Most of us are familiar with the classic picture of the beautiful but emaciated young woman looking into a mirror. From the mirror's reflection peers her obese counterpart. This young woman viewing her reflection radiates a sense of profound despair and hopelessness, yet the observer is often left with the feeling of confusion. How can this thin and attractive young woman see herself so differently than reality? How can she perceive herself as somehow deficient?

Although this severe a degree of body image distortion is seen in specific segments of clinical practice, there is evidence to support the fact that body dissatisfaction is rampant in both clinical and nonclinical populations. Monteath and McCabe (1997) found that 44% of women verbalize negative feelings about their individual body parts as well as their body as a whole. A similar survey by Psychology Today found that study respondents were concerned about their mid and lower torsos, weight and overall appearance. In this study, 56% of female respondents and 40% of male respondents were dissatisfied with their physical appearance (Cash, 1997). The later statistics are surprising as body image concerns were once thought to be a “female problem.” These trends have been conformed in a recent meta-analysis of body image among college students (Cash et al., 2004).

With statistics such as this, it’s no wonder that most clinicians have seen clients who are dissatisfied with their bodies, or whose sense of physical self is distorted. Body image plays a role in many disorders including anorexia, bulimia and body dysmorphic disorder. Even the most casual contact with a client with body image concerns demonstrates how painful this can be, affecting a client’s sense of self, and feelings about their competence. The case below provides an overview of some of the factors related to body image.

Case Study 1

Paul is a 43-year-old married male. He is seeking the services of Dr. Pine. In the phone call to set up the appointment, Paul seemed hesitant to provide many details of why he was coming for treatment, sharing only that there were some issues in his marriage. On meeting Paul, Dr. Pine immediately noted his physical condition. Although short in stature, it was clear that Paul was very muscular, likely a weight lifter.

During the assessment, Paul spoke with Dr. Pine about his marital problems. Paul's wife of 17 years was considering separation due to Paul's recent job loss and increasing distance. Paul had lost the job due to sexual harassment. He stated that he had been talking to a female co-worker about her body, but that he did not see the harm in it. In session, Paul also discussed his weight lifting, sharing with Dr. Pine that he was spending about 4 hours per day on a workout routine that consisted of aerobics and heavy lifting. To help build muscle, Paul consumed about
150 grams of protein per day. Paul confided that he was not satisfied with his current progress, stating that he felt “small” and “weak.” Paul was considering purchasing steroids from a friend at gym. He was not certain how he would do so, however, because his wife kept track of the budget and was already upset about the amount he was spending on nutritional supplements. Despite the financial strain, Paul was not yet seeking a new job, preferring to have the time to focus on his workouts.

During the psychosocial assessment, Paul disclosed that he was born with cerebral palsy. Paul’s family was quite protective of him, and sought the best treatment they could afford, often sacrificing their own needs to pay for it. Paul was happy to note that there were the only continued evidence of his condition was a slight limp.

As this case illustrates, body image is a complex issue. There are behavioral and interpersonal consequences of body image concerns. Many factors play a role in body image distortions and dissatisfaction. This course will explore these issues and provide a framework for treatment.

Objectives:

After finishing this course, the participant will be able to:

- Demonstrate familiarity with the incidence of BDD.
- Demonstrate familiarity with DSM-IV classification of BDD.
- Demonstrate familiarity with the pharmacological approach to treating BDD.
- Demonstrate familiarity with the precipitants of eating disorders.
Defining Body Image

What is body image and why is it important? Body image was defined as early as the 1930’s. Schilder (1935) provides the following definition: “the perceptions of the self that are centered on the individual’s sense of their own physical existence, both anatomical and physiological.” Slade (1988) expands this definition to include the affective domain of body image — the reactions people have to their bodies. He states that body image is “the picture people have in their minds of the size, shape and form of their bodies and to people’s feelings concerning these characteristics and our constituent body parts.”

It is easiest to appreciate the complexity of body image by looking at the components of body image (Cash, Wood, Phelps, & Boyd, 1991). These factors apply to people with healthy and unhealthy perceptions of their bodies and include:

- **Cognitive**—thoughts and beliefs about the body
- **Perceptual**—internal feelings and sensations related to one’s body. This includes feelings of vulnerability and tiredness and sensations of hunger and fullness
- **Affective**—feelings about the body
- **Evaluative**—judgments about the body
- **Social**—awareness of others’ feelings and attitudes
- **Kinesthetic**—sensed fluidity of movement (openness, heaviness, gracefulness)
- **Affective**—feelings about the body
Although these components of body image are relevant for people with and without clinical disorders, they are particularly helpful to consider when looking at dysfunctional behaviors. For example, Hilde Bruch (1973), a pioneer in the field of eating disorders, was one of the first to recognize that the perceptual aspect of body image is key in both anorexia and obesity. We will look at this in more detail in our discussion of clinical disorders.

Body Image Disturbance

It is helpful to think of healthy versus unhealthy body image as a continuum. People with positive body image view their bodies in an affirmative way. They are not unduly influenced by their weight and have a consistently accurate perception of internal body cues. Ann Kearney-Cooke (1989), a psychologist who works with guided imagery in exploring symbolic nature of body image disturbance has found that those with unhealthy observations of their bodies generally experience one of the following:

- **Body size distortion**—common in all eating disorders, the belief that one’s body is larger or smaller than it actually is. Those with body size distortion will often lose weight to an unhealthy level or will gain weight such as through increasing muscle mass.

- **Dissatisfaction with body size**—those with body size dissatisfaction accurately perceive their bodies but are disappointed by the way their bodies look. They may also engage in unhealthy dieting practices.

- **Concern with body shape**—this facet of body image concerns the belief that the body shape is not acceptable. Those with body shape concerns may exercise compulsively to achieve a lean or symmetrical look, or may focus on a discrete body part related to shape, such as the hips for females.

- **Insensitivity to interoceptive cues**—inability to recognize feelings of hunger or satiety. This is common in people with compulsive eating and bulimia.
The case study below illustrates many of these components of body image disturbance.

**Case Study 2**

Lindsay is a 16-year-old high school junior, reluctantly seeking treatment with Karen Chapin, LSW. Lindsay's parents are concerned with her recent weight loss. She is eating one small meal a day and has not had a period for the past three months. Lindsay denies that she is hungry, and states that she forces herself to eat only because she knows her mother will be angry if she doesn't. Lindsay seems unconcerned by her weight, which is currently at 75% of ideal body weight. Lindsay states that she still feels “too big” and that her hips are “huge.” Lindsay does note that she has been more depressed and is having difficulty sleeping and concentrating in school. When Karen suggests that Lindsay begin to increase her nutritional intake, Lindsay becomes tearful and angry, accusing Karen of trying to make her “fat.” Lindsay storms of session, vowing never to return.

As this case illustrates, perception of body image is often unrelated to weight. Changing negative body image is critical in treating eating disorders and body dysmorphic disorder. Negative body image can have wide ranging effects. Feminist object relations theorists such as Susie Orbach (1982) have demonstrated a relationship between the development of boundaries and body image. Thomas Cash (1997) also describes several reasons that positive body image is important. He states that a poor body image can lower self-esteem and create interpersonal anxiety. Body image is related to gender development and also impacts a person's sexual fulfillment. Cash maintains that depression and negative body image are often intertwined. He calls this interconnection, where a negative body image leads to depression or depression leads to a negative body image “a vicious cycle of despair” (p. 41).

**Body Image Development**

People with negative body image do not form these impressions in a vacuum. Body image is influenced by biological, familial, affective and cultural factors. At various developmental junctures different experiences influence body image.

There is some debate as to when body image development begins. Some theorists (e.g., Fisher et al., 1980) believe that it actually begins prior to birth with the preconceived parental image of what sex they want baby to be and what the baby will look like. Parents generally have an ideal image of what they would like their child to look like. Upon the infant's birth, if enough similarities exist between the ideal and the actual, parents welcome the infant and provide a secure base from which body image develops. If parents are unable to reconcile the baby's actual physical characteristics with their idealized body image, they may view the infant negatively, and a poor body image may develop.

Others think that body image first develops in infancy. In infancy, body image is concerned with kinesthetic, visceral and motor sensation, and an adequate amount of sensory stimulation is necessary. The infant begins to distinguish his or her body from that of others. In infancy and early childhood, the parents are the primary influence on the child's conception of his or her body. Key is how parents respond to normal developmental tasks such as toilet training and increased attempts at autonomy (Mahler et al., 1975). In the toddler years children become aware of their own gender through identification with a parent. They also learn about societal norms, such as males being valued for competitiveness and athleticism (muscles, strong legs, large arms), and females for beauty (glossy hair, unblemished skin) and smallness (tiny waist, no hips) (Benninghoven et al.,
If a child's body type or behavior does not meet these norms, the child may formulate a negative representation. At school age and continuing into adolescence, the role of the parents decreases, and peer responses become more important (Erikson, 1963). Popularity is often based on attractiveness, and those considered unattractive, such as overweight children, may be ostracized.

The teen years are a particularly difficult time with regard to body image. During puberty, the adolescent female must cope with changes such as emerging curves, weight gain, developing breasts and menarche. In girls with eating disorders, the lowering of body weight and body fat levels from self-starvation can arrest the menstrual cycle and delay other body changes related to puberty. Males experience similar changes in primary and secondary sex characteristics (voice change, genital development, facial hair) as well as alterations in height, weight and musculature. These physical changes occur at different rates within age-mates. Blos (1962) notes that "a change in one's body image and reevaluation of the self in light of new physical powers and sensations are two of the psychological consequences of the change in physical status" (p. 7.) He further states that most adolescents are concerned at one time or another with the normality of their physical status. Habitual negative body image is a psychological risk factor in adolescents (Verplanken & Velsvik, 2008).

People with a negative a body image may experience difficulty at any of these developmental junctures. In adolescence, for example, a critical event or series of events (i.e., peer rejection, teasing) may precede the perceived appearance defects. Extreme self-focused attention on negative body image leads the adolescent to assume that others have the same view of their "defect." Cognitive psychologists also point to the negative and distorted self-statements that individuals make regarding physical appearance; thoughts become automatic and deeply ingrained.

Another experience commonly thought to influence body image is aging. Many women do respond to typical effects of aging (e.g., wrinkles, weight gain) in a negative way. A recent study, however, found that body dissatisfaction was remarkably constant across the adult life span for women, until they are quite elderly. In contrast, the importance of body shape, weight and appearance decreased as women aged, highlighting a significant distinction between evaluation and significance of the body (Tiggemann, 2004).

Other experiences that may result in negative body image include those that challenge a sense of control over "ownership" of one's body, such as medical problems or surgeries, or experiences of having been abused physically or sexually. Many studies have attempted to investigate the association between experiences of abuse and body image concerns. Most have been with samples of women with eating disorders. Miller et al. (1993) studied the relationships between childhood sexual abuse (CSA) and adolescent onset of bulimia. The study found that adolescents diagnosed as bulimic reported a higher incidence of CSA than nonbulimic adolescents. Another study by Wonderlich et al. (1996) looked at female incest survivors who met diagnostic criteria for bulimia nervosa. The study found that victims of CSA presented with higher levels of other tension-reducing behaviors than control subjects. These behaviors could include eating disorder symptoms, as well as focus and distraction on body image as a way of reducing tension. For those that have been sexually abused, eating disorders may be a way of maintaining identity and self-esteem, establishing psychological boundaries, or an attempt to create a large or small body for protection (Schwartz & Cohn, 1996).
Case Study 3

Marla, a 16-year-old high school junior is seeking treatment from Dr. Pinder. In her initial assessment, Dr. Pinder notes that Marla is presenting with symptoms of depression. The previously outgoing teen states that she the depression began about 3 months ago. At this time, her close friend moved, and Marla felt very alone. She recognizes that she uses food to comfort herself. Marla has gained 20 pounds since her friend left. She states that she feels very badly about herself due to the weight gain. Marla uses adjectives such as “gross” and “ugly,” which do not apply. She also shared that her mother has been critical of her and has made comments such as “if you don’t lose this weight, no one will want you.” Marla would like to feel better, but is just not certain where to begin.

As the case above illustrates, body image concerns arise from a number of factors and play a peripheral role in many disorders. These include but are not limited to eating disorders.

DSM-IV and Body Image

DSM-IV entries that contain body image concerns include:

• **Body Dysmorphic Disorder (BDD)** —Preoccupation with an imagined defect in appearance.

• **Anorexia nervosa**—Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial or seriousness of current low body weight.

• **Bulimia nervosa**—Self-evaluation is unduly influenced by body shape and weight.

• **Eating Disorder NOS (compulsive, binge eating, obesity)**—These disorders may or may not include body image concerns.

**Related Disorders**

• Obsessive-compulsive disorder (OCD)
• Major depressive disorder
• Self-mutilation
• Trichotillomania
• Social phobia/agoraphobia
Body Dysmorphic Disorder (BDD)

Case Study 4

Alan was a 32-year-old male was referred for therapy due to self-mutilative behavior dating to high school. At this time he became obsessed with a perceived imperfection in his teeth. Alan repeatedly scraped the teeth with a knife until he severely damaged the enamel. Concern subsequently developed about facial blemishes and imperfections, which he admitted others probably would not notice. Alan repeatedly examined his face and cut at blemishes with a pin or tweezers, believing they would clear if he cut at them appropriately. He eventually required cosmetic surgery of the face and neck for resultant scarring. Alan also described multiple repeating, checking, counting, religious and contamination obsessions and compulsions that began in early childhood. At age 25, Alan began to pull out scalp, beard, mustache and arm hair. Depression, generalized anxiety, panic attacks and alcohol dependence further complicated the picture.

The case illustrates many of the clinical features of BDD. BDD is classified in DSM-IV as a somatoform disorder. It is described as a preoccupation with an imagined deficit in appearance—such as "huge" thighs, "limp" hair or a "bumpy" nose. Concerns often center on the face or head but may involve any body part. If a slight physical abnormality is present, the person's concern is extreme, and the patient may go to extraordinary lengths to hide the perceived defect. The preoccupation must cause notable distress or impairment in function and must not be accounted for by another disorder (American Psychiatric Association, 1994). Evidence suggests that BDD occurs with equal frequency in males and females (Phillips, 1996).

People with BDD are generally secretive about their difficulties. Often it is only after some time in treatment that patients feel comfortable discussing their body image concerns (Phillips, 1996). Most patients with BDD employ repetitious and time-consuming behaviors directed at concealing, diminishing or reassuring themselves about the presumed defect. These include checking behaviors, such as examining the defect in a mirror or reflective surface, camouflaging the problem using clothing or sunglasses, ritualistic and complex grooming procedures, comparing their appearance to others and asking for reassurance that the defect is not noticeable (Phillips, 1996; Veale et al., 1996). Such behaviors resemble the compulsions seen in obsessive-compulsive disorder (OCD) and may last for hours each day. These efforts are seldom successful in diminishing appearance concerns. For comprehensive discussions of this illness see Phillips (1996) and Phillips et al., (2008).
Multi-Determined Nature of BDD

What causes this disturbance of body image? Although interest in BDD has increased in the past decade, one area that remains largely conjectural is the question of what causes BDD. Based on what we know about similar disorders and about the many factors that influence body image development, it is likely that the causes of BDD are based on an interaction between personal and environmental risk factors.

As suggested by the response that many BDD sufferers have to SSRIs, there appears to be a neurochemical basis that creates a biologic vulnerability to BDD. In discussing potential biological factors, Phillips (1996) points to known neurological conditions that produce body image disturbance. Damage to the temporal lobes, for example, can result in anorexic-like distortion of body size or in facial agnosia. Phillips also talks about the biological implications of SSRI response, proposing that BDD may be due to an abnormality in the serotonin neurotransmitter system. Another neurotransmitter, dopamine, which regulates mood, has also been a target of study. Neurological explanations also include possible brain abnormalities that result in a "loop" causing obsessions and compulsions to repeatedly cycle through the brain.

Biologic vulnerability most likely interacts with personal and environmental risk factors. Veale et al. (1996) point to an innate perfectionism found in many with BDD. This perfectionism is seen in many areas, including academics, intelligence and career success. Prior to BDD onset, premorbid individuals may spend hours perfecting homework assignments, learning new vocabulary words or setting career goals. Perfectionism becomes centered on appearance concerns and affected individuals set impossible appearance standards.

Theorists (Phillips, 1996; Veale et al., 1996) also point to the role of self-esteem issues in BDD and to the influence of early experiences on self-esteem. Related to this are fears of rejection during adolescence; many individuals who develop BDD report comments and teasing by peers during adolescence as a causal factor. Perfectionism, concerns about self worth and fear of rejection may predispose those with BDD to become hypervigilant—overly focused on appearance.

Therapeutic Interventions for BDD

Several prototypes have proven effective in the treatment of BDD. Evidence indicates that SSRIs significantly lessen symptoms in the bulk of individuals with BDD; many also respond well to cognitive-behavioral therapy.

Phillips (1996) discusses a pharmacological approach to BDD, focusing on the role of selective serotonin reuptake inhibitors (SSRIs). SSRIs increase the amount of serotonin in the brain by preventing its reuptake. Individuals responsive to SSRIs report abatement or diminishment of obsessive thoughts. In cases where one type of SSRIs is ineffective, the patient may try a different medication. If preoccupations diminish but do not disappear, pharmacotherapy may be combined with cognitive therapy.
Cognitive-behavioral treatment of BDD includes a number of components (Rosen et al., 1995; Veale et al., 1996). Patients are taught about the cognitive behavioral model and the role of automatic thoughts on behavior. Individuals may be asked to identify the possible antecedents of their body image disturbance (i.e., family pressures, sexual abuse and sociocultural factors).

Exposure therapy, thought stopping and relaxation techniques are used to help individuals gain control over distressing thoughts and feelings that occur during group exercises. Automatic and critical thoughts are addressed through cognitive restructuring techniques and the use of body image diaries. Veale et al. (1996) stress the importance of challenging the meaning of distorted thoughts. For example, an individual's view that he is ugly is addressed by discussing the assumption that he or she must be "perfect" to be loved (i.e., ugly people are worthless). Patients are helped to see the irrationality of these beliefs and to substitute more accurate thoughts.

The majority of controlled studies to date have focused on cognitive therapy. Further work is needed to assess the efficacy of insight-oriented or psychodynamic approaches. Treatment results have been encouraging, and many with BDD are being helped through pharmacotherapy, cognitive-behavioral therapy or a combination of these approaches.

A more comprehensive discussion of many of these techniques can be found later in this course.

Case Study 5

Anna P., age 12, was referred for treatment due to weight loss and depressed mood. Due to her low weight, Anna met DSM-IV criteria for anorexia nervosa, but was insistent that she did not have a "food problem." Anna stated that her dieting was an effort to reduce her "huge thighs," but that the weight loss "hadn't helped." Anna felt that when she was not dieting, she ate a range of foods, including those high in fats. She had no difficulty recognizing that she was overly thin, but continued to be discouraged at her lack of "symmetry.”

Anna continuously looked at magazine advertisements; she reported that she spent several hours a day doing this. She would painstakingly focus on each part of every model's body, lingering on long "glossy" hair and symmetrical "perfect" facial features. Anna was hesitant to discuss her own perceived deficits in detail, but in comparing herself to peers she described her appearance as "geeky." She was also often seen looking into mirrors or reflective surfaces. In actuality, Anna was an attractive adolescent with long thick hair.

Anna was shy and had few peer relationships. She was a conscientious and gifted student, however, her grades were beginning to fall, due to her preoccupation with her appearance. Despite her excellent grades, Anna’s self-esteem was poor. Her mother and father set high expectations for her and frequently compared family members' accomplishments. They expressed few emotions regarding Anna's weight loss, except to say on admission that we'd find Anna "quite well disposed" and amenable to treatment.

Anna was treated using a combination of factors including work on body image and self-esteem. She was also started on a trial of fluoxetine. After several months of treatment Anna's "checking" behaviors had reduced substantially and she was able to gain weight to within normal ranges.

This case illustrates the complexity of behaviors associated with body dysmorphic disorder, as well as the possible issues in differential diagnosis. In cases such as Anna’s it is often difficult to determine whether eating disorders are an accurate diagnosis or whether body dysmorphic disorder is more applicable. In Anna’s case the later was likely a better diagnosis.
Before continuing with a discussion of how to treat body image concerns, we will discuss other disorders of body image, most notably the eating disorders.

**Anorexia, Bulimia and Obesity**

Body image distortion is a component in anorexia, bulimia, and obesity (Cash & Deagle, 1997). Although several similarities exist between BDD and disordered eating, such as faulty body representation and compulsivity of the behaviors, there are a number of dissimilarities. There is a marked gender difference in the prevalence of eating disorders with more females diagnosed with eating disorders. Estimates of male-to-female ratio range from 1:6 to 1:10 (Fosson & Knibbs, 1987) for anorexia and bulimia. In addition, men and women with eating disorders have concerns about body image, as well as concerns about food and weight. Those with eating disorders have obsessive thoughts of food or about fatness, but not obsessive thoughts of a body part, and restricting or bingeing is a metaphorical expression of psychosocial difficulties. In anorexia and bulimia, food is used as a "coping mechanism"; stress may cause the bulimic to binge to soothe stressful feelings and the anorexic to restrict to be more in control.

Eating disorders have been reported in up to 4% of adolescents and young adults. The most common age of onset for anorexia is the midteens although in 5% of the patients, the onset of the disorder is in the early twenties. The onset of bulimia is usually in adolescence but may be as late as early adulthood (American Psychiatric Association, 1994).

The DSM-IV criteria for anorexia includes refusal to maintain body weight at or above a minimally normal weight for age and height; maintenance of body weight less than 85% of that expected and an intense fear of gaining weight or becoming fat, even though underweight. In terms of body image, there is a disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight. The most notable disturbance is anorexic client's defense of his or her emaciated body. The anorexic may profess an overall denial of his or her thinness.

Bulimia differs in some ways from anorexia but still contains features of body image disturbance. People with bulimia engage in cycles of binge eating and purging. During a binge episode, a person consumes a large amount of food usually in a rapid fashion. Another essential feature of bulimia is the use of compensatory behavior to prevent weight gain after a binge. Compensatory behaviors may include vomiting, laxative abuse, diuretic use or excessive exercise. As with anorexia, a person's self-evaluation is unduly influenced by body shape and weight (American Psychiatric Association, 1994).

As obesity is a medical condition, there is no formal DSM diagnosis specific to obesity. Medically, a person is considered obese if they are 20 percent over their ideal weight. That ideal weight must take into account the person's height, age, sex, and build. Obesity has been more precisely defined by the National Institutes of Health (the NIH) as a BMI of 30 and above. Depending on the behavioral manifestation of obesity, symptoms may merit a diagnosis of "Eating Disorder Not Otherwise Specified." Another diagnosis under consideration for inclusion in the next version of the DSM is "Binge Eating Disorder." This may apply to some, but certainly not all, obese individuals. Obese individuals vary in the way they perceive themselves. People who became obese in adulthood generally have more realistic body image than those with life-long obesity. Some may avoid looking in mirrors or seeing themselves.
There are many facets of body image disturbance connected with eating disorders. In addition to a self-evaluation that is unduly influenced by body shape and weight, there is often a misperception of bodily functions. Bruch (1973) was one of the first to discuss this problem, which she labels as difficulty with “interoceptive awareness.” Those with eating disorders are disconnected from body perceptions, such as feelings of tiredness or sensations of hunger or fullness. Anorexics, for example, may complain about feeling full after one bite of food. There may also be a magical quality to the impact of weight loss and the body in anorexia, such as the belief that the body can continue to function on minimal amounts of food or that the person can perform a workout or dance routine after having consumed minimal calories. Disconnection from sensations of hunger or satiety may be found in anorexia, bulimia and compulsive eating.

Another aspect of body image disturbance that applies to many people with eating disorders but cannot be generalized to all persons with eating concerns is misperception of sexuality or the sexual role. The psychoanalytic view of women with anorexia is that they express rejection of sex or pregnancy. Anorexic young women tend to exclude awareness of curves and breasts from body image. Some anorexic patients report that they wanted to be the opposite sex in childhood. Men who have been obese from childhood sometimes express doubts about their masculinity. There is some evidence that this may also be a rejection of sex role stereotype of “rough” boy. Men who become obese in later life may see obesity as sign of status.
Multi-Determined Nature of Eating Disorders

Eating disorders arise from a combination of long-standing psychological, interpersonal, and social conditions. Those who have eating disorders may experience feelings of inadequacy, or depression, or have troubled relationships.

Between one-third and one-half of patients report having struggling with depression or anxiety prior to developing an eating disorder. These problems were severe enough that the individuals felt out of control. Restrictive eating, excessive exercise, and/or binge-purge behavior may be used as a way to contain or manage depression and anxiety (Johnson, nd).

Johnson (nd) describes the following precipitants of eating disorders.

- **Major life transitions** — Many with eating disorders have difficulty with change. Transitions such as the onset of puberty, entering high school or college, or a major illness or death of someone close cause some to feel a loss of control that they cope with using eating disorder behaviors.

- **Family problems** — Boundary issues are common in families of those who develop eating disorders. Families of those who develop anorexia are often enmeshed and/or controlling and in families of those with bulimia there may be distance. Eating disorders can help a person to feel that they can control something (i.e., their body shape and size or food), can be used as a way to individuate, or can be a way to distract from feelings of disconnection.

- **Low self-esteem** — Many people who develop eating disorders report having low self-esteem before the onset of their eating problems. They may believe that this is due to being “fat” and that weight loss will help raise self-esteem.

- **Perceived failure** — There is often a perfectionistic and driven quality to those with eating disorders. Perceived “failures” (which are often distorted) can lead to feelings of shame, guilt or low self-worth. Many times these failures involve not performing to a peak, such as receiving a “B” in a class. Eating disorder symptoms can provide a distraction from these feelings.

- **Trauma** — As mentioned previously, there is evidence that between one-third and two-thirds those with eating disorders have histories of sexual or physical abuse. Eating disorder symptoms may be an attempt to cope by consciously or unconsciously avoiding further sexual attention by losing enough weight to lose their secondary sexual characteristics (for instance, breasts). Weight gain may be a way to make oneself unattractive to potential abusers.

- **Illness or injury** — can result in an individual feeling defenseless or out of control. Anorexia and bulimia can be attempts to control or distract from such events.
Caroline is a 35-year-old single woman presenting for therapy with Dr. Milozi. In her initial phone call with Dr. Milozi, Caroline stated that she would like to come to therapy to work on long-standing issues with depression. She reported that she was having crying spells and difficulty sleeping. In their first session, Dr. Miozzi noticed several things. Caroline presented with depressed and flat affect; she had clearly been crying prior to the session. She was also extremely obese, and had difficulty sustaining eye contact. In assessing for the presence of eating disorders, Caroline stated that she had been overweight since her teens and that she knew that her eating patterns were poor. She described a pattern of restricting food intake during the day (no breakfast and a yogurt for lunch) then eating dinner. Her most difficult times both for eating and depression were after dinner. Caroline described this time as a period when she “ate constantly.” She felt that food had always been a comfort, and a way of coping. Caroline was unable to identify any other coping skills that she had used. Social contacts were minimal, and Caroline had never seriously dated anyone. In response to this query she questioned “who would want someone who looks like me?”

As Caroline and Dr. Milozi continue to work together, Caroline became more disclosing. She revealed that she had been molested by her grandfather from the ages of 6 to 13. The abuse had occurred in the evenings when her mother was working. The abuse stopped after she reached puberty and had begun to gain weight. Dr. Milozi pointed out that this defense had served her well as a teen but that as an adult it was no longer needed. As Caroline and Dr. Milozi continued to work together on the abuse issues and on positive coping skills, Caroline began to binge less and gradually reduced her weight. Her body image became more positive and she began to express some interest in dating and socializing.

As the case above illustrates, trauma is a factor in the development of body image issues and eating disorders. The factors described by Johnson (nd) are helpful in understanding some of the reasons people develop eating disorders. Another interesting viewpoint is that of feminist authors (e.g., Gutwill, 1994; Myers & Crowther, 2007; Orbach, 1982) who point to our cultural idealization of thinness. Sociocultural theories focus on the messages contained media advertisements. The message: that appearance is the key to happiness. Gutwill (1994) describes this “beauty myth”: “Targeting both the most primitive of people’s needs and their more adult aspirations, mass culture has aimed at nothing less than institutionalization, the rationalization of fantasy life around sales that focus predominantly on ... beauty” (p. 11). These ideals, in themselves unrealistic due to the inhuman thinness of models and the liberal use of airbrushing, results in impossible standards few can attain. Often people who develop eating disorders strive for the same unrealistic standards of appearance.

A topic that has received increasing attention is that of eating disorders in men (see Halliwell & Orsborn, 2007; Pope et. Al, 2000;). Although some men with eating disorders closely resemble their female counterparts, eating issues may differ in this population. Pope et al. (2000) describe phenomena that they call the “Adonis Complex.” They point to men that engage in compulsive behaviors such as excessive workouts, steroid abuse and a have a distorted perception that they are not muscular enough. They may eat limited quantities of foods, eschew carbohydrates, and consume unhealthy amounts of protein. Case study 1 is an example of the way that this “Adonis complex” may manifest. As with feminist theorists, Pope and his fellow authors suggest that the Adonis complex is related to the societal norms that tell men that they should be aggressive and competitive and have the body build to promote these ideals.
Most clinicians treating eating disorders emphasize importance of treating body image distortion for recovery and relapse prevention (rectifying distortions and developing positive attitude toward the body). Some research suggests that neglect of body image therapy may be one reason for poor long-term treatment outcomes in eating disorders (Levine & Pinan, 2004).

**Treatment of Body Image Disturbance**

It is clearly important to address the role of body image distortion in both eating disorders and body dysmorphia. Kearney-Cooke (1989) describes three critical steps to addressing body image disturbance. These steps are:

1. To reconstruct the individual's history of body image development and work through key issues (family, trauma, etc.)
2. To help clear up distortions of body image and assist clients in attaining realistic expectations (e.g., goal weight)
3. To help clients face the loss involved in developing a positive body image in which the body is accepted as a positive source of feelings, physical needs, and information about one's self

The first step in treating body image disturbance is a client assessment. The clinician must try to determine the extent of body image concerns and distortions. For example, are body concerns centered on a specific body part or parts? Do they involve the misperception that one is “fat?” Sources of information include projective measures (such as drawings), guided imagery exercises (see Hutchinson, 1985) and surveys (see Cash, 1997). The clinician may also begin with thought logs focused on body image, and which can yield important information on the affective components of body image. A related issue and ongoing component of body image treatment involves psychoeducation. In the initial stages of treatment it is often helpful to normalize body image concerns by sharing universality of body dissatisfaction.

After assessing the degree of body image distortion or dissatisfaction, it is beneficial to explore factors in the person’s body image history. One of the simplest approaches is developmental. Cash (1997) for example, breaks down body image by stages (early development, school age, puberty, etc.). Clients may be asked how they felt about their bodies at each of these stages and whether there were any events that may have affected their body image in a positive or negative manner. For example, early or late development, teasing, or experiences that resulted in a lack of body efficacy may have played a role. Often the feelings or associations related to these events continue to influence a person. Jasper (1993) suggests an alternate approach to body image history in which the participant is asked to respond to aspects of body image, such as “how parents, relatives and siblings reacted to your body”; “your experience of sexuality”; “accidents illnesses and surgeries” and other pivotal events. In instances where a person has experienced trauma, working through traumatic events and making connections between trauma and body image is key. Another helpful factor to explore at this stage are sources of body distress—things a client may avoid due to negative body feelings.
After reconstructing body image history, therapeutic interventions can then focus on helping to clear up distortions of body image and assisting people in attaining realistic expectations of body image. Clients must learn to verbalize body dissatisfaction and correct distortions in body image and self-statements. Thought logs and cognitive restructuring are useful tools. Many theorists advocate the use of group work in correcting body image distortions (e.g., Jasper, 1992). In situations in which body image work can be done in this type of setting, clients may be asked to explain as concretely the nature of distressing aspect of their appearance and be provided with objective feedback from group members. There are also a number of experiential exercises that may help to correct body image distortion. These include but are not limited to techniques using guided imagery, art therapy, psychodrama, and poetry therapy.

One such exercise is a psychodramatic technique called the “Mirror Exercise” (Callahan, 1989). Group members face an area of the wall that is an imaginary mirror. They then visualize themselves, describing what they “see.” Each person assumes the role of someone significant in his/her life that might think something similar. Following this, person asked to then assume the voice of someone who supports him or her and appreciates his or her struggle.

Another experiential technique for correcting body image distortion is Image Marking or Body Tracing. In this technique the person is asked to draw his or her body or disliked body part as accurately as possible. A group member then traces the body [part] providing a look at what is realistic. In individual treatment, the therapist can assume the role of the group member.

In the early stages of body image work it is also important to promote self and body care (Jasper, 1992). This involves helping the individual to see that there are many positive ways to care for one’s self and one’s body. Positive self-care includes appropriate nutrition, rest, exercise (if not contraindicated by the eating disorder), and activities such as massage. Yoga is particularly good for helping the client to establish the mind-body connection. For men and women with trauma histories, many of these self-care activities are difficult, but are important to healing body disparagement as well as trauma.

Relaxation training can provide important skills for clients to face distressing situations. It is beneficial to teach these skills before attempting things like desensitization or exposure. In terms of the later, the client should assess forms of avoidance, such as practices, (i.e., being photographed, eating in front of others), places, (i.e., the beach), poses (i.e., sitting or standing during interactions) and people. Recent studies have found that exposure can be helpful in decreasing negative body emotions (Vocks et al., 2008). Exposure therapy helps clients to begin to do those things that they have avoided. It is particularly helpful to encourage social interaction.

Response prevention refers to eliminating rituals and maladaptive behaviors associated with disordered body image. Tasks that fall under this realm are those such as such as having client weigh his or herself less frequently, inspecting his or herself in mirror less often, stopping complex grooming rituals, or asking others for reassurance. Begin by restricting rituals (i.e., determining how long a ritual takes and limiting it to less time). For example, clients who must check their appearance every 10 minutes may be asked to do it every 15, 20, 25, etc. You can then establish specific times that rituals may occur. Clients encouraged to developed positive body experiences such as breathing exercises, exercise, movement, massage, etc.

The final stage of body image work involves helping clients face the loss involved in developing a positive body image. For many people, body image concerns have been longstanding and have at one time served an adaptive purpose. Giving up these behaviors may involve a grieving process, but will enable people to live a healthier and fuller life.
Conclusion

Body image plays a role in many clinical disorders including anorexia and bulimia and body dysmorphic disorder. Distortions in body image are painful and can influence self-esteem and competence, and diminish social and occupational functioning. It is important to address body image concerns when working with disorders including body dysmorphic disorder, anorexia and bulimia. There are many techniques that can be useful in doing so. Helping clients address these issues will enable them to lead more contented and productive lives.
References


