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EMOTIONAL AND PERSONALITY CHARACTERISTICS OF INDIVIDUALS PRONE TO BODY DYSMORPHIC DISORDER

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The article presents the results of theoretical analysis of the problem of dysmorphophobia in scientific literature and the results of the conducted empirical study. At the theoretical level the psychological features of self-relationship of persons prone to dysmorphophobia are analysed. On the basis of the analysis of empirical data it is revealed that there is a significant difference between the conditionally healthy group and the group with a strong tendency to dysmorphophobia, according to the following indicators: self-management, reflected self-relationship, self-acceptance and self-accusation. It is shown that within the framework of psychological counselling based on the principles and methods of cognitive-behavioural, narrative and body-oriented therapy, it is possible to reduce dysmorphophobic anxiety and improve the self-esteem of persons prone to dysmorphophobia.

Keywords: *body dysmorphophobia, body perception, self-relationship, self-acceptance, psychological counselling, cognitive-behavioural therapy, narrative therapy, body-oriented therapy*.

CARACTERISTICI EMOȚIONALE ȘI DE PERSONALITATE ALE PERSOANELOR LA TULBURARE DISMORFICĂ CORPORALĂ

Articolul prezintă rezultatele analizei teoretice a problemei dismorfofobiei în literatura științifică și rezultatele studiului empiric realizat. La nivel teoretic sunt analizate caracteristicile psihologice ale relației cu sine a persoanelor predispuse la dismorfofobie. Pe baza analizei datelor empirice, se arată că există o diferență semnificativă între grupul sănătos condiționat și grupul cu o tendință puternică la dismorfofobie, în funcție de următorii indicatori: autogestionarea, autorelaționarea reflectată, autoacceptarea și autoacuzarea. Se arată că, în cadrul consilierii psihologice bazate pe principiile și metodele terapiei cognitiv-comportamentale, narative și orientate spre corp, este posibilă reducerea anxietății dismorfofobice și îmbunătățirea autoaprecierii a persoanelor predispuse la dismorfofobie.

Cuvinte-cheie*: dismorfofobie corporală, percepție corporală, relaționare cu sine, autoacceptare, consiliere psihologică, terapie cognitiv-comportamentală, terapie narativă, terapie orientată spre corp*.

Introduction

The problem of body dysmorphic disorder (BDD) is becoming increasingly relevant in modern society. There is a steady increase in dissatisfaction among people in various areas of life, especially with their bodies: appearance, weight, and body proportions.

Special attention to the problem of dysmorphophobia by researchers of the late XX century was associated with the growing popularity of cosmetic procedures [4]. Dissatisfaction with oneself and one's body has long been a widespread phenomenon, and the 'socialisation and normalisation' of dysmorphophobia makes doctors, social workers and clinical psychologists pay attention to it. The relevance of psychological aspects of dysmorphophobia is also confirmed by statistical data reflecting the high prevalence of this disorder. According to the calculations of K.A. Phillips [15], the frequency of dysmorphophobia in the population is 0.7-2.4%, in general psychiatry samples - 13-16%, in dermatology - 9-12%, in cosmetic deontology - 9.5% and in orthodontics - 7.5%.

Beauty standards change every few years, often contradicting each other, and urging people to conform regardless of their physiological predispositions and current lifestyle. In pursuit of social approval, people are willing to give up their individuality, resort to severe diets, exhausting exercise, and even surgical intervention.

Representation of one's own appearance is a part of a person's thinking about himself and his place in society [5]. Appearance is an important formation in the structure of personality, its self-concept, influencing interpersonal and emotional spheres, as well as the course of objective life processes [2]. It is widely known that in our society slimness is associated with happiness, youth, life success, high social status, and overweight is associated with weakness, laziness, weak character and other negative traits. This is why many people tend to judge obese people as less happy, confident, intelligent and disciplined.

Conceptual base

Body dysmorphic disorder is a mental disorder accompanied by a sense of personal unattractiveness or the presence of a specific physical defect despite the objective absence of such evidence. Considering its high prevalence nowadays (17-29% of the population of both genders according to the latest data [10]), it is also important to note the impact of this disorder on the quality of life of those affected. As a result - refusal of education by schoolchildren and students, inability to find a job, financial problems, inability to start a family, and much more. This disorder can significantly affect a person's emotional and psychological state, leading to decreased self-esteem, anxiety, depression, and social isolation [16].

One of the characteristic symptoms of body dysmorphic disorder is the „mirror symptom", characterized by emotions of anger and rejection in response to one's reflection (to the point of wanting to destroy the mirror). This symptom also manifests in refusal to be photographed, looking at one's photos, or excessively editing them. During self-examination, a person with this diagnosis exhibits strong selective attention, focusing only on their imagined flaws and extending these perceptions to their overall appearance, ignoring their merits [11].

Mental health professionals note numerous potential causes of body dysmorphic disorder: past abuse (psychological, physical, and/or sexual), cold or overprotective parents, inappropriate attitudes towards appearance from one or both parents, negative evaluations of a person's appearance by their environment, and others. They also noted one common trait among all people with this disorder: special aesthetic sensitivity [20].

Traditionally, the treatment of body dysmorphic disorder involves a combination of cognitive-behavioral therapy and, if necessary, medication in the form of selective serotonin reuptake inhibitors [18].

An important aspect of therapeutic relationships with a client with body dysmorphic disorder is that the therapist should not spend much time trying to convince the client that they look good because the client has already heard this from others and will likely devalue it, relying primarily on their negative experience of evaluation from others (e.g., during bullying). The client's beliefs about their appearance must be validated by the therapist and discussed through Socratic dialogue, allowing the person with body dysmorphic disorder to explore the truth and objectivity of their judgments and test the alternative theory against existing experience [13].

An important element of cognitive-behavioral therapy for body dysmorphic disorder is working with the client's unrealistic and negative automatic thoughts and core beliefs, further replacing them with alternatives. This occurs through an automatic thoughts diary and cognitive restructuring processes, allowing questioning of the client's destructive psyche elements and testing them for realism [15].

The use of metaphors in communication with a client with body dysmorphic disorder helps shift the focus of their attention and view the problem from a new angle. In further therapeutic work, one can periodically return to the images presented in the metaphor, manipulating and projecting them onto the existing reality, thus simplifying problem analysis [9].

People with a diagnosis of body dysmorphic disorder often identify their appearance as closely related to a specific meaning and unpleasant early experience. Typical themes include teasing and bullying in school, insecurity about appearance changes or acne during adolescence, medical procedures, accidents, or sometimes sexual trauma. This circumstance prompts the therapist to explore some of the client's early memories using images from the time they first started feeling ugly or hu-

miliated. Jaycox L. H., Foa E. B, Morral A. R. [12] found that imagined exposure allows a person to associate the context with a safe environment and distinguish between traumatic and non-traumatic events. Ehlers A. and Clark D. M. [7] noted that challenging images of past trauma allows detailing memory fragments and providing them with context within the autobiographical foundation and broader knowledge of current experience. Through the process of transforming and clarifying traumatic material, clients with body dysmorphic disorder rid themselves of heightened fixation on these images and, consequently, on their body image associated with painful past episodes. For this, the rescripting method (a technique allowing intervention in traumatic memories using imagination) is applied.

In addition to the cognitive-behavioral approach, many studies have shown that exercises based on mindfulness principles (such as meditation) help people with body dysmorphic disorder reduce emotional responses to dysfunctional thoughts, lower stress, depression, and anxiety, and adjust the self-perception model [19].

Mindfulness training includes acquiring qualities considered fundamental for developing and strengthening self-compassion, especially for those suffering from appearance-related disorders who often experience its deficiency. Ferreira C., Pinto-Gouveia J., Duarte C. found that increased levels of self-compassion are associated with lower levels of body dissatisfaction and weaker tendencies towards eating disorders [8].

Self-attitude is a complex psychological phenomenon characterizing an individual’s position towards themselves [1]. However, it is important to distinguish between self-esteem and self-attitude as psychological concepts. Self-esteem represents the emotional evaluation of oneself by an individual in specific situations and within the context of certain activities, while self-attitude is a more stable and enduring formation reflecting the general tendency of a person to accept or reject themselves.

Despite the existence of numerous studies in the field of mental health, the topic of dysmorphophobic disorder is still considered understudied, which certainly affects the quality of psychological care provided to them.

Research Methodology

In the *framework* of our study, we emphasised on the research of self-relationship of persons prone to this disorder. *Purpose* of the study: To identify the peculiarities of self-relationship of people prone to dysmorphophobia.

Hypothesis of the study: there are peculiarities of self-relationship in persons prone to dysmorphophobia disorder.

In our research, the following methods were used: BDDQ-DV (The Body Dysmorphic Disorder Questionnaire-Dermatology version) [6], DCQ (Dysmorphic Concern Questionnaire) [14] and Method of Self-attitude research Пантилеев С.Р. [3].

The study sample consists of 70 people (51 women and 19 men). The unequal gender ratio is due to the absence of significant statistical differences in manifestations of dysmorphophobia in men and women. The sample has an age range from 16 to 63 years (29 people from 18 to 24 years, 23 people from 25 to 34, 15 people in the 35-45 group, 2 people in the 45-55 group and 1 person over 55 years).

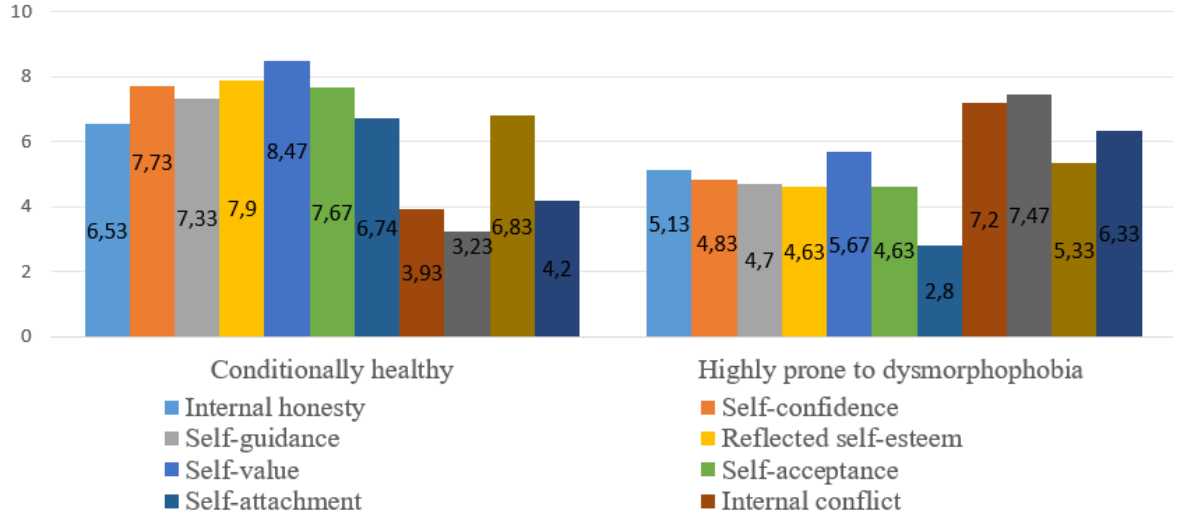
Results and Discussions

The test results revealed 30 conditionally healthy people, 10 people with a weak tendency to dysmorphophobia and 30 people with a strong tendency to dysmorphophobic disorder.

To solve the tasks of the study, we conducted a comparative analysis of the indicators of self-relationship of persons inclined and not inclined to dysmorphophobia.

The mean values of the Self-attitude methodology for the group of conditionally healthy and dysmorphophobic individuals are presented in Figure 1.

Figure 1. Comparison of indicators with a significant difference between the conditionally healthy group and the group with a strong proneness to dysmorphophobia.



In the statistical analysis, it was found that:

- There is a significant difference in the self-guidance indicator (md=2.633 Sig=0.000) between the conditionally healthy group (m=7.33 sd=1.184) and the group with a strong tendency towards body dysmorphic disorder (m=4.70 sd=2.215). This indicates that individuals with a high degree of body dysmorphic concern believe in the subjectivity of their „I" to temporary circumstances, their inability to resist fate, and also have poor self-regulation.

- There is a significant difference in the reflected self-attitude indicator (md=3.267 Sig=0.000) between the conditionally healthy group (m=7.90 sd=1.882) and the group with a strong tendency towards body dysmorphic disorder (m=4.63 sd=2.141): individuals with a high degree of body dysmorphic concern expect negative, disrespectful, and judgmental attitudes from others towards themselves.

- There is a significant difference in the self-acceptance indicator (md=3.033 Sig=0.000) between the conditionally healthy group (m=7.67 sd=1.093) and the group with a strong tendency towards body dysmorphic disorder (m=4.63 sd=2.566). This is due to the fact that individuals prone to body dysmorphic disorder do not accept themselves as they are. They have an unfriendly attitude towards themselves, do not accept their own desires and feelings.

- There is a significant difference in the self-esteem indicator (md=2.767 Sig=0.001) between the conditionally healthy group (m=6.70 sd=1.750) and the group with a strong tendency towards body dysmorphic disorder (m=3.93 sd=2.765): individuals prone to body dysmorphic disorder have an inflated self-esteem, which prevents them from self-developing. They experience exaggerated guilt and inferiority feelings.

- There is a significant difference in the self-understanding indicator (md=2.500 Sig=0.000) between the conditionally healthy group (m=7.13 sd=1.408) and the group with a strong tendency towards body dysmorphic disorder (m=4.63 sd=2.141). This indicates that individuals prone to body dysmorphic disorder have a lower level of self-knowledge, are poorly oriented in their feelings, emotions, and experiences, and do not know themselves well.

- There is a significant difference in the self-blame index (md=-4.233, Sig=0.000) between the conditionally healthy group (m=3.23, sd=1.591) and the group with a strong propensity for dysmorphophobic disorder (m=7.47, sd=2.063). This reiterates the importance of guilt as a component of the picture of a person's propensity for dysmorphophobic disorder. People with high dysmorphophobic anxiety tend to blame themselves for any of their lapses and failures.

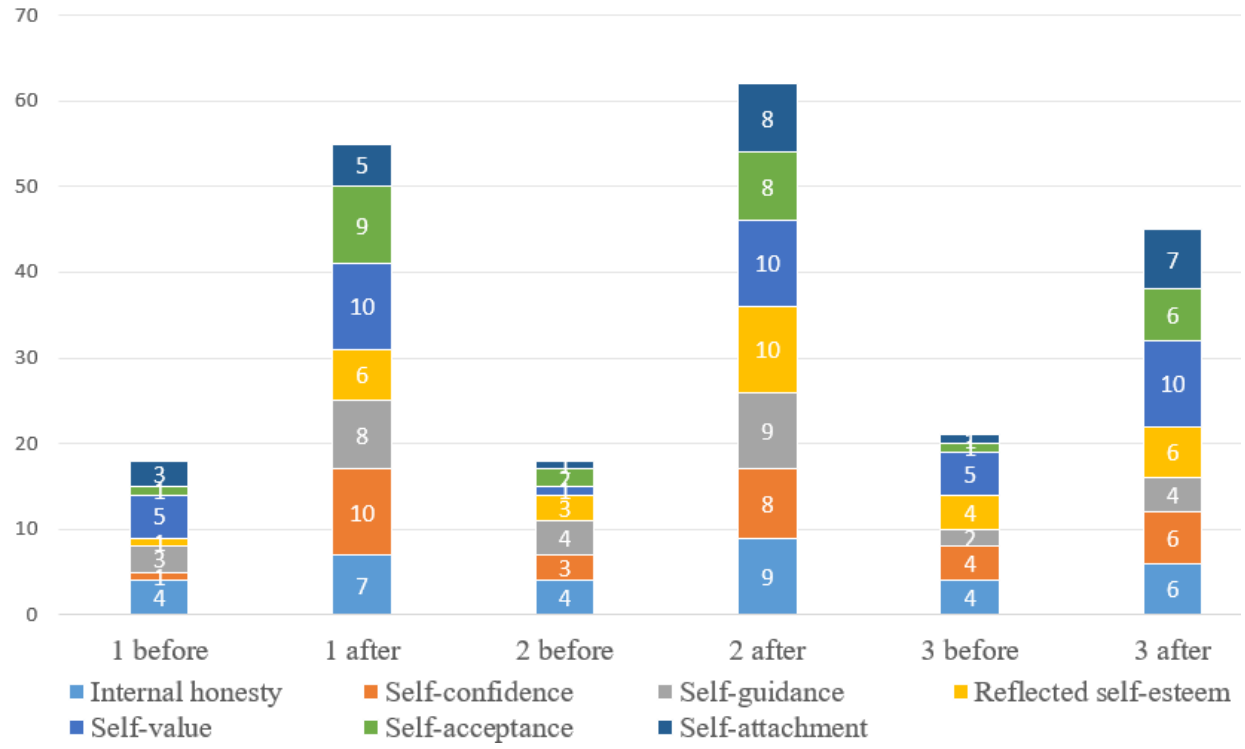
During the psychotherapeutic intervention, we applied methods from cognitive-behavioral therapy, narrative therapy, and body-oriented therapy (specifically: Socratic dialogue, externalization of the problem, metaphorical method, automatic thoughts diary, work with core beliefs, establishing contact with the inner

child, work with body awareness and establishing functional relationships with the body, catastrophic scenario, meditations, and bibliotherapy). The sample consisted of 3 clients, each exhibiting varying degrees of body dysmorphic disorder: a 33-year-old man and two women aged 25 and 24. Sessions with clients were conducted twice a week, each lasting 60 minutes, with an average of 25 sessions per participant.

The techniques we selected demonstrated their effectiveness, significantly reducing body dysmorphic concern (from 28 to 22, 25 to 9, 23 to 14) and the number of perceived flaws (from 12 to 3, 5 to 0, 3 to 0) in all three participants of the formative experiment.

Figure 2 shows changes in the respondents' self-attitude before and after psychological counselling. A notable trend is the improvement in self-attitude in all three participants of the formative experiment.

Figure 2. Comparison of respondents' self-esteem before and after psychological counselling.



In the course of psychological counselling, we found significant similarities in the history of all three dysmorphophobic clients (namely the presence of a violent component, bullying, comorbidity with affective disorders, and conflicts with parents). Dysmorphophobia with an earlier debut and a more pronounced trauma base required more psychotherapy sessions than dysmorphophobia that began in adolescence. Also in the course of the work, all three clients revealed blocked emotions of anger, which was subsequently reflected in their autoaggressive behavior. Our chosen techniques of cognitive-behavioral, body-oriented and narrative psychotherapy proved to be effective in dealing with the self-perceptions of people prone to dysmorphophobia.

Conclusions

Despite the fact that the diagnosis of dysmorphophobia syndrome is relatively simple, on the one hand, many patients try not to demonstrate symptoms or do not realise that they have painful experiences. On the other hand, this form of pathology is not always well known to narrow specialists, which leads to incorrect assessment of the clinical picture and, as a consequence, to unjustified diagnostic and therapeutic (including surgical) interventions. At the same time, the disease usually has a chronic course: according to Phillips K., McElroy S., Keck R, Pope H., Hudson J. [17], in diagnosed cases only 9 per cent of patients managed to achieve permanent remission and only 21 per cent - partial remission.

Thus, it is necessary to further improve the methods of timely detection and correction of this form of mental pathology in order to prevent severe personal and social consequences of the disease.

Based on the analysis of the obtained data, we propose the following recommendations for mental health professionals working with body dysmorphic disorder:

- Explore the core beliefs of clients prone to body dysmorphic disorder regarding themselves and their relationships with others (use the Core Beliefs Questionnaire).
- Separating the problem from the client helps in forming an alternative attitude towards their perceived flaw and transforming their self-perception.
- Pay special attention to the clients' connection with their own bodies, which is often disrupted.
- Investigate the presence of comorbid disorders in the client and, if necessary, involve a specialist in psychiatry.
- Working with the inner child helps clients prone to body dysmorphic disorder develop a more understanding and gentle attitude towards themselves.
- Use an automatic emotions diary and assign reading thematic literature as homework.
- Pay attention to the presence of blocked anger and address its processing.

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