FACTORS INFLUENCING THE DEVELOPMENT OF POTENTIAL BODY
DYSMORPHIC DISORDER IN ADULT MALES: A PHENOMENOLOGICAL INQUIRY

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FACTORS INFLUENCING THE DEVELOPMENT OF POTENTIAL BODY DYSMORPHIC DISORDER IN ADULT MALES: A PHENOMENOLOGICAL INQUIRY

This clinical dissertation, by Michael A. Archer, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University Seattle, Center for Programs in Psychology in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

FACTORS INFLUENCING THE DEVELOPMENT OF POTENTIAL BODY DYSMORPHIC DISORDER IN ADULT MALES: A PHENOMENOLOGICAL INQUIRY

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Concern with body image is on the rise among American males. Although alone this may not be cause for alarm, a preoccupation with appearance can impact self-esteem and level of functioning and lead possibly to the development of Body Dysmorphic Disorder (BDD). Although biological, psychological and sociocultural factors are implicated in the onset of BDD, it is vital to explore which specific factors men themselves attribute to its development. To understand BDD and its phenomenological impact among males, it is necessary to explore its epidemiological aspects, treatment methods, and assessment issues. In this study the specific factors six men feel impact the development of their negative body image and potential BDD are defined and explored. Results from this study support existing literature highlighting the positive correlation between specific psychological and societal factors and the development of BDD in men. Participants of this study commonly cited negative comments from family members during childhood and the impact of culture and media as prime factors. Unique factors such as seeking acceptance from others, participation in the performing arts, clothing and not being in a relationship were also cited. Understanding the impact of these factors can shine light on the severity, prevalence, and impact of this disorder on men.
Dedication

This is for Jim, who is the blood in my veins, the light in my eyes and the life in my soul. I am honored to stand by your side, for you fortify me with love, passion, friendship and so many other things that to list them would fill another dissertation length paper. I am blessed that you are part of my life and I am truly honored for that privilege.
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We live in a society that equates physical attractiveness with happiness. Whether we are at the grocery store, shopping mall or in the comfort of our own homes, we are subjected to images and experiences that support the notion that the way we look affects our mental happiness and physical health. This campaign purports that if we are a particular weight, have shiny, full hair, perfect skin or “rock hard abs” that we will feel better about ourselves, and other people will admire us and want us as friends. However, how this physical attractiveness is defined is a highly subjective topic with far-reaching implications that not only affect the sense we have of ourselves and our physical well-being, but also our success as contributing members of society. For the majority of this blitz, the focus has been primarily on women. Although many women still battle factors that often make them feel dissatisfied with their bodies, the feminist movement has helped increase female awareness around this issue and provided tools to combat often unrealistic body image stereotypes (Pope, Phillips & Olivardia, 2000). However, over the past two decades there has been a steady increase from various sources to specifically target the male consumer. Men, who do not have the same strong history of awareness afforded to women, are now becoming increasingly influenced by these images, ideals and thoughts of hyper-masculinity. In an age where women are gaining ground in traditionally-held male bastions, men often see their bodies as the last defining factor of what makes them masculine (Pope, Phillips & Olivardia, 2000). Because of the cultural stereotype that men should not care about how they look, they are often left with conflicting feelings about their own self-image, self-worth and place in society. Such feelings of negative body image or increase in body dissatisfaction may result in severe enough clinical symptoms to be diagnosed with Body Dysmorphic Disorder (BDD). Coupled with this, the troubling fact that many clinicians are unfamiliar with BDD
contributes to it being under-diagnosed, and its lack of accurate prevalence in literature (Phillips, 1986; Pope, Phillips & Olivardia, 2000). Without the proper awareness of how this diagnosis is impacting men, the impact of BDD on the lives of these men can be devastating.

For this study, six participants who met screening criteria were recruited. They were self-identified as having concerns about their bodies and scored in the clinical range on a BDD screening tool. In order to fully understand the experiences of these men and what elements contributed to their BDD development, some groundwork is necessary. First a general discussion of BDD, its epidemiology, current treatments and assessments will frame the disorder to allow the most accurate relation of the phenomenological experiences of these men. Second an in-depth analysis of the most common factors and of the most unique factors discovered will be discussed in order to give full depth and breadth to the experiences.

*Purpose of the Study*

The purpose of this phenomenological study is to identify and understand the impact of the factors that contribute to the potential development of Body Dysmorphic Disorder (BDD) from the perspective of the male (heterosexual and/or homosexual) participants. The impact these factors have on the participants’ views of their development of BDD will be generally defined by the qualitative experiences of the participants and by using the DSM-IV TR to establish criteria for a possible diagnosis of BDD. The DSM-IV-TR categorizes BDD as a Somatoform Disorder. The common feature of this disorder is the presence of physical symptom(s) that suggest a general medical condition, but the disorders are not fully explained by a general medical condition alone. Furthermore the disorder must cause clinically significant distress or impairment in social, occupational, or other areas of functioning (APA, 2000). Specifically for BDD, the diagnostic criteria would include a
preoccupation with an imagined defect in appearance or if an imperfection or defect is present it is so slight that the person’s concern regarding it appears excessive. A BDD screening measure was used to elucidate further information. Interviewees were self-selected and drawn from readers of local Seattle area newspapers. They were contacted individually, screened for participation criteria, and asked for informed consent.

Research Question

Participants were asked one main question, “What factors do you think have impacted the development of your negative body image and/or potential development of BDD?” They were free to discuss any factors or experiences they wished in order to provide the opportunity for as much inductive input as possible. Several sub-questions were asked, to provide support for the main question, help ensure the most accurate representations of those experiences, and provide a framework for all participants to cover, at minimum, the same basic themes:

a. What is the major bodily concern?

b. Why is it important to the individual to have a good body image?

c. How long have these negative perceptions of body image been present?

d. What are the cultural influences that outline the need to change the perceived defect in appearance?

e. What type of factors (childhood memories, adult experiences, TV, print, film, etc.) are the individuals exposed to, and at what frequency?

f. What specific factors are the most influential in developing negative body images and why?
g. What behaviors does the individual engage in to improve body image and how does the individual feel about these behaviors?

A copy of these questions can also be found in Appendix B.

*Expected Outcomes*

It was hoped that by describing how the influences that impact the development of their negative body image and the subsequent potential development of BDD, participants would gain insight into these influences and thus be better equipped to address these factors in a positive way. It is also hoped that results will increase awareness of this debilitating disorder among professionals in the mental health community. These influences may come from a variety of sources. Although theories about what specially causes BDD are speculative (Phillips, 2005), according to Pope, Phillips and Olivardia (2000), factors that impact negative body image in men come from three areas:

…certainly a genetic, biologically based component…a predisposition to developing obsessive – compulsive symptoms….The second likely component is psychological…from one’s experiences growing up, such as being teased…And finally we believe that society plays a powerful and increasing role, by constantly broadcasting messages… that “real men” have big muscles…thus laying the ground work for…the Adonis complex in adulthood (pp. 11-12).

The Adonis complex, “…refers to an array of usually secret, but surprisingly common, body image concerns of boys and men (Pope, Phillips & Olivardia 2000, pp. 6-7). It was suspected that factors would emerge, both thematic and unique, all vital to understanding the experiences of the participants.
Background

*General Discussion of BDD*

Most of us are concerned about the way we look. According to Phillips (1998a), “A recent survey of 30,000 people…found that 93% of women and 82% of men care about their appearance and work to improve it” (p. 3). In the popular media, an article in the February/March 1999 Health News states, “…a 1992 survey found that 70 percent of healthy college students said they were unhappy about a particular feature” (p. 1). The question arises then, when does this seemingly ubiquitous concern about appearance become unhealthy? The answer seems to lie in the frequency of the individual’s concern, coupled with how this concern is affecting social functioning.

The Diagnostic and Statistical Manual of Mental Disorders (2000) (DSM-IV TR) defines Body Dysmorphic Disorder as “a preoccupation with a defect in appearance…The defect is either imagined, or, if a slight physical anomaly is present, the individual’s concern is markedly excessive…The preoccupation must cause significant distress or impairment in social, occupational, or other important areas of functioning” (p.466).

For example, an individual may be preoccupied with the fact that they have slight acne. The acne would probably not be the first thing noticed by an observer, but the individual with BDD might perceive that everyone else is focusing on his or her acne. He or she might not leave their house and avoid social activities for lengthy periods of time for fear other people would see the flaw. Thus, this preoccupation with acne prevents him or her from achieving a “normal” level of functioning. This is not to say that all people with BDD are affected in this severe way. In general most people with BDD spend at least one hour a day thinking about their “defect”; however, there are varying degrees. These varying degrees of
BDD can range from mild, where the individual knows they have a preoccupation problem, but are not sure how to overcome it, to excessive, where sufferers perceive only their reality and whole-heartedly believe that their “defect” is cause for major concern because they do not look like other people. This mildness or severity then dictates the level of functioning that the individual can achieve. An exploration of some of the major epidemiological factors of BDD is necessary to gain further insight into its effects on the mental health of its sufferers.

*Epidemiology of BDD*

Although people have probably been unhappy with some aspects of their appearance since the beginning of recorded time, the significant impact of this unhappiness and its psychological preoccupation and subsequent maladaptive social functioning, as experienced in BDD, has only been recognized by the American Psychological Association since 1987. Since it has been recognized only recently, information regarding its prevalence is sketchy, although the recent attention it has received in the media and professional journals may point to the fact that it is more common than once thought, and might affect up to one percent of the population (Health News, Feb/Mar 1999). Both mental health and medical professionals are realizing that concerns with appearance, comparisons, and time-consuming grooming behaviors are not just the domain of aging women or men, but are a common occurrence within our culture. The excessiveness of these concerns point to the fact that some people are not just “shallow,” but that they suffer from a serious psychological and/or medical condition, such as is manifested in BDD. To explore the broader picture of BDD’s epidemiology, it will be necessary to examine not only theories surrounding its etiology, but also symptomatology, gender differences and ethnic and cultural variations.
Examining the etiology of BDD, we find several theories that attempt to explain its origin. Hypotheses fall into three categories: biological, psychological and sociocultural. To attain the most accurate information regarding how these etiologies formulate BDD, it is important to explore each category individually. This will then allow an informed observation as to how they compare and contrast with regard to the impact on the individual.

In considering BDD’s biological origins the first professionals who wrote on the subject of body image were neurobiologists (Phillips, 2005). They were the first to hypothesize that several types of distorted body images experienced by their patients might be connected to a brain process. As Phillips (2005) points out, the types of distortions they were studying, such as “anosognosia (the inability to recognize…impaired bodily function) and neglect of one side of the body…are often caused by brain damage, such as a stroke, in the brain’s parietal region” (p. 161). This connection laid the foundation for the further exploration that damage to different regions of the brain, such as the occipital or temporal lobes, might produce different “distorted” perceptions of how an individual views him or herself. Additional evidence to support this biological etiology is the fact that some patients with BDD can experience relief from their symptoms by taking medications known as selective serotonin re-uptake inhibitors (SSRIs). Slaughter and Sun (1999) point out, “Two prospective studies that used open-label SSRIs demonstrated clinical efficacy including decreased preoccupation with the perceived defect, decreased ritualistic behavior, improved insight, and improved social, academic and occupational functioning” (p. 3). Further studies are needed on the effect of SSRI’s and BDD but these early correlations suggest that, at least in part, BDD may have some neurobiological underpinnings.
Keeping these hypothesized biological etiologies in mind, it is also important to examine psychological theories of origin of BDD. The psychoanalytical perspective has long viewed symptoms of mental illness as having psychological causes. Could such things as childhood trauma, neglect and negative reinforcement play a role in the development of BDD? Possibly, perhaps. We are the sum of our parts, and what makes up these “parts” could be at least partially grounded in developmental experiences. The key is how we perceive and express these experiences. Phillips (2005) states the following:

Some authors, for example, have suggested that BDD arises from the unconscious displacement of sexual or emotional conflict, or feelings of inferiority, guilt, or poor self-image, onto a body part. Conflicts or feelings such as these are considered the underlying problem and cause of BDD symptoms. This displacement process is presumed to occur because the underlying problem is too emotionally threatening or anxiety provoking to be dealt with more directly—thus it is unconsciously displaced into the more psychologically manageable arena of appearance. (p. 169)

It is not known for certain which psychological factors, if any, contribute to the development of BDD, but it is probably safe to say that whatever these factors may be, they do not exist in a vacuum. Not everyone who suffers from these types of experiences develops BDD. The development of these psychological factors is probably affected by environmental factors as well. This combination might contribute to the development of personality traits that may predispose an individual to develop BDD or they might develop as a result of BDD. Further studies are needed to discern this. It is the author’s opinion that psychological factors alone
are not enough to explain the development of BDD. They need to be examined along the same spectrum as biological factors and socio-cultural factors.

Socio-cultural factors that could contribute to BDD are all around us. We see them on television, on tabloid and magazines covers, and in films. The message seems clear: To be happy you must look a certain way. The constant focus on factors concerning appearance might become overwhelming for some people. Some individuals may feel the need to identify with “ideal” individuals, i.e., to look just like them. The feelings and perception of body dissatisfaction that may lead to BDD can develop if they feel they do not, or cannot conform to these appearance standards. Indeed, we as a society spend millions of dollars a year on “beauty enhancement” expenses such as make-up, diets, clothing and cosmetic surgery. This is supported by Sarwer & Crerand (2004) when they state “In 2002, almost 6.6 million Americans underwent cosmetic surgical and non-surgical treatments, an increase of 1600%” (p. 99). Phillips (2005) also highlights this fact:

Increasing numbers of people, including men and teenagers, are having cosmetic surgery. In 1997, plastic surgeons, dermatologists, and ENT doctors in the United States performed about 2 million cosmetic procedures (surgical and nonsurgical); by 2003, that number had risen to nearly 8.3 million. The marketing of beauty has become a multibillion dollar industry. Men and boys, too, are increasingly getting this message – from advertising, toys and other sources (p. 176).

Pope, Phillips & Olivardia (2000) also comment specifically about how this impacts males:

Millions of men are sacrificing important things in their lives to exercise compulsively at the gym, hoping for a bigger chest or a flatter stomach. Men and young boys alike are buying billions of dollars worth of “muscle-building” food
supplements and diet aids. As many as three million men have taken anabolic steroids or other dangerous black-market drugs to buff up their bodies. An equally large, even more secret group of men has developed eating disorders—compulsive binge eating, dieting, and exercise rituals… (p.xiii).

Although BDD is classified as a mental health diagnosis, many people suffering from BDD seek cosmetic surgery procedures to change their imagined or slight defect. In fact, Wilson & Arpey (2004) report “patients with body dysmorphic disorder more often consult dermatologists or plastic surgeons rather than psychiatrists for treatment of their “defect” (p. 1391). This may speak to the ingrained perception within the patients that the defect is in fact a real, physical problem that can be alleviated by a medical intervention. Wilson & Arpey (2004) further state “In the largest published series of patients with body dysmorphic disorder evaluated in a psychiatric setting, 46% had sought treatment from a dermatologist and 38% had received dermatologic treatment, making dermatologists the preferred physician for this population” (p.1391). According to these sociocultural messages, people should strive to reach an ideal, strive to be attractive. Unfortunately, this ideal is often out of reach, both physically and perhaps monetarily, for the “average” person. Being bombarded with these images may be a factor in contributing to the development of BDD, since these factors focus on a preoccupation with physical attractiveness. As Phillips (2005) points out, “About 60% of the people in my studies said that they believe society’s focus on appearance increases their BDD concerns” (p. 177). Although sociocultural etiologies increase BDD concerns, it cannot be said that these factors alone cause BDD. Again, if this were true, every one who experienced these factors would develop BDD, which is not the case.
Reviewing the literature suggests the etiology of BDD lies somewhere in the intersection of biological, psychological and sociocultural factors. Alone, these etiologies can have significant impact on personal perception of body image, but it is a combination of all three that purports a stronger case for the development of symptoms of preoccupation with the imagined or slight defect and causes impairment in social, occupational or educational functioning.

An exploration of the symptomatology of BDD will further help to understand its epidemiology. As previously noted, the diagnostic criteria for BDD, as outlined in the DSM-IV TR (2000), are:

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa). (p. 468)

Most commonly the “imagined defect” centers on concerns of the face and head, but can also involve any body part. McKay (1999) pointed out, “The primary body areas resulting in dysmorphic reactions were face (90%), thighs (30%), hairline (30%), buttocks (30%), feet (20%), and genitals (20%). Percentage of body concerns exceeds 100% as several patients had multiple bodily concerns. None of the patients in McKay’s study were excessively
concerned with body weight” (p. 622). Sufferers display a reluctance to share their symptoms, even with medical professionals, because of feelings of shame and embarrassment. Individuals with BDD can manifest their distress with different symptoms. For example, people often spend several hours a day checking themselves in a mirror, or conversely, others may ignore mirrors altogether, taking special steps to avoid them. People with BDD often seek medical procedures to correct the “defect.” However, even when these procedures are carried out, the vast majority perceive the defect as still being present.

BDD usually develops during adolescence, but may also develop in younger children, although it is harder to diagnose at younger ages. The onset of symptoms varies, and may either manifest abruptly or over a period of time. There are usually few symptom-free episodes and, according to Phillips (1998), “…the disorder is usually chronic, often with waxing and waning symptoms over time…” (p. A38). Through the continuous course of the disorder the individual may, but does not always, shift the focus of their preoccupation to a different body part. The preoccupation with an imagined defect is so intense as to be immobilizing, or nearly so, in the life of the sufferer.

Even though BDD has been characterized as a Somatoform Disorder in the DSM-IV, it displays similarities to the Obsessive-Compulsive Disorder (OCD) family. The most common comorbidity occurs with major depression. Phillips (1998) comments on this with reference to “… one study reporting a current rate of about 60% and a lifetime rate of more than 80%” (p. A38). Other studies point to percentage correlation as high as 68% for current rate and 93% for lifetime rate (Phillips, 2005). BDD has also been shown to have a comorbid relation with social phobias, substance abuse disorders, and obsessive-compulsive disorders. All of these have shown lifetime rates of more than 30% (Phillips, 1998).
Because BDD is concerned with appearance, it may be difficult to diagnose from other disorders that focus on appearance. As stated earlier, nearly everyone has expressed a desire that they care about their appearance and want to work to improve it. It must be understood that this is a “normal” desire and that the diagnosis of BDD would only apply if the individual were excessively preoccupied by a slight or imagined defect(s) and that this preoccupation was causing clinically significant social and or occupational impairment. Similarly, BDD must be differentiated from eating disorders such as Anorexia Nervosa, where the concern is focused on body size, shape or fat content. If the concern is with weight, then it should be categorized as an eating disorder. Also, since BDD shares common characteristics with OCD such as repeated ritualized behavior it is important to note if the obsessions or compulsions occur around the focus of appearance or other concerns. If the focus is not centered on appearance, then the individual may be diagnosed with an Obsessive-Compulsive Disorder. Also, the same conditions would apply to Major Depression, as many people suffering from BDD show signs of this disorder.

Another aspect that would help with the exploration of the symptomatology of BDD is a discussion of the differences between male and female sufferers. Generally, there doesn’t seem to be a difference between the genders with relation to quantity of sufferers. BDD, for the most part, seems to occur equally among men and women. Phillips and Diaz (1997) in a study reviewing gender differences among 93 women and 95 men diagnosed with BDD found that “Although the clinical features of BDD appear remarkably similar in women and men, there are some differences, some of which reflect those in the general population, suggesting that cultural norms and values may influence the content of BDD
symptoms” (p. 570). Using a variety of instruments to assess clinical features of BDD, prior treatment histories and comorbid Axis I disorders, their conclusions point out:

Men and women were excessively preoccupied with a similar number of body parts over the course of their illness (three to four), and they were equally likely to engage in most BDD-related behaviors, such as mirror checking, reassurance seeking and excessive grooming. Both groups reported similar rates of social and occupational/academic impairment, psychiatric hospitalization, and suicide attempts. (pp. 572-573)

Similarities in treatment issues can also be pointed out, as both genders were as likely to seek out non-psychiatric medical treatment, cosmetic surgery, dental procedures, etc. However, there are differences that can be noted. Men who suffered from BDD were more likely to be single than women sufferers. Both men and women displayed concerns about their hair, but for women the concern was around how hair (on their heads) looked, while men displayed a concern over loss of or thinning hair (on their heads). Women were more likely to pick at their skin and to use cosmetics as a way to hide their “defect,” while men were more likely to use a hat to disguise theirs. Both displayed concerns regarding their bodies, but the women’s concerns centered on body weight (being too large) and hip size, while men were concerned with being under weight and having too small of a build. Men were more concerned with their genitalia, mainly their penis size being too small, while women concerned themselves with unhappiness about breast size (being too small). Also, Phillips and Diaz (1997) found, “...women were more likely to have comorbid bulimia nervosa and any eating disorder, and men had a significantly higher rate of alcohol abuse or dependence and any substance use disorder” (p. 574).
Finally, to round out the discussion on symptomatology, a brief exploration of ethnic and cultural differences should be addressed. In-depth studies on this topic have not yet been done; however, from what research has been conducted, it can be seen that more similarities than differences exist across ethnic and cultural boundaries (Phillips, 2005). Basically, this means that the factors influencing the formation of BDD are not limited to our American culture. Italy, England, Turkey, India, Ecuador, Guatemala, Peru, South Korea, Japan, Bahrain, and Australia are just some of the counties that have documented cases of people diagnosed with BDD. Studies conducted in England, France, Japan, Germany, Russia, and Italy point to BDD as a disorder that is not culturally bound and point out that scientists found a high concordance cross-culturally on what is considered attractive. This supports “…a “universalist” point of view: culture appears to provide nuances and accents on a basically invariant, or universal, expression of BDD” (Phillips, 2005, p. 179). Age of onset, gender breakdown, and preoccupation with areas of head and face were prevalent cross-culturally. Phillips (2005) further notes:

People in different countries generally focused on similar body areas and performed similar BDD behaviors, such as mirror checking and camouflaging. Across cultures, there was a high rate of being housebound, high rates of coexisting depression and anxiety, and moderate-severe social and occupational impairment (p. 179).

However, each culture can have specific cultural differences. For example, in Japan, there seems to be a strong preoccupation with the eyelids, whereas this does not seem to affect most sufferers in the United States (Phillips, 2005). A culturally bound syndrome called Koro exists in Southeast Asia. It focuses on diminishing penis size and eventual death, and might be linked to BDD, although this is not conclusive (DSM-IV, 1994). Despite slight
cultural differences, BDD and BDD-like symptoms seem to exist cross culturally, leading to the possible conclusion that concern with appearance and the subjectivity of beauty are universal concepts. These ideas, combined with biological and psychological factors give credence to a multi-etiological hypothesis of BDD.

*Treatment of BDD*

When discussing the treatment options available to people with BDD, it is important to explore the two prevailing ideologies that exist in the mental health profession today: psychotherapeutic treatment and psychopharmacological treatment. Each has its own supporters and dissidents, and each have their positive and negative features. A separate exploration of each one is necessary in order to allow an independent evaluation as to what each has to offer and what limits they place on people suffering with BDD.

The main psychotherapeutic treatment today for BDD is Cognitive-Behavioral Therapy (CBT). Although there is not extensive formal research on its effectiveness, many clinicians find it to be a helpful approach for people suffering with BDD (Geremia & Neziroglu 2001; Rosen, Reither & Orosan 1995). CBT may work because it focuses on the “here and now” and works to help change “problematic” behaviors and processes (Phillips, 2005). CBT has had proven success with people suffering from disorders similar to BDD, such as panic disorder, obsessive compulsive disorder and depression because it focuses on changing problematic thoughts and behaviors (Phillips 2005) and has a comorbidity rate of 6 to 14% with anxiety and depressive disorders. However, this estimate may be low because people with BDD often do not seek treatment (Feusner, Winograd & Saxena, 2005). CBT has probably had success with BDD and other disorders because of its two-pronged approach. The cognitive aspect focuses on thought processes and ways of changing them into more
healthy patterns. The behavioral part focuses on changing the “problematic” behaviors such as mirror checking and social isolation. From the data and research available, it has been shown that two types of behavioral therapy, called Exposure and Response Prevention, have had the greatest impact on changing BDD behaviors. Exposure forces the individual suffering from BDD to confront his or her fears by exposing the area of the “defect” to people and situations which have been desperately avoided. The concept is that through this exposure, the individual’s fear will diminish with time. Response Prevention focuses on diminishing the compulsive and ritualistic behaviors, such as mirror checking so that these behaviors are not engaged in. Although this sounds simplistic, it is not, and the result can often be a reduction of the desired BDD behavior (McKay, Todaro, Neziroglu, Campisi, Moritz & Yaryura-Tobias, 1997).

As with any type of therapy, education on the part of the sufferer is a necessity in order to ensure understanding of the procedure and to elicit the sufferer’s help with the therapy. Such steps as keeping a journal to monitor BDD behaviors, thoughts, emotions, or “triggers” have been found to help the sufferer realize the impact of the disorder on his or her life, thus laying the foundation on which to build a healthy and productive therapeutic process.

With regard to psychopharmacological treatments for BDD, it is evident that more research needs to be done in order to discover which medications provide the best relief. In the past, sufferers were given medications that had little effect alleviating their symptoms. These included non-SSRI antidepressants, such as bupropion (Wellbutrin) and venlafaxine (Effexor), neuroleptics, such as olanzapine (Zyprexa), as well as mood stabilizers, stimulants and benzodiazepines (Phillips, 2005). Recently, as noted earlier, BDD sufferers have been
given a class of drugs called Selective Serotonin Reuptake Inhibitors (SSRIs), which seem to be very effective. For example, in a randomized, double-blind, placebo-controlled, parallel group trial comparing fluoxetine (Prozac) and a placebo among 67 patients over 12 weeks, fluoxetine was found to be significantly more effective in treating BDD symptoms (53% vs. 18%) (Phillips, Albertini & Rasmussen, 2002). In a 16-week, double blind, randomized study comparing clomipramine (Anafranil) and desipramine (Norpramin) in 29 patients, clomipramine was found to be significantly more effective for treating BDD (65% vs. 35%) (Hollander, Allen, Kwon, Aronowitz, Schmeidler, Wong & Simeon, 1999). Citalopram (Celexa), in an open label trial lasting 12 weeks, found 73% of the 15 subjects responded positively and reported a significant improvement in their quality of life. (Phillips & Najar, 2003). Other studies with SSRIs have produced similar outcomes (Perugi, Giannotti, DiVaio, Frare, Saettoni, Cassano, 1997; Phillips, Dwight & McElroy, 1998).

These drugs act by inhibiting the reuptake of the neurotransmitter Serotonin by pre- and post- synaptic terminals in the synaptic cleft, thereby presumably making more Serotonin available for hormonal action in the Central Nervous System. SSRIs are a type of anti-depressant that can also counteract the obsessive and/or compulsive effects of BDD, making it useful in its treatment. The February/March 1999 issue of Health News published an article that pointed out, “In the past, people with BDD were treated with older style anti-depressants, tranquilizers and anti-psychotic drugs, but these were not effective…While research is limited, some studies have found that more than half of patients experienced a partial or complete response to SSRIs” (p. 5).

This could suggest the etiology of BDD as occurring at least partially biologically, in the brain, possibly due to a lack or insufficient metabolism of serotonin. BDD sufferers
who respond to such medications appear to have a much easier time focusing on other areas of their life that do not relate to their “defect,” and are noted to have a decrease in obsessional preoccupation (Phillips, 2005). They might also experience increased self-esteem and decreased anxiety. Phillips (2005) substantiates this by referring to independent research, “Of 61 treatment trials with an SRI in 41 patients, 70% resulted in clinically significant improvement in BDD symptoms” (p. 244).

It should be briefly mentioned that several approaches to treating BDD have been found to be ineffective. Such approaches would include going on a diet or having plastic surgery (these may not be effective because the defect is primarily “imagined” and the perception of body image might not change, even if there are actual physical changes to the body, homeopathic remedies (at least there is no current data to support their effectiveness), hypnosis, just “trying harder,” or constant reassurance by friends or relatives. Although some of these, like “trying harder” can contribute to the overall process of mental wellness, they should be seen as an orientation in the right direction, not as a resulting effective treatment.

Assessment of Issues and Tools

Given cross-cultural and sociocultural attitudes that impact our perceptions of our appearance and selves, how can it be determined that someone is suffering from BDD? Basically, mental health and medical professionals use the diagnostic criteria set forth in the DSM-IV as a standard guide. Due to the nature of BDD and the relatively recent interest in clinical studies surrounding the disorder, there are currently no concrete medical tests that would help in the assessment process. However, some clinical researchers specializing in BDD have developed their own tools of assessment. Phillips, a leading researcher and
clinician specializing in BDD, developed one such set of tools. Her approach is two-fold. Phillips (2005) utilizes a self-assessment report in conjunction with a clinical interview, both utilizing DSM-IV diagnostic criteria, to help ascertain if a diagnosis of BDD is warranted, and then to determine the mildness or severity of the disorder. In the self-assessment questionnaire, aptly called the Body Dysmorphic Disorder Questionnaire (BDDQ), Phillips asks questions regarding perceived body appearance, establishing whether or not preoccupation and impairment exist. Her questionnaire also tries to ascertain approximately how much time is spent during each day thinking about the “defect.” Phillips (2005) comments that, “…I have significant reservations about diagnosing BDD in anyone who spends less than an hour a day thinking about their defect, because I’d generally consider them insufficiently preoccupied to fulfill criterion 1 for the diagnosis” (p. 42). Self-reporting is helping because it ascertains the perception of the individual about his or her appearance, and perceived defect. It must be kept in mind, however, that the BDDQ should only be used as a screening tool, not a diagnostic one. Diagnosis should only be made after a consultation with a trained medical or mental health professional.

Several instruments have been found useful to clinicians in determining the presence of BDD. In the clinical interview, Phillips, as well as other professionals in the field, utilizes the Yale-Brown Obsessive Compulsive Scale Modified for BDD (BDD-Y-BOCS), the National Institutes of Mental Health’s Obsessive Compulsive Scale Modified for BDD, the Clinical Global Impression Scale, and the Body Dysmorphic Disorder Questionnaire (BDDQ). All four of these methods have proven to be useful in a clinical setting for helping to assess BDD; however, the BDD-Y-BOCS seems particularly useful in assessing BDD severity (Phillips, 2005). The scale rates responses and severity of symptoms for the past
week (for behaviors, thoughts, insight and avoidance) from an individual based on 12 questions. The ratings for each question range from “None” to “Extreme.” (It should be noted that the individual being rated should already have a diagnosis of BDD.) The information gained does not only help the clinician determine the current severity of BDD, but can also be serially administered over time to ascertain the increasing or decreasing severity of symptoms.

Individual clinical interviews, combined with self-reporting, help the mental health or medical professional to ascertain not only a correct diagnosis, but also the severity of the symptoms and their disabling effects. As with any mental illness, it is imperative for a health prognosis that as many tools as applicable are used in order to gain the fullest understanding of the impact of the disorder. This is especially important given the fact that individuals do not function in a one-dimensional world, but operate in a world with influences from mental, social and cultural processes.
Literature Specific to BDD in Men

Part of the confusion surrounding the etiology, prevalence and diagnosis of BDD is that although it is characterized as a somatoform disorder in the DSM-IV TR, it is more commonly treated by medical and mental health professions familiar with the disorder as an Obsessive Compulsive Spectrum disorder (OCSD). Locher & Stein (2001) state in reference to Stein & Hollander (1993) and McElroy, Phillips & Keck (1994):

Over the past decade, it has been suggested that a number of disorders with phenomenological and psychobiological overlap with OCD lie on the so-called OCD spectrum of disorders. One suggestion has been that OCD, Body Dysmorphic Disorder, hypochondriasis, anorexia nervosa, Tourette’s Syndrome, trichotillomania, pathological gambling, sexual compulsions and impulsive personality disorders span a continuum from compulsive to impulsive disorders (p. 19).

Although this view of OCSD is not without debate in the literature (Locher & Stein 2001), there seems to be evidence that BDD responds to the same types of psychopharmacological and psychotherapeutic treatments that have been found to be effective in treating patients diagnosed with OCD (Cororve & Gleaves 2001, Frusner, Winograd & Saxena 2005, Geremia & Neziroglu 2001, McKay et. al 1997, Pato & Phillips 2003, Rosen, Reiter & Orosan 1995, Wilhelm & Otto 1999).

Even though BDD may fall within the realm of OCSDs with regard to treatments methodology, it is still a distinct pathology. In their review of BDD assessments and treatment strategies, Cororve & Gleaves (2001) state that, “Although BDD has been viewed as a variant of an eating disorder, obsessive compulsive disorder, or a somatoform disorder, it
appears best conceptualized as a body image disorder with social, psychological, and possibly biological influences” (p. 949).

Most current (and past) research focuses primarily on women’s body image concerns and often link body image concerns with eating disorders. This is problematic as it indicates that many researchers were, and are, not focusing on body image concerns and BDD as a stand-alone diagnosis. Additionally, this also indicates that men have traditionally not been viewed as having body image/BDD issues by these researchers. Lynse, Engel, Taheri & Wonderlich (2002) comment on this when they discuss that, “In the past several decades, there has been a large body of empirical research on anorexia nervosa (AN) and bulimia nervosa (BN). Much of this work focused on cultural, biological, and psychological aspects of eating behavior and body image concerns in women, largely because these…disorders generally afflict females” (p. 56). Body image concerns are often viewed both by the larger society and by mental health professionals in Western societies as predominantly a women’s issue (Lynse et. al. (2002). Harvey and Robinson (2003) go on to state that, “There may be stigma for both patient and therapist about this disorder in men. The bias may lead to under diagnosis as well as improper treatment because eating disorders and body image problems have been considers a woman’s disease” (p. 298).

Previously it was thought that homosexual men, because of the equation with women as being overly concerned with physical attractiveness, were more susceptible to developing body image disorders and BDD. For example Harvey & Robinson (2003) state that “Gay men and heterosexual women…show the highest concern for physical attractiveness…Similar to heterosexual women, gay men were found to view their bodies as sex objects to attract men, making them more prone to body dissatisfaction” (p. 301).
Tiggemann, Martins & Kirkbride (2007) in their study of 143 gay men and 119 heterosexual men comparing body dissatisfaction and body ideals, found that although body dissatisfaction was widely experienced by both gay and straight men, it was greater for gay men. However, other research has shown that this is not the case, and that there is no difference between heterosexual men and homosexual men concerning body image dissatisfaction (Hausmann, Mangweth, Walch, Rupp and Pope 2004). In a study looking at body image dissatisfaction between gay and straight men, Hausmann et. al (2004) compared 37 gay males with 49 community recruited heterosexual men and 24 clinic recruited heterosexual men diagnosed with eating disorders. They found that:

Gay men were indistinguishable from the community recruited heterosexual comparison men on measures of both body ideals and body-image distortions. By contrast, eating-disordered men were significantly distinguishable from both other groups on body-image distortion…If our findings are valid, it follows that some previous studies of body image in gay men may possibly have been influenced by selection bias. (p. 1555).

These contrasting results fuel the need for additional research into the area of male body dissatisfaction with relation to gay and straight men. Assessing the factors that may contribute to the development of negative body image and how these factors may be compared and contrasted when looking at the impact on gay and heterosexual males may help to clarify the muddy waters of this emerging debate.

As with the aforementioned studies targeting women, when research has been conducted that highlights the potential negative impact body image concerns have on men, much of it seems to be focused on linking body image with eating disorders (Boroughs &
Thompson 2001; Harvey & Robinson 2003; Lynse et. al 2002; Mangweth et al 2004; Rosen & Ramirez 1998). Although there is some overlap in terms of both producing potentially negative mental and physical impacts and the misconception that they both only affect women or gay men, these two pathologies need to be examined separately as the etiologies and diagnostic criteria are quite different. The danger with this, as can be seen in the Hausmann et. al (2004) study, is that males with eating disorders seem to have a higher rate of body dissatisfaction, which may distort results when eating disordered men are grouped in research studies with men suffering from BDD. Furthermore, within the limited research conducted where the focus of the body-image or BDD research is limited to males without eating disorders, much of it seems to focus on men who are specifically concerned with developing a muscular or “hypermasculine” appearance such as the “Adonis Complex” (Pope, Phillips & Olivardia (2000). Cafri & Thompson (2004) rationalize this by stating:

The exact nature of male body image concerns appears to have been neglected in the paradigm of research emphasizing thinness because males are more concerned with a muscular appearance (McCreary & Sasse, 2000). A lack of past attentiveness to male body image issues is one reason why assessment of muscularity has become a topic of interest (p. 18).

Although this should not discount the importance of muscularity in men’s development of BDD, it should be considered only one factor, not the only factor, to be addressed when exploring factors that influence the development of BDD in males.

Actual prevalence rates are unknown, but the DSM-IV states that “Body Dysmorphic Disorder may be more common than was previously thought” (p. 467). Lochner & Stein (2001) reference McElroy et. al (1994), Phillips et. al (1994) and Fukuda (1997) when they
state “The gender ratio of BDD appears to be approximately equal (1:1) or slightly more frequent in males (3:2) (p. 22). Even though it is unclear as to how many men might be suffering from BDD it is clear that it can have devastating results. This can be highlighted by the fact that recent surveys have found that 43% of U.S. men experience some level of dissatisfaction with their appearance (Pope, Phillips, & Olivardia 2000).

Because the impact of BDD on men is backed by limited research, “…less is known about what pressures our society places on men regarding body size and shape” (Lynse et. al (2002). Simply because these pressures are unknown or unrecognized by our society, the negative impact these factors can have on men is not lessened. In fact, being under-diagnosed or unrecognized may have the potential of making this disorder worse among male sufferers as they may not have adequate educational and/or therapeutic resources on which to draw, which may result in more negative outcomes such as increased shame and embarrassment.

Because of lack of knowledge and stigma surrounding BDD in men, many may turn to dermatologists and cosmetic surgery as a way to deal with these feelings (Castle, Molton, Hoffman, Preston & Phillips 2004; Castle, Phillips & Dufresne, 2004). Unfortunately, for most men suffering from BDD, Phillips & Castle (2001) posit the cosmetic changes they make to their bodies do not help alleviate their symptoms for any significant length of time. This is mainly because the source of their body image concerns and subsequent BDD are not driven by outward appearance, but by a complex interaction of factors (biological, psychological, cultural). These factors, although sharing some common elements, are unique for each individual.

Paid little attention in the current literature, in this study we will explore these unique lived experiences in order to gain further insight into the impact of BDD on these men’s lives
and the factors that have led to its development. The lack of focus in the literature on this phenomenological area is evident and it is hoped that this research can help fill this void. Results from this study will help identify individual unique experiences of men with BDD. A brief review of the existing literature will be undertaken to discuss how these inductive results compare and contrast to the broader published findings regarding factors that contributed to the development of BDD.

It is hoped that these exploratory and phenomenological findings will increase knowledge and awareness, and reduce stigmata among the men suffering from this disorder. It is hoped sufferers may gain a clearer understanding of themselves that will help them to lead healthier, happier lives. It is also hoped that the knowledge gained from their experiences will add to the literature and raise the awareness of this disorder in the mental health community. Only through ubiquitous understanding will more attention be paid and greater outcomes achieved when working with men suffering from BDD.
Methods

*Characteristics of phenomenological research*

The phenomenological researcher attempts to identify the “essence” or “lived experience” of the participant’s experience concerning a specific phenomenon, as described by the participant’s own words. Typically, this involves studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meaning (Moustakas, 1994 in Creswell 2003). Traditionally, the researcher brackets his own experiences and preconceptions in order to more fully understand those of the participants, “relying on intuition, imagination, and universal structures to obtain a picture of the experience” (Creswell, 1998). However it is felt by this author that this traditional tactic of bracketing may not be an appropriate strategy, as it is not clear if one can truly bracket one’s own lived experiences when attempting analysis of data. LeVasseur (2003) appears to also agree with this perception when discussing the problems with bracketing:

Salsberry (1989) observed that all knowledge of the external and internal world is mediated by conceptual frameworks. Presumably, these concepts are operative not only in the researcher’s interpretation of events but also in the participants’ remembered telling of events. Thus, the vexing question of whether we can ever be free of our own conceptual understanding and particular historical point of view is doubled: Even if we, as researchers, can bracket our own viewpoints, what of the participants? Does the fact that participants do not bracket their own preconceived notions in the telling of experience mean that our knowledge is based on a flawed understanding, already skewed from the things themselves? …this [bracketing]
would be strictly impossible, because human beings are always already engaged in interpreting their experience (p. 416).

Additionally, classic phenomenological thinkers, such as Martin Heidegger, Jean-Paul Sartre and Maurice Merleau-Ponty denied the possibility that bracketing existed (Encarta, 1999).

In lieu of engaging in traditional bracketing, this author will attempt to be conscious of his biases, i.e. how he views the world, in order to understand how these views might potentially impact the participant’s data and resulting analysis. Specifically this will reflect the researcher understanding and exploring his own biases regarding the factors impacting negative body image and the high potential for the development of BDD. This is necessary in order to attempt inductive research and to be open to accepting all data the participants might suggest. LeVasseur (2003) supports this new definition of bracketing when she discusses the difference between natural attitude (our everyday view of the world) and philosophical attitude (a reflective and questioning perspective) in the context of phenomenological bracketing. She states, “I believe that a distinction focused on bracketing the natural attitude…would be possible with the interpretive paradigm and serve as a bridge to the philosophical attitude” (p. 417) (LeVasseur 2003). Wertz (2005) also comments on the reality of what phenomenological researchers may bracket:

The existence and validity of human situations are “bracketed” only in order to allow the shift from naïve, straightforward encounters to a reflection on how the life-world presents itself, that is, to its constitutive meanings and subjective performances…the analyses that follow from it allow us to recollect our own experiences and to empathically enter and reflect on the lived world of other
persons in order to apprehend the meaning of the world as they are given to the first-person point of view (p. 168).

Role of the Researcher

Screenings and interviews were conducted solely by the researcher. The primary tasks included developing a recruitment advertisement to solicit participants and placing the advertisement in local newspapers. All screenings were conducted over the telephone and all interviews were conducted in person. The researcher’s knowledge and familiarity with screening measures and development of clinical and interpersonal skills, such as rapport building, compassion and humor was seen to encourage participation and exploration of lived experiences. Lived experience with regard to phenomenological inquiry may be defined as “…the importance of individual experiences of people as conscious human beings” (p. 236) (Moustakas, 1994 as cited in Creswell 1998).

Participants

The study was open to all adult males, over the age of 21, of any ethnic or cultural background and any sexual orientation and was drawn from the Seattle, Washington, metropolitan area. The participants were asked to fill out a demographic information form (Appendix E), based on the ADRESSING model (Hays, 2001), in order to obtain background information on each participant. The ADRESSING model is a widely known demographic guideline developed by Pamela Hays, Ph.D. It is supported by both the American Psychological Association (APA) and the Canadian Psychological Association (CPS) as a tool that adequately attends to cultural issues. Its’ framework examines cultural factors from nine different areas: Age, Disability, Religion, Ethnicity, Socioeconomic Status, Sexual Orientation, Indigenous Heritage, National Origin and
Gender. Demographic variables are described in tables of frequencies and percentages in the Results section, and are used as descriptors of the sample, both in terms of the number of potential participants who self-selected for the study, and the final number of participants who completed the study. Relevant frequencies in themes as they relate to various cultural factors are also discussed in the Results section.

Data Collection Procedures

Self-selected interviewees were drawn from the Seattle metropolitan area. A recruitment advertisement was placed in a diverse cross-section of both pay and free local Seattle area newspapers (The Stranger, Seattle Gay News, Times-PI, Seattle Weekly and the Beacon Hill Journal) so as to garner participants from a varied socioeconomic cross section. The advertisement initially ran for one month. The goal was to recruit 10 qualified participants during that time. After one month’s time, only four qualified participants were recruited, so it was decided to run the advertisement for another month in hope of soliciting additional participants. After running for the second month, only two additional qualified participants were recruited for the study. At that time, due to a variety of factors including time and financial constraints of the researcher, it was decided that the study would proceed with the six qualified participants. In total, 14 men responded to the recruitment advertisement, seven during the first month and six during the second month. Of the initial seven respondents, five qualified for participation in the study, but one withdrew prior to the in-person interview. Of the remaining seven responders, two qualified for the study, two did not meet screening criteria, and three were unreachable after their initial contact prior to the initial phone screening.
Responders to the recruitment advertisement were screened with the Body Dysmorphic Disorder Questionnaire (BDDQ) to identify participants who met screening measure criteria and DSM-IV-TR criteria for BDD. Responders were also evaluated for participation in this study by their ability to provide a good description of their experiences. This was evaluated by the primary researcher based on participant answers to questions during the initial phone screening. During this initial screening, the potential participants were asked how comfortable they were answering personal questions regarding their history and background experiences related to their own body image. These open-ended questions were standardized using a script (Appendix F) and asked participants to talk about: 1) their willingness to discuss, over the phone, details concerning their body image concerns, and how comfortable they are speaking in person about their own body image issues, and 2) how they heard about the study (which paper, how did they find the on-line forums, etc.). If during the course of answering the questions the potential participants signified their unwillingness to discuss their own body image concerns and/or they did not articulate at least three complete sentences for each of the screening questions, they were thanked for their participation and excused from the study. For those participants who did not initially give a response that includes three full sentences, they were prompted once to elaborate. This screening increased the chances that the participants could accurately convey the essence of their lived experiences. Due to the nature of phenomenological research, the findings can not be generalized beyond the sample of the individuals interviewed.

The newspaper advertisement consisted of a recruitment advertisement (Appendix D), briefly defining the study and asking if the reader was dissatisfied with his body and
asked for men to self-select for participation. Telephone responders to the recruitment advertisement talked with the author of this study and were given the phone screening and modified BDDQ (Appendix A). Those who passed the phone screening, indicating the ability to give an in-depth description of their lived experiences about their body image concerns, and whose answers on the BDDQ indicated their body image concerns were within the clinical range for the likely diagnosis of BDD, were selected for participation.

All in-person interviews took place in a room on the Antioch University Seattle campus. All phone screenings were conducted on a dedicated landline phone number based at AUS. The phone is located in a private office on the main AUS campus, which increased confidentiality. Participants were interviewed using the BDDQ and asked the research question/sub-questions. All interviews were audio recorded by the researcher. Interviews were conducted inductively, with a focus on having the participants answer the main research question, with follow-up probes and inquiries by the researcher for clarification. Inquiries and probes were limited to sub-questions on the research questionnaire. The sole researcher then transcribed all in-person interviews. Transcription by the researcher helped to generate a greater understanding of the study data by increasing exposure to the material, rather than having the data transcribed by a third-party.

*Body Dysmorphic Disorder Questionnaire (BDDQ)*

The Body Dysmorphic Disorder Questionnaire (BDDQ) is a widely used self-report questionnaire that screens for the possibility of BDD. As reported by Bohne, Keuthen, Wilhelm, Deckersbach, & Jenike (2002), the BDDQ is “…based on the criteria outlined in
DSM-IV and is used to assess body image concerns. It is highly correlated with clinicians' diagnoses of body dysmorphic disorder. It has a reported sensitivity of 100% and a specificity of 89% among individuals with a psychiatric diagnosis” (p.487). Similar reports of use, sensitivity and specificity have also been reported (Veale, De Haro & Lambrou, 2003). As elaborated by the author of the BDDQ (Phillips, 2005), this means:

…that in a group of individuals who are judged by a clinician to really have BDD, the BDDQ will accurately ascertain that BDD is present in 100% of the cases…and in a group of individuals whom a clinician judges really don’t have BDD, the BDDQ will accurately determine that BDD is not present in 89% of the cases (p. 379).

The BDDQ consists of four main questions, with three of the questions having sub-questions for clarification. Although it follows DSM-IV criteria for diagnosis of BDD, it is not a diagnostic tool, merely a screening tool that assesses whether BDD may be present. Individuals are likely to meet BDD diagnostic criteria if they answer yes to both parts of question one, any part of question three, or choose answers b or c for question four. It is important to emphasize that the BDDQ is a self-report format questionnaire that does not focus on severity, but rather is designed to help the clinician assess whether BDD may or may not be present and not designed to definitively diagnosis the presence of BDD.

For this study, a modified version of the BDDQ was used. This modification consisted of an addition to the end of question two, which currently reads, “Is your main concern with your appearance that your aren’t thin enough or that you might become too fat?” The addition changed question two to read as follows: “Is your main concern with your appearance that you aren’t thin enough or that you might become too fat or too thin?” It is felt that the addition of “or too thin” is necessary to address participants who do not feel that
they are currently too thin, but worry about becoming too thin. This could be the case with men who fear losing muscle mass. A copy of the modified BDDQ can be found in Appendix A.

Data Analysis Procedures

After approval was obtained by participants in regard to accuracy of their interview data, all interviews were entered into NVivo 7 and cross-referenced for themes. NVivo is qualitative analysis software commonly used in the study and meaning making of qualitative data (QSR International, 2006). Key points were assigned visual codes to allow categorizing, tracking and collating of information from the transcripts of the in-person interviews. Themes were compared and contrasted in order to explore the research question. In addition to common themes, attention was also paid to unique responses as a means to truly highlight and give meaning to the individual’s experience. Both common themes and unique responses were analyzed and discussed in the context of the research question.

The framework for the data analysis and interpretation was drawn from Creswell (2003) and mirrored the following six-step procedure. All analysis was conducted by the sole researcher. First, on completion of the phone screenings and in-person interviews, data were organized and prepared for analysis. This was initially done by reviewing all field notes, screening measures, and audio interviews to insure legibility, audio clarity and understanding. The second step involved transcribing the interviews using word-processing software. Each transcript was then read in order to obtain a general sense of the data and to allow reflection on the overall meaning(s) presented in each interview. Step three involved entering the data into NVivo to begin the coding and analysis process. This was accomplished by a simple means of uploading the word-processing files into the software.
Once the interviews were uploaded into NVivo, coding began by organizing the data into “chunks” and labeling them into categories or “nodes”. During step four, the codes were used to generate descriptions and identify words, phrases, ideas and details that reflect the meaning of the participants lived experiences about their negative body image and potential BDD. The coding was used to generate categories that were shaped into a general description, reflecting both common themes and outliers found in the responses. Step five involved identifying and highlighting these themes by using narrative passages from the interviews. During step six, the final process of reflection on the interpretation and meaning of the data was undertaken.

*Ethical Issues*

Confidentiality of participants was ensured through use of pseudonyms and coding identifiable data. All identifying data not pertinent to the study was changed or omitted. Use of informed consent, both written and verbally, was utilized at every step possible to ensure willingness and understanding of participants to participate in the research. Upon completion participants received an abstract with findings and results of this study. Referrals were made available to participants who wished to seek treatment, however, none of the six participants asked for referral contact information.

*Delimitations*

Because of the lack of accurate statistics on prevalence and the rarity of the diagnosis, finding people diagnosed with BDD or who potentially have BDD was expected to be difficult. Advertising in several newspapers was an attempt to reach a wider recruitment sample and thus help counter this. This proved insufficient however, even though the initial recruitment period was extended an additional month to meet the original study requirement.
of 10 participants. Also, the time of year might have been a factor here as the recruitment advertisement ran from October to December, which encompasses many holidays and time-consuming activities, which could have precluded participants from self-selecting for the study. Social stigma regarding men feeling embarrassed about admitting they have a severe negative body image issue might have also limited participation.

Significance of the Study

Although this study is small, results of this research will contribute to the developing literature on the impact of factors that lead to the potential development of BDD in males. It might raise awareness about this issue in order to facilitate appropriate interventions, diagnosis and treatment. Additionally it is hoped that increased awareness and understanding of BDD will also be achieved so that medical and mental health professionals can appropriately screen for BDD in male patients.
Results

Fourteen men between the ages of 29 to 57 years responded to the recruitment advertisement. Six men of ordinary appearance, without visible unusualness, met study criteria and became the study sample. Although all met screening criteria for BDD, this study did not confer or require a formal BDD diagnosis. Those who did not meet screening criteria spent less than one hour per day thinking about their perceived defect.

Table 1 provides demographic characteristics of the six final study participants. Their mean age was 41 (range 32 to 57). Two of the six participants identified as having a disability (asthma 16.7% ; paruresis, also known as pee shyness,16.7% ), and half did not belong to or currently practice any religion. The majority (n=5) were Caucasian (83.3%) and one was Filipino-American. Fifty-percent (n=3) identified as coming from middle class households, 33.3% (n=2) from upper-middle class households and 16.7% (n=1) from a lower income household. Highest level of education completed was evenly distributed, with each of the six participants achieving a different level, from high school to graduate school. The majority of study participants (5 of 6) identified as gay (83.3%) and claimed no indigenous heritage (83.3%). All study participants were born in the United States.

As discussed earlier, the majority of current literature hypothesizes three main etiologies for the development of BDD: genetic factors, psychological factors and socio-cultural factors. A discussion of the potential genetic factors that may contribute to BDD is beyond the scope of this study. However, responses from this study support current findings in the literature that psychological and socio-cultural factors may also and undoubtedly do contribute to the development of negative body image and potential development of BDD in adult males (Table 2). Stanford & McCabe (2005) state that psychological and socio-cultural
Table 1

Demographic Characteristics of 6 Study Participants

<table>
<thead>
<tr>
<th></th>
<th>Percentage of Sample</th>
<th>Number of Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Mean 41 years (age range 32 to 57 years)</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Paureisis</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>No disability</td>
<td>66.6</td>
<td>4</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Hindu</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Catholic</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>No Religion</td>
<td>49.9</td>
<td>3</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>83.3</td>
<td>5</td>
</tr>
<tr>
<td>Filipino-American</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Socio-economic Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Middle</td>
<td>49.9</td>
<td>3</td>
</tr>
<tr>
<td>Upper-Middle</td>
<td>33.3</td>
<td>2</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>High School + some college</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational/Trade School</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>AA</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>BA + some graduate</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>MA</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>83.3</td>
<td>5</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>Indigenous Heritage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part Native-American</td>
<td>16.7</td>
<td>1</td>
</tr>
<tr>
<td>No Indigenous Heritage</td>
<td>83.3</td>
<td>5</td>
</tr>
<tr>
<td>National Origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S.A.</td>
<td>100</td>
<td>6</td>
</tr>
</tbody>
</table>
Table 2

*Common Themes Among Study Participants*

<table>
<thead>
<tr>
<th>Psychological Factors*</th>
<th>Percent</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments by family members during childhood</td>
<td>100</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Socio-cultural Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media+</td>
</tr>
<tr>
<td>Culture**</td>
</tr>
<tr>
<td>Gay Culture**+</td>
</tr>
</tbody>
</table>

*perceived negative statements contributing to emotional development and self-perception in childhood
+film, movies, magazine articles, advertisements and photos, books
**culture defined as the mores, customs, norms and social institutions of the U.S. population
++gay culture with emphasis on what is needed for acceptance within the group
factors together specifically combine to predict body dissatisfaction among males. The result of their study, looking at the impact of messages from parents, friends and the media on 362 adolescent males found that “…parental messages were the strongest influence on body image, and that parents, the media, and to a lesser extent messages from male friends were the strongest predictors of body change strategies” (p. 105).

All of the participants (n=6) stated an unhappiness and preoccupation regarding their body build or not being muscular enough. In other studies among male sufferers of BDD, approximately 25% report this type of preoccupation, which is the largest single percentage preoccupation of any bodily area of distress (Pope, Phillips & Olivardia 2000).

Two participants were concerned with their breast size and felt they were too large. This also concurs with findings of Pope, Phillips & Olivardia (2000) who found 12% of the 95 men in their study reported concern with breast size. In addition to these two common areas, one participant was concerned with his penis size, feeling it was too small, and one was concerned about his brow, feeling it protruded too far out from his skull. These are also areas of documented dissatisfaction among men as about 15% of men with BDD share a preoccupation with genital size and about 8% have some preoccupation regarding the size and/or shape of their face (Pope, Phillips & Olivardia 2000) (Table 3). All of the participants stated that they spend an average of one to three hours per day thinking about their perceived body defects.

*Phenomenological Factors Contributing to Potential BDD Development*

Common themes began to emerge from participants’ experiences that supported psychological and socio-cultural factors as contributors to their negative body image and potential BDD development. Psychological factors, almost exclusively focused on negative
Table 3

*Major Areas of Body Concern Among Participants*

<table>
<thead>
<tr>
<th>Area</th>
<th>Percent</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body build/not enough muscularity</td>
<td>100</td>
<td>6</td>
</tr>
<tr>
<td>Breast size too large</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Penis size too small</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Brow protuberance</td>
<td>17</td>
<td>1</td>
</tr>
</tbody>
</table>
messages and interactions the participants received from family members during childhood. Socio-cultural factors focused mainly on the impact of media and cultural expectations. Additionally, factors that were unique in nature, compared to the other participants, will also be discussed. Because of the in-depth nature of phenomenological inquiry, some information surfaced that, although not directly related to the main question, was rich in detail and relevant when attempting to understand the lived experiences of the participants and should not be overlooked. Avoided activities emerged as one such area resulting from their negative body image/potential BDD (Table 4). These activities included social situations, locker rooms, mirrors, swimming, being shirtless, and flying.

*Common Themes*

Overarching was the contribution of psychological factors to the development of the participant’s negative body image and potential BDD development. Psychological factors can further be broken down to include childhood experiences growing up, which would include as a primary component negative interactions and comments by family members. Carroll, Seahill and Phillips (2002) support this when they reference Phillips, 1991 in an article stating:

Several factors have been proposed to contribute to the cause of BDD. Family characteristics such as “unharmonious” backgrounds and “unfavorable” childhood experiences such as teasing, which produce feelings of insecurity, poor self-esteem and rejection have been hypothesized to predispose to BDD…(p. 76).
Table 4

*Common Areas of Avoided Activity*

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social situations</td>
<td>100</td>
<td>6</td>
</tr>
<tr>
<td>Locker rooms</td>
<td>67</td>
<td>4</td>
</tr>
<tr>
<td>Mirrors</td>
<td>50</td>
<td>3</td>
</tr>
<tr>
<td>Swimming</td>
<td>50</td>
<td>3</td>
</tr>
<tr>
<td>Being shirtless</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Flying</td>
<td>33</td>
<td>2</td>
</tr>
</tbody>
</table>
Cororve and Gleaves (2001) also endorse how negative interactions with family members during childhood may influence the development of BDD and provide a more detailed explanation:

…the risk for developing BDD is even greater when critical events or traumatic incidents occur that involve appearance features. The most common example is being teased about appearance. Previous research testing the negative verbal commentary theory of body image dissatisfaction has indicated that specific teasing about weight or size was a significant predictor of body dissatisfaction (Biby, 1998). Some BDD patients are subjected to repeated criticism about their appearance by their family members. It has been suggested that unharmonious family backgrounds and unfavorable childhood experiences producing enduring feelings of being unloved, insecure, and rejected serve as contributing factors to the development of BDD (Phillips, 1991) (p. 957).

Amongst the six men who participated in the study – Rodger, Sam, Luke, Michael, Evan and Nick (pseudonyms) – all discussed vivid memories and experiences associated with their childhood and families that they felt contributed to their current feelings of negative body image and potential BDD development.

Rodger, a 39 year-old sales manager, discussed how interactions with his family in general, and one incident with his grandfather specifically, has impacted him:

My family would always tell me I was way too thin and I had to eat more. They would say, “I can see your ribs, you need to eat more food.” My mom would always give me seconds, whether I wanted them or not, to make me gain weight. But it never worked of course. It never worked. I just had one of those metabolisms
where I burned it really easily. When I was nine or ten, this incident stands out like it happened yesterday. I swear it just happened because I don’t have the best memory in the world, but it is bizarre because it really stands out. I remember one summer I was with my granddad and we had been up at their campsite or something, and it was a really hot day, and even when I was young, I would never take my shirt off in public, but I remember my granddad saying to me, “Take your shirt off, it’s too hot.” But I wouldn’t do it and he called me a name. To this day, him saying that and the way he looked at me stands out so clearly, and it really had an impact on me. Going back to childhood, I just have a lot of negative memories. It’s one thing for strangers to call you names, but for your family…it makes a huge impact. It really sticks with you. I would say that is part of it, that it always comes back up. Look at my granddad, that was 30 years ago. You would think I could forget it, but no. I know very well my granddad loved me a lot. I guess I was just vulnerable enough that it really made that much of an impact, because when you are young, you really want to be loved and accepted by your family. I mean, you may feel loved, but don’t always feel 100% accepted. The comments lead you to believe you are not something, you are something you shouldn’t be, you are not good enough. I never really felt accepted by my own family, because my step dad hated me, and my real father abandoned my mother when I was two years old. I mean a long list of stuff like that. I never really felt accepted.

Sam, a 32 year-old state employee and part-time theatrical performer, also mirrored Rodger’s feelings concerning family based comments fueling the need for acceptance and approval:
A lot of it starts in childhood especially if you are constantly being told that you are fat or skinny or you don’t look good enough. For example, “…you look too skinny, eat more” would be a comment from my mom. That stayed with me for a while. It probably still is with me to some extent. I remember comments by my mom specifically that I feel impacted the development of my negative body image. She would always make some type of comment like “you are too skinny” or “you are too fat and you need to eat less.” She often contradicted herself so I got mixed messages. I think she was trying to have my best interests in mind, but there are better ways to phrase that and encourage that than with saying things like you are too skinny and eat more. I’ve felt depression about it. I was having feelings about not being happy with my body image and I went to my brother, telling him how I felt about my situation and he kind of got tired of me whining to him about it. It is how I conceptualized it because he said he felt overwhelmed by my always talking about it.

Nick, a 40 year-old customer service manager, not only has vivid childhood recollections of negative comments and experiences from his family, but adamantly cites it as the number one factor for his current body dissatisfaction and preoccupation:

The number one factor would be my family. I am adopted. As a child around four or five I was extremely, extremely thin, to the point where my mother had taken me in to have me put on an appetite stimulant. Over the course of the following summer I put on a lot of weight, and that is where it all started. My family started calling me fat. My father would typically start off a conversation with “how’s it going lard-ass?” My mother would put me on “diets” that were horrible. I began to resent diets. She forced me to exercise, but I found ways to
avoid it. I began to resent exercise. I think it was an embarrassment for them, to have one of the fat kids. My class was only 36 kids, so if you were one of the larger kids, you really stood out. I went through my preteen and teen years and most of my adult life being ashamed of my appearance. It all goes back to my family. For example, my sister has talked about if she is standing in line at a fast food place and there is someone she considers fat in front of her and he orders a chicken sandwich and she was there to order a chicken sandwich, she will change her order and get something different every time because she doesn’t want to be associated with what that person is eating.

Evan, a 44 year-old city employee, discussed how he recalled comments made by his mother about pictures he brought home from school and the lasting impact of those comments:

I remember when I was in third or fourth grade, I brought pictures home, and I remember my mom telling me how horrible the pictures looked and how un-photogenic I was. To this day I shy from cameras. There’ll be a group thing going on and someone will say “move in” and I have this line I use, “You can’t have my picture because I am in the witness protection program.” People laugh and while they laugh I move out of the pictures. If you feel loved, your image of yourself could be better. But I never really felt love from my mother, or from anybody else. I mean my mom was pretty physically and emotionally abusive. And my dad was very self-absorbed and would just separate himself from everyone. So I remember my mom saying to me that I didn’t take pictures well and that I was un-photogenic, and it’s hard. Sometimes I think I should realize that that was a stupid
thing for her to say and I should just get over that, but then I look at every picture that I’m in and it’s not a very good picture. Many people say they don’t like the pictures they are in, and things like, “don’t look at my driver’s license picture because it is shitty.” Then you look at it and think that’s a great picture, wait until you see mine. That is how I feel all the time you know, because I don’t have any good pictures of myself. I think it is funny, I always thought that I took a poor picture. You know when you are growing up and your parents put pictures up and you kind of get used to seeing them around. I got used to the fact that my picture was not going to be as good as everybody else’s. And now I look back at those pictures that my mom still has on the wall from when I was in high school, you know, and I want to take them all down. It’s actually starting to bother me more now. Not only is it bothering me more about the way I look today, but it’s bothering me more about the way I looked then, if that makes any sense. It’s getting worse. I always hoped that as I got older, and made more money, I would learn to live with it. I feel it’s affected my whole life. I don’t like family pictures either. We all get together for pictures and I try to hold my head a certain way or try to do all these things to make me not look the way I look, and then when the picture comes out, there’s me. I think a lot of parents don’t realize what they are doing to their kids or don’t realize how much of an impact their parents and their upbringing has on who they are and what they are and who they become and that kind of stuff. I don’t want to blame this all on my parents, but I often wonder if they told me everyday, like I tell my kids everyday, that they loved me, or if my parents hadn’t told me that I take horrible pictures, if my
parents hadn’t beaten me whenever they felt like it…I wonder. I still question if my parents love me.

Again, with Michael, a 35 year-old banking executive, it is evident that statements from his family while growing up made a great impact on his developing his negative body image and potential BDD:

I remember back to when I was seven or eight my brother would make negative comments about me being overweight all the time. And actually my dad used to tease me about it too. Mom would holler at them and say “stop picking on him,” which of course they didn’t. My dad was the type who teased a lot. He teased so much I do remember crying from stuff he would be teasing about – he would not let go of stuff. He would just keep picking and picking and picking. My mother would get very mad at him for that. You know I think I tried to block some of those things out of my mind because he died when I was 10, so you try and remember the positive things and not necessarily the negative ones. But it’s hard to forget them. He was very much a tormentor. My brother got it from him and carried on the torch.

Luke, a 57 year-old software engineer, quite clearly recalled comments by his mother and their impact on his sense of body satisfaction:

So my earliest recollection is when I was about seven years old. My mother, who was not particularly sensitive in some ways, came into this mud room we had in the back of the house where we would change our swimming suits. Now even at this age I knew enough about the genital differences that I was already embarrassed about it and I would stand in the corner when I was changing out of my bathing suit and into my clothing. One day my mother came in and kind of abruptly asked me why I was
always in the corner and said “turn around I want to see you.” And she was horrified, she said, “Oh my God, what is the matter with you? For a big boy like you, you should have more down there than that.” It was a very crushing statement. That is my earliest association of being different in a negative way. Well the whole thing led to this big family ordeal about, you know, I had to go to the doctor’s and everyone seemed totally disgusted with me and it was such a big hassle. Well I wouldn’t go see the doctor so my father had to do this kind of testicle check on me. The doctor said that it was really important that my testes had developed normally and it was determined that everything was ok. Well it was the circumstance around which my parents decided to tell us about the facts of life, which of course was weird because we didn’t know what they were talking about. Anyway, from that time on I had an obsession about it. I would be shocked if my mother even remembered that whole thing. She had no idea what affect that had on me. But my mother was, and is, pretty judgmental and I think in a generalized kind of way that feeling of who my mother is is still with me a lot.

The second area that all six participants felt influenced the development of their negative body image and potential BDD centered around socio-cultural factors, specifically the impact of the media and cultural expectations. This second common area is also supported by the current literature as hypothesizing that socio-cultural influences, more precisely exposure to specific forms of media, (Ricciardelli, McCabe & Banfield, 2000; Leit, Gray & Pope, 2002; Labre, 2005; Stanford & McCabe, 2005) is one factor that contributed to body dissatisfaction among males. Five of the six participants, who identified as gay, also endorsed a common sub-theme that exposure to “gay culture” specifically contributed to the
participant’s potential BDD development. Gay culture was defined by the participants as what physical characteristics an individual must possess in order to be accepted within the gay community. However, it should be noted that recent research by Tiggemann, Martins & Kirkbride (2007) contradicts this finding. In their study comparing body dissatisfaction and body ideals among 134 gay and 119 heterosexual men they found, “…involvement with the gay community was not related to body dissatisfaction” (p. 15) among gay men. This may be due to any number of factors, and indicates more research is needed to provide clarity on this issue and its potential implications. As for this study, the findings are very clear about the impact that gay culture had on the development of body dissatisfaction and potential BDD among the five gay participants.

As with the findings on psychological influences, each participant was able to speak in great detail about how specific socio-cultural influences contributed to their potential development of BDD. The impact of various forms of media (exposure to television, magazines, books, movies) was the most influential for all participants. In conjunction with this, the gay participants further elaborated how exposure to various aspects of gay culture in particular has also been a factor.

Rodger commented:

Print media is a main factor, I read a lot of magazines. I look at my magazines and the cover model and think, oh God, I wish I could look like that and have that little body fat. The first thing I read is what does he do to make that happen. I put the pictures of the models in my home gym for motivation and I look at them all the time and think, am I ever going to get there, am I ever going to get there, am I ever going to look like that? I also watch some T.V., not much, but I do like Project Runway,
which focuses on beautiful designs. I know it is shallow of me, but I do try to pick out the winners based solely on how beautiful they are. It’s a horrible thing, but it is a gut reaction with me. Also the gay community is a big factor too. I discovered what it took to be accepted in that community. Individuality really isn’t encouraged for the most part. It’s about conformity just like any other subculture. And beauty is what is accepted. Beauty gets you in the door and having a nice body. I learned quickly that a skinny boy necessarily wasn’t exactly want everyone was looking for either. I think there was a real desire to be accepted into this environment and I think…I remember my earliest times going out to bars and feeling really inadequate. I don’t have that as much anymore. Its is not because I don’t have those feelings still, I do, but I have learned to suppress it and get over it and try to deal with things. It still surfaces a lot, but to a certain degree I can overcome some of that, but not always.

Sam’s comments addressed not only the media, but because he is Filipino-American, he had the additional complexity of bi-cultural messages and expectations:

I don’t know, even know where to begin to talk about television and the movies and all that media. I do watch a lot of T.V. The actors and models are all nice looking. It’s depressing. I like a lot of gay movies, but many times in those stories it’s like young boys coming out and they are very pretty and nice to look at and the story is wonderful and I think, why isn’t my life like that, on top of me thinking why can’t I look like that? I also look at the Advocate and GQ, nice to look at, but again, I think why can’t I look like that? Even though I know the images may not be real, it doesn’t make it any easier knowing that, even when I know they are photo shopped or the image has been altered. It still doesn’t bring any comfort because you still have to
be able to have a basic body structure or something they can build off of. Culture is a big part too. In Filipino culture a common topic of discussion is a person’s weight. It is almost as if to an outsider that they have run out of things to talk about, so the topic of discussion always comes to a person’s weight – positive or negative. It is almost the second thing that happens after, “hi, how are you?” It’s “gee, you’ve gained weight, or gee you’ve lost weight.” I hate to have to brace myself for that, but it’s a sad reality in the culture. Sometimes I wish they would just forget about me or not make any comments at all. Everything you do is a reflection on your family, so you don’t dare do anything that shames the family, and people that are overweight are perceived as a negative. People are free to think whatever they want, but I would just rather not have them say anything out loud to me. The gay community is also a part that has influenced my body image. I don’t go out anymore to bars or clubs to socialize because I feel inadequate compared to the bodies of the other guys. It is too competitive and I don’t enjoy myself enough. It’s hard for me to turn off messages that I am not good enough because of the way I look. It is very youth orientated, very pretty boy oriented. And unless you fall within a certain range of body type or age, it’s like you get the message, you aren’t worth our time. That is not to say that there aren’t segments of the gay community who likes diversity in body types, but those are the groups you never really hear about, or that the media would focus on. I never see larger guys or non-muscular guys in media representation…magazines, print, movies, the pretty boy look is all you see. And while it is positive to see things like those stories I talked about, it is discouraging to constantly see traditionally pretty looking people in these movies because you know, like fat kids and ugly kids have to come
out too. I guess I am wanting a more realistic representation that I am not always seeing.

Nick followed suit when he discussed the impact the media and culture have played in his own development of body dissatisfaction:

Society values thin, good-looking people. Look at models in magazines and in other media. I look down on myself and think no way am I ever going to get to their level. I could spend the rest of eternity eating carrot sticks and working out and I’m not going to get there. The male models are obviously nice looking. And look at film too. It is not too different from the model thing. But if you look at movies that I grew up with, which is in the 70s, 80s and 90s, there has never been a movie where an overweight or non-beautiful person was portrayed positively. You’ve got Booger in the movie Nerds as a prime example. He was the fat nasty slob. And you’ve got John Candy as some stupid fat guy and the guy from Saturday Night Live who died, again fat and stupid. Growing up there was never a positive role model. There’s nobody. Even to take it a step further, look at the gay community. You won’t see an overweight person in the Advocate – they are all going to be young and buff. Again the Advocate was the one link I had to the gay world while growing up. There were no realistic role models in there. There wasn’t anything I could look at and say you know this person was happy or this person was portrayed as a good person, who wasn’t muscular and pretty.

Evan’s experiences also support the impact the media has on his potential BDD development. Evan, as the sole heterosexual participant, also speaks to how being part of the mainstream culture does not insulate him from messages that his body is not adequate. He
also comments about the double standard he feels exists about how society deals with body images issues between men and women:

Generally, in this culture what is considered attractive is based entirely on the media and advertising. I hear women talking about magazines telling women how to look, and they don’t think it’s that way for men. Women get the idea that women are held to a higher standard, but most don’t get it that men are held to the same higher standard when it comes to looks, and in fact most people don’t get that. Just like there are women’s magazines that send these messages, men have one’s like Men’s Health. If a woman has a preoccupation with her appearance, people feel sorry for her because of the influence of the magazines and media, but with men we don’t get that. If a woman goes and gets breast implants, people say, “oh, that’s nice” but if a man goes and has cosmetic surgery he is labeled as being vain and worrying about things he shouldn’t be worrying about. We feel bad about ourselves and there are just as many magazines and messages for men. The majority of media idolization has men that are good looking, with certain facial features. My brow, which I feel is ugly, it bothers me that people shun it off. If a woman had a problem she’d get comfort because people in general think she is a victim of the media, and that I am not because I am a man. There are certain expectations the media says you need to have as a man. As a man, you aspire to this, because this is what it will take to be successful and popular. It’s tough on me because I will never have it. It frustrates me and I get upset and then my brow protrudes even more. It’s a cycle. Magazines tell me the same thing they tell a lot of women and you end up only seeing your faults. A huge chest, perfect hair, no body
fat – that’s perfection – and that is where I should be trying to get and I can’t get there, so I feel somewhat like a failure. Generally, society doesn’t give much attention to the feelings that men have. Women are encouraged to be “feeling” and men are taught to internalize everything and be a “man”. I feel I do not get the same comfort that women get for their poor body image. I just repeatedly get told that I’m making a big deal out of nothing. Society makes my feelings about myself worse because I don’t feel like I have an outlet as a man. Most counselors kind of pass it off as not that big of a deal or not to worry about it.

Michael spoke at great length in his interview about the impact gay culture and media have had on his life since “coming out”. During his childhood he was raised in a strict religious household where television and other forms of mass media were not permitted. This sheltering allowed him to address the specifics of how these factors influenced his negative body image and potential development BDD, specifically with reference to gay media:

Most of this has come into existence after I came out, after I was 20, and after I started realizing I was gay and then starting to get exposed to the gay community and realizing, hey, you can’t be average looking in the gay community. I like what someone said about Los Angeles’ gay community, they said, “They are all a bunch of 9’s looking for an 11.” I sometimes feel that is how the gay community is in general. You can have someone who looks very similar and they match each other very well, but they are always looking for something on another level. There is always someone out there who is better looking. Honestly, I don’t think I would have the body image issues I have now if I wasn’t gay. I know that sounds kind of weird, but as I think
back, I probably wouldn’t be living here, I would be in Pennsylvania and be married with 2.5 children and be the pastor of a church somewhere. I might not be happy living that life, but I don’t think I would have body image issues either because I would be in a relationship, I’d have a family and the community and culture I would be living in would not be all about having a certain appearance. I am now to the point where it is like, fuck, I need to work really hard at this so I can be thin and muscular and at least semi in-shape because I am not going to find anybody if I am not. That is the perception I have of the gay community, it may be unfair, but there is great value placed on first impressions and visual appearances. As for specific forms of media, since I grew up in a very religious household, TV was not ever a factor until I was much older. The things that would affect me in popular media are that everyone is always good looking and they are always thin. If there is a fat person, they are comedy relief. For example, actors in general on TV shows, women are always pressured to be thin and beautiful. It’s like, who are the heavier women, like Rosie O’Donnell and those guys, all comedians. Look at Harvey Fierstein. He is much more of a comedic person. He is a serious actor, but as a whole, plays the drag queen kind of thing, like in Torch Song Trilogy. If you ever watch Logo at all, Noah’s Ark or Queer as Folk, they are all perfectly chiseled and gorgeous. Queer as Folk at least had some different body types, but there is not anybody who is overweight on that show. Different body types in the media are ok, but overweight or underweight are not ok. I won’t watch those shows anymore because it didn’t seem very real to me. I think it all ties into being gay and what you perceive as the perfect little body image that is projected by the gay media.
Luke’s comments about the impact of both various forms of media and culture reflected many of the same sentiments as the other participants about the negative influence they have had on his body image:

Culturally, any magazine or television commercial you see reminds you of how inadequate your body is. Even commercials purporting to be dealing with normal men, mostly, I mean sometimes you see overweight guys, but mostly you see really attractive men, raising their families and everything. Which by the way brings up another cultural issue for me - we don’t see many images of gay men in advertisements on television. We see gay men on sitcoms, but they are still mostly laughingstocks as far as I am concerned. But rarely do you see a gay man in an ad and if you do it’s usually explicit, dealing with a specific gay market, but you don’t see that very often. But certainly the cultural influence is that you see an abundance of attractive people all the time who are apparently seen as being very comfortable with themselves. This occurs in all kinds of media, print media, the internet, movies, TV, so I think that is probably the biggest cultural influence, but I think just in terms of the gay world as we have created our own cultural influences. It would be hard for me to hear anyone argue that there hasn’t been a fair degree of obsession with beauty and youth in the gay community. Gay culture and our own gay media certainly hype it a lot and of course it is going to have an impact on you. I don’t spend a lot of time with media anymore because I feel it points out my inadequacies. But when I was younger I did, but it was mostly print media as we didn’t have a computer back then and television wasn’t showing the same kind of images that they show now. Now I mostly read. I read books and I will look at the
Advocate. I just read an old book called the Culture of Desire. It deals a lot with these presumptions men have about other men and their bodies. Even the cover is kind of erotic; a pretty Chelsea boy is on the cover. So I read those kinds of things and I feel and see myself, in general, as a spectator in life, not a participant. Especially when I read, more than TV, more than movies or anything. I feel I am always looking in. I’ve never been there doing that. That’s the way I feel.

As can be seen and validated by the preceding statements, all of the study participants believed and were impacted by psychological and socio-cultural factors that they were exposed to both as children and as adults. They attributed these factors to leading to the development of their overall negative body image and their potential development of BDD. The depth and emotional investment of these statement makes clear the fact that these men are indeed experiencing negative consequences because of their preoccupation with their perceived defects with their bodies.

Unique Factors

There were other factors not shared commonly, but that still greatly impacted the lives of the participants with respect to developing their negative body dissatisfaction. Unique factors were categorized as influences that participants felt contributed to the potential development of their BDD, but that were not mentioned by the other study participants. Of the six study participants, four cited factors that were unique.

Rodger felt that his need for acceptance from other people greatly impacted the development of his negative body image and discussed the impact this has had on him:

I think back on it and I think to myself, why do I do it? It is for some form of acceptance that I need. Because what really happens is I get uncomfortable
sometimes because I am standing there next to these big muscular boys and they are very hot and I think, oh God, I am this little guy. My mind just starts going and going. At night I sit there thinking about this while I try to fall asleep. I will tell you this, I am much better now than I used to be with the acceptance level for myself from others. There was one point when I actually tried to commit suicide over this sort of thing. I would never do that now. It is really interesting to me as I talk to hear how deep it is and how much I don’t think about it as I really should. I thought I had overcome a lot of things from when I was younger and how I felt about myself and my need for acceptance from other people. I thought I dealt with all that. Obviously I haven’t.

Sam felt that his role as a theatrical performer impacted his negative body image when he discussed his experiences at auditions:

My appearance is greatly dependent on the type of acting gigs I get. Although I don’t think it is right, some directors make impressions and it is not unheard of for them not to consider people for parts because of their appearance. I feel if I were more height/weight proportionate, it would increase my chances of being hired. Going to auditions is stressful enough, but having to see the other people you are competing against who have better bodies than you – it is not a fun thing to do in that respect. I feel inferior. I feel like why did I even show up. I feel, why bother. I mean, you can only get so many positive images of yourself, for example you tell yourself you are only competing against yourself but even with all that kind of positive reinforcement, it is really hard for me to block out the negative messages. Perception has a lot to do with ability because people make an instant impression before you
even open your mouth or take your first step. I believe I have not gotten parts because of the way I look, although nobody ever said that outright. My self-esteem is pretty low because of it, despite the appearance I give to other people. I really don’t have a lot of people I can talk to about this. It is kind of sad actually.

Nick felt that clothing and the process of shopping for clothes were extremely frustrating and a contributing factor. He also addressed how this has impacted the relationship with his partner:

If I looked the way I wanted to look, I would not have to worry about my clothes not fitting. Dressing is traumatic for me. I try to wear the darkest clothes to cover up. There are days that it gets really really bad. We, my partner and I, have actually cancelled trips out because I can’t find anything I can wear comfortably. Also, the experience of buying clothes is degrading. I will often buy the biggest cut thing I can find or the loosest sweatshirt I can buy. They charge extra for them. It’s humiliating. Sometimes the negative impact of trying to find the right clothes to wear can last for one to two days and has severely impacted me and has ruined some of our trips. My partner and I will have big fights at home because he thinks a shirt looks great on me and I don’t. We will get into a screaming fight because I am so stressed over trying to dress myself. All it takes is that one t-shirt that feels a little too snug and then nothing works, I can’t put anything on at that point. And it impacts us, it seriously impacts us.

Michael felt that not being in a romantic relationship was a factor that contributed to his negative body image and potential BDD development:
It is not just coming from people around me, it is coming from me internally. In some ways in my mind, it is because I have not really been in a relationship for a long time. I think that is part of the reason that I don’t feel good enough or don’t feel I have a nice enough body. There was a period of time when I was dating somebody who had one of those perfect bodies. I was very much crazy for that individual. Even though he cared a lot about me and loved me, it was not in the way I loved him. I kind of sometimes feel like that was what kind of fed into my preoccupation with the way I looked even more.

Although these individual factors are not mentioned in the current literature as primary contributors to BDD, they are vital to understanding the phenomenological aspects of BDD for these specific participants. This allows a greater depth, specificity and intimacy into areas that are important for the participants, and it places value and gives credence to their experiences as individuals.

Limitations of this study include the small sample size, which prevents generalizations to the larger BDD community, but allows a more in depth exploration of the lived experiences of a few individuals.
Discussion

Western culture historically emphasizes body image concerns among women far more than among men. Consequently, abundant progress has been made in preventative awareness and treatment options for women. However, when addressed in men, body image concerns of sufficient severity to cause clinical symptoms are oftentimes either completely overlooked, under-diagnosed, or categorized with a co-occurring eating disorder, and are not seen as sole contributors to BDD. Women have been encouraged, through various means including, in grand part, the feminist movement, to resist negative body image messages from all sources. Although gains have been made in this area, they are only beginning to provide tools necessary for women to combat the multidirectional sources that attribute to their negative body image ideals. Men, on the other hand, have yet to benefit from any such focused attention. This lack of encouragement, combined with a distinct absence of specific training around clinically significant body image concerns among treatment providers, and an ever-growing cultural emphasis on youth and beauty, makes the impact of this disorder among men potentially devastating because it is so poorly recognized.

Lasting and pervasive effects of BDD are revealed through the stories and experiences of the six participants in this study. The challenges these men face, such as an enduring sense of shame and isolation, greatly impact their self-image and level of functioning. This can be seen through their avoidance of social situations and activities they previously enjoyed, and by changes made to their lives to accommodate their negative body images. For example, one participant recounted a recurring Friday night ritual of spending hours grooming and preparing himself, careful to choose clothes that highlight his best features and camouflage his “defect”. All this time and effort is spent in preparation for
driving to his local grocery store, buying a six-pack of beer and spending about an hour walking through the store so that other people will notice him and think he has plans for the evening. He then returns home, alone, undresses and watches television until he falls asleep. Weekly, he repeats this ritual, wanting desperately for anyone who might see him in the store to think he is “worthy” of being someone that people want to be around and thus has great Friday evening plans. As his “defect” goes mostly unnoticed by those around him, his preoccupation and loneliness become hallmarks of his diminished sense of self-image and his increasing sense of isolation and shame.

Although the six men who participated in this study come from varying backgrounds and experiences, their experiences reveal a cohesive story about long-term, painful, deeply rooted struggles that a man may face when suffering from a distorted body image. The resulting negative impacts can be, and often are, debilitating, as can be seen from responses among these participants. Another participant spoke repeatedly about the fights he would get into with his partner over how he looked when dressing for work or social events. This increased tension, specifically related to his negative body image, put a great amount of stress on his relationship with his partner, resulting in further isolation, both from his partner and others, as he would refuse to leave the house because of the way he looked. A third participant discussed the impact on his ability to successfully date and have a romantic relationship, citing difficulties with intimacy when he would have to remove his clothing.

The story of BDD potential establishes its roots in childhood, where, clearly shown here and corroborated in the existing literature, negative comments by family members can be one major factor influencing the development of distorted body image. Negative thoughts and feelings about body image may become internalized and are oftentimes exacerbated by a
zeitgeist influenced by the media’s hyper-masculine messages of what it means to be a man. The confluence of these factors may become a severe detriment to developmental and emotional resources that allow people to live healthy lives unencumbered by difficulties in social and occupational functioning.

The story continues into adulthood as participants normalize the implementation of coping mechanisms i.e., clothing choices and excessive workout regimens, and avoidance techniques, i.e., calling off trips out and making excuses for not being in photographs, in frequently desperate attempts to navigate their lives without the support or understanding necessary to cope with the effects of body dissatisfaction. Although such coping mechanisms might become an adaptive status quo for affected men, in the vein that they occur on an almost daily basis, they are neither healthy nor welcome. Mechanisms such as these promote a negative downward emotional spiral which results in a far reaching and insidious impact on their lives.

The story reaches its pinnacle as the participants arrive at an understanding of influences throughout their lives that have created a reality which isolates and impedes their social, personal and occupational functioning. In telling their stories, these men generously share their personal experiences as they actively pursue better awareness of their own suffering, while providing rich phenomenological information for professionals who strive to advance better understanding and subsequent treatment of BDD. Results from this study add to an expanding discussion on BDD by elaborating on factors that contribute to its potential development in men. With a clearer understanding of underlying contributors, more effective prevention and treatment may be researched and provided by mental health professionals who are aware of its prevalence and impact.
Though results of this study tell a story that is ongoing, they also provide examples that give insight into the everyday struggles and experiences of these six men. Through increased awareness, both by society at large and phenomenologically within the individual male, appropriate steps could be initiated to ensure proper diagnosis and treatment, thereby providing the best opportunities for positive recovery and a return to improved social, occupational and personal functioning for individuals with BDD.

Current treatment approaches for those suffering with BDD include both psychotherapeutic and psychopharmacological interventions. Cognitive-Behavioral Therapy (CBT) seems to be the most efficacious therapeutic intervention, as its “here and now” approach and focus on dysfunctional thinking and changing maladaptive behaviors targets some of the main components of BDD. Either alone or in combination with CBT, SSRIs are often used as the medication class of choice for psychopharmacological treatment, and are thought to counter-act some of the obsessive and/or compulsive aspects of BDD.

The most effective strategy is one that is individualized and geared to the specific needs of each person. This most often lies at the intersection of the psychotherapeutic and psychopharmacological approaches. An individualized approach cannot be taken however, if clinicians do not recognize diagnostic warning signs. Men suffering from BDD may go undiagnosed or may be misdiagnosed, seemingly most often in relation to the lack of awareness about the prevalence of BDD among men. Taken one step further, preventative measures, such as more widely disseminated information about the impact of psychological and socio-cultural factors are needed. These preventative measures may take the form of programs that help families, institutions and the larger society realize the insidiousness of media and intra-familial messages that are sent implicitly and explicitly to men and boys as
well as to women and girls, and the potentially damaging impact they may have on those so exposed.

Awareness alone of factors that influence BDD development was not significant in alleviating or halting negative outcomes among these six participants. Even when cognitively aware of specific factors/events/experiences that influenced their own negative body image development, i.e., negative comments from family members or messages from the media, the impact these comments had (and still have) on their sense of self as it related to their negative body image was not lessened.

None of these six participants received a formal diagnosis of BDD prior to their participation in this study, and no diagnosis was given during the study as that was outside the study scope. It is likely, however, that any individual who expressed an equal or greater level of body image dissatisfaction and/or disturbance regarding an imagined or very slight body defect might qualify for a diagnosis of BDD, even in the absence of a formal diagnosis.
Conclusion

BDD is a devastating diagnosis that can have a great impact on those who suffer from it. Most of us are unsatisfied with some aspect of our appearance at some point in our life. However, for sufferers of BDD, whether diagnosed or not, dissatisfaction with a perceived defect in their appearance can be life-long and potentially devastating, as can be seen by the information provided from this study. In spite of Western culture’s ready acknowledgment of body image problems in women, research shows an almost equal distribution rate between men and women, demonstrating a clear need for information like that included in this study. Identifying potential causes of BDD may help to provide improved diagnoses and treatment outcomes, and increase awareness for both the general public and for treatment providers who may be seeing these men.

The nature of phenomenological inquiry is to separate and investigate the facets of lived experiences in order to gain a clear understanding of how specific experiences impact lives. The lived experiences of men who may have BDD can be linked to psychological and socio-cultural factors.

This study provides a glimpse into the lives and experiences of six male participants, as well a rich source of data from which we can attempt to understand the factors that contribute to their negative body image and subsequent potential BDD development. This study is not definitive in its findings, as many men have similar backgrounds and do not develop negative body image issues or BDD. This speaks to the need for further research in this area. With additional data to drive professional response, steps can be taken to develop and activate preventative programs to educate individuals, families and society as a whole on the potential negative impact of our words, interactions and interpretation of the media,
leaving men like those in this study with an improved chance of avoiding this potentially devastating path.

The richness of individual phenomenological experience provides insight into factors that may potentiate and contribute to the development of this disorder, and as well, adds to the existing body of literature. Further research is needed in exploring the experiences of men who meet screening criteria for BDD, without formal or previous diagnosis, to deepen awareness and understanding about the prevalence and impact of this disorder among males in our society today.
References


Appendices
Appendix A

Body Dysmorphic Disorder Questionnaire (Modified)
This questionnaire assesses concerns about physical appearance. Please read each question carefully and circle the answer that best describes your experience. Also write in the answer where indicated.

1. Are you very concerned about the appearance of some part(s) of your body that you consider especially unattractive? Yes  No

   If yes: Do these concerns preoccupy you? That is, you think about them a lot and wish you could think about them less? Yes  No

   If yes: What are they? _______________________
   _______________________

   Examples of areas of concern include your skin (e.g., acne, scars, wrinkles, paleness, redness); hair (e.g., hair loss or thinning); the shape or size of your nose, mouth, jaw, lips, stomach, hips, etc.; or defects of your hands, genitals, breasts, or any other body part.

   If yes: What specifically bothers you about the appearance of these body part(s)? (Explain in detail): _______________________
   _______________________

   NOTE: If you answered “No” to either of the above questions, you are finished with this questionnaire. Otherwise please continue.

2. Is your main concern with your appearance that you aren’t thin enough or that you might become too fat or too thin? Yes  No
3. What effect has your preoccupation with your appearance had on your life?
   • Has your defect(s) caused you a lot of distress, torment, or pain?  
     Yes  No
   • Has it significantly interfered with your social life?  
     Yes  No
     If yes: How? ________________________________
     ________________________________
     ________________________________
   • Has your defect(s) significantly interfered with your school work, your job, or your ability to function in your role (e.g., as a homemaker)?  
     Yes  No
     If yes: How? ________________________________
     ________________________________
     ________________________________
   • Are there things you avoid because of your defect(s)?  
     Yes  No
     If yes: What are they? ________________________________
     ________________________________
     ________________________________
   • Have the lives or normal routines of your family or friends been affected by your defect(s)?  
     Yes  No
     If yes: How? ________________________________
     ________________________________
     ________________________________

4. How much time do you spend thinking about your defect(s) per day on average? (circle one)
   (a) Less than 1 hour a day
   (b) 1-3 hours a day
   (c) More than 3 hours a day
Appendix B

Research Question
Research Question

Main Question:

**What factors do you think have impacted the development of your negative body image and/or potential development of BDD?**

Supporting sub-questions:

a. What is the major bodily concern?

b. Why is it important to the individual to have a good body image?

c. How long have these negative perceptions of body image been present?

d. What are the cultural influences that outline the need to change the perceived defect in appearance?

e. What type of factors (childhood memories, adult experiences, TV, print, film, etc.) are the individuals exposed to, and at what frequency?

f. What specific factors are the most influential in developing negative body images and why?

g. What behaviors does the individual engage in to improve body image and how does the individual feel about these behaviors
Appendix C

Recruitment Advertisement
Are you a man who is dissatisfied with your body or appearance?

If so, you may be eligible to participate in a research study examining what factors influence body image dissatisfaction that may lead to Body Dysmorphic Disorder in men.

This research is part of a clinical psychology doctoral dissertation approved by Antioch University Seattle.

For further information, please contact Mike by phone 206-992-9192 or email mikearcher@comcast.net
Appendix D

Informed Consent Document
Antioch University Seattle Informed Consent Form

The Doctorate of Psychology Program supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of penalty.

Procedures to be followed in the study, identification of any procedures that are experimental, and approximate time it will take to participate:

I have been invited to participate in a research study examining what factors I believe influence the development of Body Dysmorphic Disorder (BDD). If I agree to participate in the study, I will be asked to answer questions during an initial phone screening interview and then may be asked to answer questions on a BDD screening questionnaire. If I meet the study screening criteria, an in-person interview time will be scheduled during which I will be asked questions regarding my own views about what may contribute to the development of BDD. The phone screening interview will take approximately 10 minutes and the BDD screening questionnaire will take approximately 5 minutes to complete. The length of the follow-up in-person questioning will vary depending on the answers given but an estimate is between 1-2 hours. I understand that the in-person interviews only will be recorded and transcribed. I also understand that the researcher will give me the opportunity to review my answers to the questions in order to ensure that the answers are an accurate reflection of my experiences. On completion of the research, I may request the final results of the final study from the researcher.

Description of any attendant discomforts or other forms of risk involved for subjects taking part in the study:

Although there is no direct risk to my health by participating in this study, I understand that due to the personal nature of the questions being asked, I may feel uncomfortable at times. I acknowledge that I may refuse to answer any question at any time. I am also aware that if, due to the nature of the questioning, I become emotionally overwhelmed, referrals to mental health professionals will be made available to me. I also understand that to further protect my confidentiality, a pseudonym will be used to disguise my name, data will be stored in a secure area with access only by the primary researcher and all data will be kept for 7 years and then erased.

Description of benefits to be expected from the study or research:
It is hoped that the results of this research will contribute to the developing literature on the impact of factors that lead to the development of BDD in males and raise awareness about this issue in order to facilitate appropriate interventions, diagnosis and treatment.

Additionally it is hoped that an increased awareness of BDD will also be achieved so that medical and mental health professionals can appropriately screen for BDD in male patients.

*Appropriate alternative procedures that would be advantageous for the subject:*

Because this is an information gathering study there are no other alternative treatments, except that I may refuse to participate. My participation in this study is on a voluntary basis; if I decide not to participate, or decline to continue at any time, I will do so without penalty.

I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach. I may ask for the results of the final study.

Signature ___________________________________________ Date _________
Subject and/or Authorized Representative

Signature ___________________________________________ Date _________
Appendix E

Demographics Form
BODY DYSMORPHIC DISORDER STUDY
DEMOGRAPHIC INFORMATION FORM

All information is from self-report data

Name: ________________________________

Responding to recruitment letter posted in: __________________________

Age: __________

Disability: __________________________
(e.g. developmental or acquired physical, cognitive, psychological disabilities)

Religion: ____________________________

Ethnicity: ____________________________
(e.g. people of Asian, South Asian, Pacific Islander, Latino, African, African-American, Arab, Middle Eastern Heritage, self-described Other)

Socio-economic Status: ____________________________
(e.g. status by occupation, income, rural or urban habitat)

Highest level of education completed: __________________________

Sexual Orientation: ____________________________
(e.g. gay, bisexual, heterosexual)

Indigenous Heritage: ____________________________
(e.g. North America-American Indians, Alaska Natives, Native Hawaiians, Samoans, etc.)

National Origin: ____________________________
(e.g. immigrants, refugees, international students)

Gender: ____________________________
(e.g. male, transgender)

Additional Information:
Appendix F

Initial Phone Interview Screening Form
BDD Study
Initial Phone Interview Screening Form

Hello, my name is Mike Archer and I am a doctoral student at Antioch University Seattle. I am conducting a study for my dissertation on the factors that influence the development of Body Dysmorphic Disorder in men. Body Dysmorphic Disorder, or BDD at it is often known, is a mental health condition in which people affected are very preoccupied with a some aspect of their appearance. This preoccupation is so distressing that it causes them great difficulty in their lives both in how they feel about themselves and often how they relate to other people. In order to determine if you are to be selected for participation in this study I am going to ask you a few questions. You may choose to end this interview at any time or refuse to answer any of the questions.

1. Before I ask the first question, do you have any questions for me about BDD or about the study? (If yes, address questions, if not go on). What city do you live in?

2. OK, now I’d like to ask you a few questions to see if this study would be a good fit for you. Is that all right? (If yes, go on to question #3; If no, thank for participation so far)

3. How comfortable are you talking about your own body and about your feelings about your body over the phone? (Prompt “tell me more about that” if they initially give a response less than 3 sentences)

4. How comfortable do you think you would be talking about your body image concerns in person? (Prompt “tell me more about that” if they initially give a response less than 3 sentences)

5. How did you hear about this study? (Inquire “Which newspaper did you see the ad in?” if not given in initial response; if responding to online ad, inquire: “How did you find the bulletin board/chat room?”) (Prompt “tell me more about that” if they initially give a response less than 3 sentences)

That was the last question. Thank you. Do you have any questions? (If yes, address questions)
If unable to provide at least 3 full sentences for questions 2-4: Based on your answers to the questions, I’m not sure this study would be a good fit for you. Thank you again for your time. I very much appreciated your willingness to talk with me today. Good-bye.)

If able to answer at least 3 full sentences for questions 2-4: Based on your answers to the questions, I think this study might be a good fit for you. Are you willing to move forward in the screening process?

(If yes - Great. Next I would like to tell you a little more about this study: REVIEW INFORMED CONSENT FORM. (Will review this again in person and get signature) Do you have any questions? (If yes, address questions) Remember you can withdraw from this study at any time. Now I’d like to ask you a few screening questions: ADMINISTER BDDQ. If no - OK, well thank you again for your time. I very much appreciated your willingness to talk with me today. Good-bye.)

BDDQ ADMINISTRATION
(If answers yes to both parts of question #1, any part of question #3 or picks b or c for question 4 schedule in person interview.
If not - Based on your answers to the questions, I’m not sure this study would be a good fit for you. Thank you again for your time. I very much appreciated your willingness to talk with me today. Good-bye.)

If person is from the Seattle area:
The next step is to schedule an in-person interview. The interview will most likely last two hours. We will review some paperwork, answer any questions you have and then begin the interview. The interviews will take place at Antioch University room____. The address is 2326 6th Ave., Seattle, WA 98121. Are you available on (set date and time)? What number is best to reach you? You can contact me at 206-268-4845 if you have any questions prior to the interview. Thank you again and I will see you soon.

If person is from outside the Seattle area:
Let’s make arrangements for you to read and sign the informed consent form. Would it be best for me to mail a copy to you, send a copy via email or fax a copy to you? I would like you to review the form, sign it, and return it to me. Once I have it we can proceed with the study.

The next step is to schedule a phone interview. The interview will most likely last two hours. We will review some procedures, answer any questions you have and then begin the interview. Are you available on (set time and date)? What number is best to reach you? You can contact me at 206-268-4845 if you have any questions prior to the interview. Thank you again and I will talk with you soon.