the skin is a door to physical and psychological problems and processes, and in order to understand the psychological consequences of cutaneous illness and to treat these effectively, there is a need to view the patient holistically, and to address the reciprocity between body and mind (3). Although it is said that "beauty is only skin deep", people respond positively to those who are attractive and negatively to those who are unattractive (4).

Skin diseases such as acne, psoriasis and vitiligo produce cosmetic disfigurement and patients suffering these and other visible skin conditions have an increased risk of depression, anxiety, BDD, feelings of stigmatization and self-harm ideation.

BODY IMAGE

BI development is a lifelong process, inevitably influenced by the significant others who play the most central roles at different times in our lives. Thus young

children may be most influenced by parents, whereas adolescents' BIs may be more affected by interactions with peers. Adults' BIs are likely to be influenced by romantic partners, who are often important sources of feedback and support (5).

A person's perception of his or her attractiveness is largely determined by social experience, and by prevailing cultural values (6). Western cultures prize smooth, unblemished skin and skin blemishes can lead to negative reactions from others which can impact on how people experience and evaluate their own attractiveness (7, 8). These effects can be more marked for women than for men due to greater social pressure on women to have flawless complexions. Negative impact would be expected to be greater on people with skin conditions in parts of the body that are more clearly visible in general social encounters (9).

Shame is central to the experience of BI and stigma, yet the concept of body shame has received less attention than BI. Some patients comment that although they know that other people do not notice or respond to their appearance, they have strong feelings of revulsion or disgust about themselves (internal shame). Others may feel that although other people have issues about their appearance, personally they are not ashamed of their appearance, but they maybe nevertheless worried by anticipated negative reactions of others (10).

BODY IMAGE AND SELF-ESTEEM

BI is defined as "a multidimensional construct encompassing self perceptions and attitudes regarding one's physical appearance". It is important for understanding fundamental issues of identity. BI concerns are significant to self-esteem. In fact, of all the personal attributes that influence the development of BI, self-esteem may be the most important. Self-esteem is an essential component of mental health, rising gradually until the age of 65 years and usually declining sharply after the age of 70 (11).

A positive self-concept may facilitate development of a positive evaluation of one's body and serve as a buffer against events that threaten one's BI. Conversely, poor self-esteem may heighten one's BI vulnerability. Perfectionism is another potentially influential personality trait that may lead the individual to invest self-worth in lofty or exacting physical ideals (5).

BODY DYSMORPHIC CONCERNS

Appearance concerns may relate to any part of the body, but often include the skin. Insight is sometimes poor and beliefs about appearance may be accompanied by delusional ideas. Visits to a dermatologist, a surgeon, or other medical specialist are common in people with body dysmorphic concerns (12).

Appearance concerns in acne patients

Acne is often un-aesthetic and can increase an individual's self-consciousness and lead to social stigmatization, resulting in social withdrawal, underachievement at school or work, and even serious psychological problems (13).

Teenagers are at high risk for BI impairments and the resulting loss of self-esteem. Healthcare providers should strive to identify patients whose quality of life (QoL) impairments are out of proportion with the severity of the disease. This will help to improve treatment adherence and QoL, to identify patients at high risk for depression and/or suicidal behaviours and, perhaps to minimize social avoidance behaviours in the long term (14).

Cutaneous body image dissatisfaction

Gupta & Gupta (15) refer to cutaneous body image (CBI) to describe an individual's mental perception of the appearance of his or her integumentary system. CBI dissatisfaction can contribute to significant morbidity in dermatologic disorders and is often the primary consideration in deciding whether to proceed with some cosmetic procedures. Assessment of CBI has important clinical implications because it can significantly affect the patient's QoL. CBI dissatisfaction can increase the overall morbidity in dermatologic disease and has been associated with intentional self-injury, such as self-induced dermatoses and suicide.

Aging and ageism

In the process of aging, we begin to lose strength, agility, speed, health, wit and beauty. Large doses of adaptation and acceptance are required to assimilate these changes, and coming to terms with a changed BI, can be rather traumatic for some individuals.

The social and cultural meanings of growing old are constantly changing in time, and being old nowadays has negative connotations. Old age is viewed as a medical and social problem that needs to be addressed. There is a high value placed by society on the maintenance of a youthful appearance and even the reversal of some of the aging-related bodily changes (16).

Aging lies within the spectrum of normal human experience, however aging of the appearance can adversely affect the QoL. Some of the psychosocial factors associated with aging skin include the effect of an aging appearance upon interpersonal interactions, which can lead to social anxiety, and social isolation. Excessive concerns about an aging appearance may be associated with BI disorders (16).

Ageism is socially constructed and reproduced at all levels of the society. Ageist practices harm everyone, not just elders. Currently, women of all ages receive anti-aging messages just by turning the pages of fashion magazines. These messages fuel a fear of natural pro-

cesses of aging, damage female self-esteem, and compel women to hide their true self behind extensive beauty work or engage in unhealthy dietary practices (17).

BODY DYSMORPHIC DISORDER

BDD is characterized by excessive concern and preoccupation with an imagined or a slight defect in bodily appearance that is not better accounted for by another mental disorder. The skin and the hair are common body areas of concern. The preoccupations caused by the appearance are intrusive, unwanted, time-consuming and difficult to resist or control. Time-consuming rituals include mirror gazing and constant comparing of their imagined ugliness with others. These patients often seek unnecessary dermatologic treatment and cosmetic surgery.

The newly published DSM-5 (18) classifies BDD in the obsessive-compulsive and related disorders (OCRDs) category. BDD has been included in this category due to similarities with obsessive-compulsive disorder (OCD), including repetitive behaviours, although BDD is characterized by poorer insight than OCD.

Insight, considered the degree of an individual's conviction in his or her disorder-relevant belief, is an important dimension of psychopathology across many mental health disorders. Insight regarding BDD beliefs can range from good to absent/delusional. On average, insight is poor; one third or more of individuals have delusional BDD beliefs. The risk of suicide is higher in patients with delusional beliefs (18). BDD patients hold their beliefs to a degree that they become delusional, however, the delusional intensity may vary and fluctuate significantly.

Rates of suicidal ideation and suicide attempts are high in individuals with BDD. Consequently, a risk assessment is always necessary. Suicide risk increases vastly if the patient considers to have come to the end of the line as far as possible treatment options are concerned. Explore patients' suicide ideation, as well as risk of self-harm.

Patients with BDD typically describe themselves as looking ugly, abnormal, deformed, or disfigured. Those with a delusional form of BDD are completely convinced that their view of their appearance is accurate, and the ones with a non-delusional type may recognize that their perceived deformities may not be accurate (19).

As appearance is believed to be very important, people with BDD perceive themselves as unattractive and they evaluate themselves negatively. These negative beliefs about their appearance often lead to anxiety, shame and sadness, which in turn lead to maladaptive coping strategies, such as excessive mirror gazing and/or avoidance behaviours. Sufferers of BDD often perceive themselves as vain when admitting how much importance they place on physical appearance, and the feeling of shame keeps them from talking about their worries (2).

INTERVENTION

Helping patients to define their problem

It is important not to make assumptions about the nature of the patient's problem and the way that it affects them. In doing this, there is a danger of over-emphasizing certain issues while ignoring others that may be more pertinent to the patient. In order to avoid making assumptions, the healthcare giver should allow the patient to explain what issues that are worrying him/her, and not assume that patients will be able to "open up" and discuss their feelings immediately; be patient and let them "set the pace".

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is a treatment grounded in the idea that our perception influences how we think and behave, and that psychological problems are acquired and altered through learning processes. Patients are helped to identify, challenge and modify the problematic thoughts and behaviour patterns that maintain their symptoms. CBT is adapted for each person and for his or her specific problem. This psychological intervention can be effective in reducing symptom severity, reducing psychological distress and increasing the ability to control and adjust to the skin condition (20).

Psychoeducation

Programs providing patients with detailed information about their skin disease, including aetiology, therapeutic options, and prognosis, can be helpful in enhancing compliance with treatment regimen. Additionally, psychoeducation directed at educating the patient with regard to common emotional reactions to their skin disease can be helpful in reducing the patient's sense of isolation (21).

Screening for body dysmorphic disorder in a dermatology setting

Generally speaking, there is a low level of awareness about BDD among health care professionals, and BDD is, thus, often overlooked. Direct questioning about appearance satisfaction is needed for the diagnosis, as these patients are often too ashamed to reveal the true nature of their problem. When they do seek help, they either consult a dermatologist or a cosmetic surgeon, and if they visit a doctor or a mental health care professional, they usually consult for other symptoms, such as depression or social phobia (21).

We need to bear in mind that people with BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms. Therefore, health care professionals should be especially sensitive when exploring the hidden distress and disability commonly associated with this disorder (22).

Clinicians should ask appearance-specific questions in order to identify patients who are suffering from BDD symptoms and to be able to offer information about their difficulties as well as treatment options.

Management of body dysmorphic disorder

Little research has been performed on the outcome of dermatologic treatment in patients with BDD. The dermatology literature informs that these patients can be difficult to treat and are often dissatisfied with and have a poor response to dermatologic treatment. In addition, these patients consult numerous physicians and pressure dermatologists to prescribe unsuitable and ineffective treatments (23).

One approach to treating patients with BDD is to change their appearance. However, this is not recommended as the altered appearance may fall short of patient expectations and fail to relieve the underlying problem. Consequently, the most important management is to help these patients to avoid surgical “corrections” (24).

In general, a physician who is empathetic and non-judgemental should not encounter difficulties in fostering a relationship with BDD patients.

With regards to psychological treatment, cognitive behavioural strategies have demonstrated efficacy. Wilhelm et al. (25), have recently published a modular cognitive-behavioural treatment manual specifically for BDD.

CONCLUSIONS

BI is a topic that has fascinated psychologists and neurologists for many years. It concern not only external and objective attributes but also subjective representations of physical appearance. Our image of our body plays a major role in how we feel, what we do, whom we meet, whom we marry, and what career path we choose.

Promotion of positive BI is highly recommended, as it is important in improving people’s QoL, physical health, and health-related behaviours. Dermatologists have a key role in identifying BI concerns and offering patients possible treatment options.

The authors declare no conflict of interest.

REFERENCES

- Grogan S. *Body image: understanding body dissatisfaction in men, women, and children*. London; New York: Routledge, 2008.
- Williams H. *Body image*. Farmington Hill, MI: Greenhaven Press, 2009.
- Papadopoulos L, Bor R. *Psychological approaches to dermatology*. Leicester: The British Psychological Society, 1999.
- Datta P, Panda A, Banerjee M. The pattern of appearance schema in patients with dermatological disorder. *Int J Ind Psychol* 2015; 2: 73–83.
- Cash TF, Pruzinsky T. *Body image: a handbook of theory, research, and clinical practice*. New York: Guilford Press, 2002.
- Thomson JK, Heinberg LJ, Altabe MN, Tantleff-Dunn S. *Exacting beauty: Theory, Assessment, and treatment of body image disturbance*. Washington DC: American Psychological Association, 1999.
- Gupta MA, Johnson AM, Gupta AK. The development of an acne quality of life scale: Reliability, validity and relation to subjective acne severity in mild to moderate acne vulgaris. *Acta Derm Venereol* 1998; 78: 451–456.
- Loney T, Standage M, Lewis S. Not just skin deep: Psychosocial effects of dermatological-related social anxiety in a sample of acne patients. *J Health Psychol* 2008; 13: 47–54.
- Kellett SC, Grawkrödger DJ. The psychological and emotional impact of acne and the effect of treatment with isotretinoin. *Br J Dermatol* 1999; 140: 273–282.
- Clare A, Thompson AR, Jankinson E, Rumsey N, Newell R. *CBT for Appearance Anxiety*. Chichester: John Wiley & Sons Ltd, 2014.
- Baker L, Gringart E. Body image and self-esteem in older adulthood. *Ageing Soc* 2009; 29: 977–995.
- Baldock E, Veale D. Body dysmorphic disorder. In: Bewley A, Taylor RE, Reichenberg JS, Magid M, editors. *Practical Psychodermatology*. Chichester: John Wiley & Sons Ltd, 2014: p. 127–133.
- Panconesi E, Hautmann G. Stress and emotions in skin diseases. In: Koo JY, Lee CS, editors. *Psychocutaneous Medicine*. New York: Marcel Dekker, 2003: p. 41–63.
- Feton-Danou N. Psychological impact of acne vulgaris. *Ann Dermatol Venereol* 2010; 137: S62–S65.
- Gupta MA, Gupta AK. Evaluation of cutaneous body image dissatisfaction in the dermatology patient. *Clin Dermatol* 2013; 31: 72–79.
- Ginn J, Arber S. Aging and cultural stereotypes of older women. In: Johnson J, Slater R, editors. *Ageing and later life*. London: Sage, 1993: p. 60–67.
- Lewis DC, Medvedev K, Seponski DM. Awakening to the desires of older women: Deconstructing ageism within fashion magazines. *J Aging Stud* 2011; 25: 101–109.
- American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, Fifth Edition*. Arlington, VA: American Psychiatric Publishing, 2013.
- Buhlmann U, Teachman BA, Naumann E, Fehlinger T, Rief W. The meaning of beauty: Implicit and explicit self-esteem and attractiveness beliefs in body dysmorphic disorder. *J Anxiety Disord* 2009; 23: 694–702.
- Shah RB. Psychological assessment intervention for people with skin disease. In: Bewley A, Taylor RE, Reichenberg JS, Magid M, editors. *Practical Psychodermatology*. Chichester: John Wiley & Sons Ltd, 2014: p. 40–49.
- Fried RD. Nonpharmacological treatments in psychodermatology. In: Koo JY, Lee CS, editors. *Psychocutaneous medicine*. New York: Marcel Dekker Inc, 2003: p. 411–426.
- Tomas-Aragones L, Marron SE. Body dysmorphic disorder in adolescents. In: Tareen RS, Greydanus DE, Jafferany M, Patel DR, Merrick J, editors. *Pediatric Psychodermatology: A Clinical Manual of Child and Adolescent Psychocutaneous Disorders*. Berlin; Boston: De Gruyter, 2013: p. 201–215.
- Castle DJ, Phillips KA, Dufresne RG. Body dysmorphic disorder and cosmetic dermatology: more than skin deep. *J Cosmet Dermatol* 2004; 3: 99–103.
- Hunt TJ, Thienhaus O, Ellwood A. The mirror lies: body dysmorphic disorder. *Am Fam Physician* 2008; 78: 217–222.
- Wilhelm S, Phillips KA, Didie E, Buhlmann U, Greenberg JL, Fama JM, et al. Modular cognitive-behavioral therapy for body dysmorphic disorder: A randomized controlled trial. *Behav Ther* 2014; 45: 314–327.