Body Dysmorphic Disorder and its Suicidal Implications Pertaining to Adolescents

by

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ABSTRACT

Body dysmorphic disorder (BDD) is a relatively new disorder with many implications including suicide, which has an impact on youth today. Previous studies have assessed BDD's associated features and demographic characteristics. The current study is a review of the literature. The purpose of this study is to review the research and gain more knowledge about body dysmorphic disorder and its suicidal ideation implications in youth. This study also aims at critically analyzing the current research as well as providing recommendations for future research. Also, recommendations specifically pertaining to school counselors are suggested in regards to how to deal with and prevent BDD's impact in the schools. A more developmental and preventative approach is suggested in regards to school counselors role with BDD, which is also generalized and referred to as body dissatisfaction in the schools.

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Chapter 1: Introduction

Body dysmorphic disorder (BDD) is a recognized mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000). Body dysmorphic disorder briefly defined is the "preoccupation with some imagined defect in appearance" (APA, 2000, p. 510). BDD occurs in about 1-2% of the general population (Claiborn & Pedrick, 2002). BDD is actually "relatively common" (Phillips, Coles, et al., 2005, p. 717). Studies specifically pertaining to adolescents and young adults show even higher rates, from more than 2% in high school students to up to 13% in college students (Phillips, 2005). The average age in which BDD first appears is before the age of 18 in 70% of BDD cases (Albertini & Phillips, 1999). A study by Phillips, Menard, and Fay (2006) stated that there are more commonalities than differences in regards to the majority of demographic characteristics, age of onset, and functional impairment, among other things, between genders.

The Journal of Psychiatric Research cited BDD as being a somewhat confusing disorder, stating that DSM-IV's classification of BDD has many conflicting components (Phillips, Menard, Pagano, Fay, & Stout, 2006). Olivardia (2004, p. 542) pointed out, BDD is "one of the most misunderstood diagnoses in the DSM-IV." The main source of confusion is that of whether BDD should be identified under somatoform disorders, under anxiety disorders, or under psychotic disorders because it seems to possess attributes of all of the previously listed. Currently, BDD exists under the category of somatoform disorders in DSM-IV (Stein, Carey, & Warwick, 2006). Brown, Di Nardo, Lehman, and Campbell (2001) stated that there are some boundary problems in the DSM-IV.

Even though adolescence is when BDD typically first occurs, it is often not diagnosed right away. Usually 10 to 15 years pass before its diagnosis (Veale, 2004). Many individuals with BDD go undiagnosed. Rief, Buhmann, Wilhelm, Borkenhagen, and Brahler (2006, p. 878) identified that "although 13% of psychiatric inpatients had BDD, all of these patients reported that they would not reveal the disorder to their physician unless specifically asked."

BDD, although seemingly a rather new and unheard of disorder since it has only been recognized in the DSM-IV-TR since 1987 (then called DSM-III-R), was actually conceptualized over 100 years ago by Enrico Morselli, who originally named it dysmorphophobia, a Greek derivative meaning ugliness (Olivardia, 2004). Not only has BDD been around for over a century; cases have also been reported around the world. (Albertini & Phillips, 1999).

Many individuals have times when they feel that their body is less than perfect and they feel dissatisfied with how they feel about themselves in relation to their appearance. The nature of the American society and its emphasis on thinness sets the framework for feeling unattractive. However, for those suffering from BDD, it is more than the "body blues." BDD involves the "most extreme form of body shame" (Gilbert & Miles, 2002, p. 267). According to Albertini and Phillips (1999), BDD involves more than the average feelings about appearance dissatisfaction. According to Phillips (2005, p. 27), "they may describe the body area or areas as... 'not right', deformed, disfigured, or even grotesque, hideous, repulsive, or monstrous."

There is a preoccupation with how individuals look (Phillips, 2005). And as Claiborn and Petrick (2002, p. 10) stated, this preoccupation is in regards to a feature as

identified by DSM-IV-TR as "either imagined or slight." Olivardia (2004, p. 543) stated that it is hard to say how exactly those with BDD physically see themselves, but the individual either "actually *sees* the body part differently (sensory difference) or may see it accurately but *thinks* or *feels* about it differently." They often see themselves as "aesthetic objects" (Gilbert & Miles, 2002, p. 269). In response to preoccupation with a perceived flaw, individuals with BDD have observable behaviors that are often characteristic of the disorder. The most common behavior is mirror checking or using other reflective areas, of which 73% of sufferers do (Olivardia, 2004). Individuals without BDD check mirrors, but the difference according to what Olivardia (2004, p. 547) found was that individuals with BDD were "driven by the need to assess their exact appearance and were more likely to attend to internal feelings about their appearance" instead of only on the particular body part."

An individual is not classified with BDD just by having a preoccupation with his/her appearance; there is also the impact on different areas of life that relate to the disorder. The self esteem of an individual with BDD is deeply affected, and he/she experiences large amounts of stress due to the disorder (Olivardia, 2004). Especially pertinent to the adolescent age group, BDD may lead students to stop sports, have substantially increased school absences, have social withdrawal, have poor grades, and quit high school (Albertini & Phillips, 1999). Dyl et al. (2006, p. 370) stated that for individuals with BDD, there is a "notably poor quality of life."

The teenage years are hard enough as they are, but to teenagers suffering from BDD, life is especially distressing. As Rayner (1978, p. 105) stated, "adolescence is a normal crisis of life." Rayner (1978, p. 107) stated that the adolescent, unlike children,

has the ability to "manipulate ideas unrelated to the immediate world." The teenage years represent changing times. Rayner (1978) identified adolescence as a time of physical development, so boys and girls are naturally going to change their mental image of themselves in relation to their bodies.

Teenagers often look to their social group for support and recognition. Buhlmann, Etcoff, and Wilhelm (2006, p. 105) stated that teenagers with BDD are usually "characterized by fear of appearance-related negative evaluation by others." In this respect, those with BDD are positive that others not only notice their perceived flaw(s), but also take the time to discuss and laugh about their perceived imperfections. In a time when adolescents are already concerned with what their peers think of them, for those with BDD, this is only magnified. Thompson and Smolak (2001) reviewed a study that found 55 % of girls and 35 % of boys ages 8-10 to be unhappy with their body size.

BDD has many associated features, and many of those impact an individual's life. But one of the largest and most fatal issues is that of suicide. Suicidal ideation can precede suicide acts (Lai & Mcbride-Chang, 2001). A study by Phillips, Coles, et al. (2005, p. 722) stated that, "lifetime suicide attempt rates" in individuals with BDD are approximately 6 to 23 times more than when compared to the general U.S. population. Phillips, Coles, et al. (2005) also stated that in the month before the study proceeded with an intake evaluation, suicide attempt rates were 30 times higher than in the general population. Phillips, Coles, et al. (2005) identified 78% of its participants to have a history of suicidal ideation, and over half stated that BDD was the main reason for the suicidal thoughts. Another study by Dyl, Kittler, Phillips, and Hunt (2006) showed a

relationship between weight related concerns and increased psychopathology, including suicide, among adolescents.

There are many things involved in suicidal ideation, but factors of particular importance in adolescents include depression, poor self-esteem, hopelessness, and poor school performance, among others (Lai & Mcbride-Chang, 2001). Phillips (as cited in Veale, 2004, p. 114), found "a degree of distress" in patients with BDD "that is worse than that of depression, diabetes, or bipolar disorder."

The exact cause of BDD is unknown, but many possible influences have been researched and proposed. Gilbert and Miles (2002) gave reasons in regards to the beginnings of BDD and body shame, as possibly being attributed to early experiences that involved shame. These include things like rejection from peers and parental criticisms (Gilbert & Miles, 2002). Children perceive the reason for the rejection as themselves (Gilbert & Miles, 2002). Other possible causes include environmental factors such as the surrounding culture. In American society, being thin is idolized. It is no surprise that BDD is as prevalent as it is.

Some studies say that environmental factors contribute most heavily to the development of BDD (Gilbert & Miles, 2002), whereas others say it is more biological (Stein, et al., 2006). Stein, et al. (2006, p. 420), "found in a sample of 200 patients with BDD, the disorder occurred in 5.8% of first degree relatives. BDD is familial." This study shows that there is some evidence that BDD is passed on from one generation to the next. However, as other studies have suggested (Gilbert & Miles, 2002), other factors such as the environment play a role in the development of BDD, and no particular contributor necessarily stands alone.

Statement of the Problem

Higher incident rates and age of onset of BDD among younger populations show the importance of understanding what BDD is and how to recognize the symptoms, especially for counselors and other educators working in the schools who deal with these particular populations on a daily basis. BDD can affect many areas of life, including social/personal functioning, academics, and careers, all three of which are areas that counselors are concerned about and are stated as three domains by the American School Counselor's Association (ASCA, 2003).

Not only does BDD affect sufferers' functioning in various areas of life, it is also very serious due to high rates of suicide associated with the disorder. The suicide rates and decreased functioning are both very important reasons why "school counselors need to be aware of both risk and protective factors" (Akos, & Levitt, 2002, p. 137).

Purpose of the Study

The purpose of this study is to review the research and gain more knowledge about body dysmorphic disorder and its suicidal ideation implications in youth. Specifically, this study will address the following research questions:

1) What is BDD?

2) What are the suicide implications of BDD?

3) How does BDD appear in adolescence?

4) How can school counselors respond to the needs of individuals of BDD?

Definition of Terms

The following terms will appear throughout the study. They are listed here and defined in order to gain a clearer understanding.

Body Dysmorphic Disorder. "Preoccupation with some imagined defect in appearance. The person's concern is markedly excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning and is not better accounted for by another mental disorder" (Phillips, 2005, p. 27).

Body shame. "Internalized beliefs and self-evaluations derived from how far one's body varies from social depictions of the ideal of acceptable body. A state of self-consciousness and embarrassment evoked when individuals view their body shape or appearance as falling short of society's representation of the ideal male of female" (Gilbert & Miles, 2002, p. 55).

Suicidal ideation. "Thoughts about fatally harming one's self" (Wikipedia, 2006).

Limitations of the Study

One limitation is that although research involved with BDD has grown exponentially in the last 20 years, there are still things that are unknown about the disorder. This study in particularly examined research done in the last 5-7 years, but another limitation includes that the information presented is not exhaustive or comprehensive.

Chapter 2: Literature Review

This Chapter will thoroughly review information related to BDD. Specifically, this chapter will first explore the definition and symptoms of BDD. This will be followed by risk factors, adolescence, prevalence, suicide implications, and finally treatment options and school counselor implications.

Definition and Symptoms

The term body dysmorphic disorder (BDD) may conjure an image of an individual with severe mental dysfunction and susceptibility towards self-destruction. BDD involves the "most extreme form of body shame" (Gilbert & Miles, 2002, p. 267). Although some cases of BDD are more severe, there are a lot of individuals with BDD who are actually living somewhat "normal" lives and are functioning on the surface quite well (Phillips, 2005). As Phillips stated (2005, p. 25), "all of them suffer, but they manage, sometimes well." Phillips (2005, p. 51) also stated that there are similarities among individuals with BDD, but "each person's experience is also in some ways unique."

If an individual with BDD outwardly appears to be living life like the general population, how is this particular individual differentiated and identified as having BDD? This is often a difficult question to answer because, as Olivardia (2004, p. 542) pointed out, BDD is "one of the most misunderstood diagnoses in the DSM-IV." The main source of confusion is that of whether BDD should be identified under somatoform disorders, under anxiety disorders, or under psychotic disorders because, it seems to possess attributes of all of the previously listed.

The *Journal of Psychiatric Research* agreed with BDD being a somewhat confusing disorder, stating that DSM-IV's classification of BDD has many conflicting components (Phillips, Menard, et al., 2006). However, it is important to consider that this is an issue with the DSM-IV in general, not just specifically for BDD. As Rief et al. (2006, p. 883) stated, "the DSM criteria do not reflect empirically validated, naturally occurring, and distinct prototypes, but define sometimes arbitrary dichotomies." There are limitations of the DSM (Rief et al., 2006). Currently, BDD exists under the category of somatoform disorders in DSM-IV (Stein, et al., 2006). DSM-IV deals with these conflicting views of BDD by allowing the different categories of the disorder to be "double-coded" so that individuals who are delusional may be seen as having both BDD and a delusional disorder (Phillips, Menard, et al., 2006).

There are various comorbid disorders that may be associated with BDD. The disorder that is most often comorbid with BDD is depression (Olivardia, 2004). Sixty percent of individuals with BDD are also depressed, and over 80% experience depression over their lifespan (Olivardia, 2004). Another common comorbid disorder found with BDD is Obssesive Compulsive Disorder (OCD) (Olivardia, 2004). Twelve percent of individuals with OCD also had BDD (Olivardia, 2004). Interestingly, insight decreased more in the individuals with both OCD and BDD than those with only BDD (Olivardia, 2004). Other comorbid disorders found along with BDD include social phobia and eating disorders (Olivardia, 2004). A study by Phillips and Diaz (as cited in Olivardia, 2004) found 38% of individuals with BDD were also diagnosed with social phobia. A study by Gran, Kim, & Eckert (as cited in Olivardia, 2004) found that 39% of female anorexics also had BDD, preoccupations not related to their weight.

Despite the seemingly confusing information, there are various criteria and symptoms of BDD. As Phillips (2005, p. 27) stated, the first criteria as identified by DSM-IV is "preoccupation with some imagined defect in appearance." In the handbook of eating disorders, Olivardia (2004, p. 545) stated that individuals with BDD are not just preoccupied, they are "obsessed, fixated, and tormented." This is where the possibility of BDD being able to be classified under obsessive-compulsive disorder (OCD) appears. Both OCD and BDD have the similar feature that includes "obsessional thoughts that are difficult to resist or control" (Phillips, 2005, p. 311).

The difference between the two disorders lies, however, in the type of thoughts (Phillips, 2005). Thoughts of individuals with BDD focus on appearance, and thoughts of individuals with OCD tend to focus on contamination, fear of harm, or other things (Phillips, 2005). About one quarter of individuals with BDD think about their perceived flaw about 1 to 3 hours per day and about another quarter of those individuals think about it for 3 to 8 hours per day (Olivardia, 2004).

In addition to these shocking numbers, about a quarter of individuals with BDD think about their physical appearance more than 8 hours per day (Phillips, 2005). As Phillips (2005, p. 69) states, "it's always on their mind, making it difficult to focus on anything else." This preoccupation that is involved with individuals with BDD is "maintained by continual rehearsal of negative self-statements that become automatic and avoidance behaviors" (Neziroglu, & Khemlani-Patel, n.d., p.7).

Making the distinction between the two disorders is important because differentiating BDD from other disorders is actually a portion of how DSM-IV defines BDD. The point behind this portion of the definition is to ensure that BDD, or BDD-like

symptoms, are not accounted better by another disorder such as OCD, anorexia, among others (Phillips, 2005). For example, DSM-IV states that individuals who have a concern that they are too fat and are significantly underweight (about 15% or more) and meet the other criteria for anorexia should be diagnosed with anorexia versus BDD (Phillips, 2005). Anorexia and BDD also have a lot in common, like OCD and BDD; however, it is essential to remember that an individual can have both BDD and an eating disorder such as anorexia (Phillips, 2005).

The "defect" presumed by an individual with BDD is considered to be imagined because others do not see the defect that the individual with BDD sees (Phillips, 2005). This delusional aspect shows how BDD can be thought of as a psychotic disorder (Marazziti et al., 2006). A study by Dyl et al. (2006, p. 378) found that most of the subjects who had excessive weight concerns were actually of a normal weight (as determined by measuring their body mass index), which showed that their "body image concerns were not realistic."

Most people when feeling unattractive feel overall that their appearance is less than desirable. A recent survey of 30,000 individuals in the U.S discovered that 93% of women and 82% of men care about and make an effort to improve their appearance (Phillips, 2005). As Phillips (2005) stated, the worries of individuals with BDD parallel the normal concerns of the general population; however, individuals with BDD have concerns that are on a more extreme level. But for those with BDD, there is a specific area, often referred to as a "flaw," about which they are concerned, versus their overall appearance. They often see themselves as "aesthetic objects" (Gilbert & Miles, 2002, p. 269). Most of these perceived flaws tend to remain centered mainly on the head and face

of an individual (Olivardia, 2004). In more specific terms, the most common areas in which individuals with BDD focus on include skin (about 80%), hair (about 57.5%), and nose (39%) (Phillips, Menard, Fay, & Weisberg, 2005). Other "perceived flaws" that are not as common, but still exist include chin, teeth, ears, buttocks, and arms (Olivardia, 2004).

There are specific behaviors associated with BDD. These behaviors vary and depend on the particular individual's "perceived flaw." Over 90% of patients are involved in some sort of repetitious behavior (Powley, Powley, & Boorboor, 2003). The handbook of eating disorders (Olivardia, 2004) described some of the observable behaviors of individuals with BDD. Seventy-three percent of BDD sufferers do mirror checks or use another type of reflective area; this is the most common behavior (Olivardia, 2004).

Gilbert and Miles (2002, p. 270) stated other observable behaviors of individuals with BDD such as feeling the contours of their skin repeatedly, taking photos or videos of themselves, measuring their perceived defect, wearing makeup 24 hours per day, excessive cleansing of the skin, excessive grooming of the hair, beauty treatments, skin picking, asking others to "verify the existence of the defect," and facial exercises to increase muscle tone. In some individuals with BDD, the disorder is often endured or escaped with the use of alcohol, illegal substances, or safety behaviors such as those found in individuals with a social phobia in order to cope (Veale, 2004).

Looking at the cognitive side of this behavior, Olivardia (2004) stated that individuals with BDD are motivated to look at themselves, hoping to feel better about the way that they look, when in fact the opposite occurs, which is mainly due to extremely

high expectations prior to looking in the mirror. Olivardia (2004, p. 543) stated that it is hard to say how exactly those with BDD physically see themselves, but the individual either "actually *sees* the body part differently (sensory difference) or may see it accurately but *thinks* or *feels* about it differently." Most of the thoughts of an individual with BDD are negative (Phillips, 2005). The appearance concerns of individuals with BDD are not just fleeting thoughts; they cause actual stress and/or emotional pain (Neysa Jane BDD Fund, n.d.b). In addition to the cognitive side, often unrecognized are the values of those with BDD. As identified by Gilbert and Miles (2002), these values include perfectionism and social acceptance.

Preoccupation is not the only presenting factor. Many individuals feel at times concerned about a particular part of their appearance. The difference between the general population and those with BDD is that in those with BDD, the preoccupation goes beyond mere dissatisfaction. The preoccupation actually causes significant distress or impairment in various areas of an individual's life (Phillips, 2005). Dyl et al. (2006, p. 370) stated that for individuals with BDD, there is a "notably poor quality of life." Individuals with BDD often avoid a variety of social situations, as well as close relationships (Gilbert & Miles, 2002). Gilbert and Miles (2002) continued to say that those who choose to go out publicly or become involved in relationships do so only as long as they are able to cover their perceived flaws or are involved in other hiding behaviors. Individuals with BDD think that those around them hold the same opinion as themselves and therefore often avoid social situations (Neziroglu, & Khemlani-Patel, n.d.). Choate (2005) stated that there is a connection between poor body image and a plethora of psychosocial problems. Choate (2005) continued to state that some of the

psychosocial problems that are related to negative body image include poor self-esteem, anxiety in regards to social evaluation, depression, being self-conscious in public, as well as sexual inhibition.

Risk Factors

Along the same lines as other psychological disorders, BDD does not have any one known cause (Neziroglu, & Khemlani-Patel, n.d.). Instead, BDD involves the interaction of a number of various factors which include early environmental factors, psychological factors, social-cultural factors, as well as neurobiological variables (Neziroglu, & Khemlani-Patel, n.d.). Cash & Pruzinsky (as cited in Olivardia, 2004, p. 543) stated that the way that we create out body image is derived from both "visual and cognitive/attitudinal cues."

One risk factor involved in the development of BDD includes early experiences. It is hard to understand why and how an individual can come to have such a low opinion of him/herself as seen in those with BDD. Gilbert and Miles (2002) stated that early experiences attributed to the development of BDD and body shame. These experiences occur around the age of 2 or 3 and are risk factors for developing a "sense that one is flawed, inadequate, and undesirable" (Gilbert & Miles, 2002, p. 56). They include things like rejection from peers and parental criticisms (Gilbert & Miles, 2002). Children perceive the reason for the rejection as themselves (Gilbert & Miles, 2002). Other examples of early experiences include any public humiliation that involves some form of movement of the body, such as dance and athletics (Neziroglu, & Khemlani-Patel, n.d.).

Other early experiences that have an affect on the development of negative body image include certain family traits (Choate, 2005). As Choate stated, these family traits

are things such as: negative attitudes and behaviors of family members in regards to things such as thinness and shape issues, critical comments, and/or parental history with dieting and/or being overweight.

A longitudinal study by Didie et al. (2006) proposed that childhood sexual abuse would be a common risk factor for individuals with BDD. The study had 52 female and 23 male participants all diagnosed with BDD, ages 12 and older. The participants completed self-report questionnaires to gather information on their abuse experiences. Results of the study showed that more than three-quarters of the participants (78.7%) noted childhood maltreatment (Didie et al., 2006). Sixty-eight percent reported a history of emotional neglect and 56% a history of emotional abuse, two of the most prevalent types of abuse found among the participants. Scores also did not differ between genders (Didie et al., 2006). The study also found that "lifetime suicide attempts were significantly related to perceived emotional abuse, physical abuse, and sexual abuse" (Didie et al., 2006, p. 1109). Didie et al. (2006) also found that BDD severity was associated with perceived sexual abuse.

Other possible causes include environmental factors such as the surrounding culture. In American society, being thin is idolized. It is no wonder BDD has relatively large prevalence rates as it does. Canadian researcher Gregory Fouts (as cited in Media Awareness Network, 2006), stated that "over three-quarters of the female characters in TV situation comedies are underweight, and only one in twenty are above average in size." Most of the bodies of individuals in the media are not even attainable to the general public (Media Awareness Network, 2006, n.p.). Individuals with BDD "compare themselves to an ideal of perfection that is impossible to attain" and often disregard

information that does not match their current belief about themselves (Neziroglu, & Khemlani-Patel, n.d.).

The Media Awareness Network (2006) stated that some of the possible reasons the media is pushing such unattainable beauty standards is mainly for economic reasons. "By presenting an ideal difficult to achieve and maintain the cosmetic and diet product industries are assured of growth and profits. And it's no accident that youth is increasingly promoted, along with thinness, as an essential criterion of beauty" (Media Awareness Network, 2006). The National Eating Disorders Association (as cited in Choate, 2005) stated that the media's version of beauty does not fit most women in the United States, where the average female is 5'4" and weighs 142 pounds.

Choate (2005) also stated that there is an association between media's presentation of beauty and women's body satisfaction. Choate (2005) also stated that the media presents a myth that once you meet certain standards of beauty, the end result will be an improved social life as well as success in all other aspects of life. These standards of beauty are one of the possible contributors of BDD. In cultures where the Western standards of beauty have not been adopted, particularly found "within the African American community, the reduced cultural emphasis on weight appears to translate into more positive image for Black women" (Choate, 2005, p. 323).

Some studies say that environmental factors contribute to the development of BDD (Gilbert & Miles, 2002), whereas others say it is more hereditary (Stein, Carey, & Warwick, 2006). The latter authors, in a study that consisted of 200 patients with BDD, found that the disorder occurred in 5.8% of first degree relatives. From these results, it was concluded that BDD is familial (Stein, et al., 2006).

Adolescence

Adolescence is a time of change. Rayner (1978, p. 105) identified adolescence as a "normal crisis of life." Rayner (1978) also stated that adolescence consists of the psychological changes that occur due to puberty and includes changes in expectations, such as taking on more adult-like responsibility. Piaget stated (cited in Rayner, 1978, p. 106) that most adolescents are in the stage known as "formal operations." This particular stage marks the transition from childhood to adolescence. The adolescent has the ability to "manipulate ideas unrelated to the immediate world" and think about abstract possibilities (Rayner, 1978, p. 107).

Particular to body image in adolescents, Rayner (1978) identified that adolescence is a time of physical development. Boys and girls are naturally going to change their mental image of themselves in relation to their bodies (Rayner, 1978). The difference between normal adolescent body image concerns and those of adolescents with BDD is as previously stated in the definition of BDD: there is a "preoccupation with an imagined defect" that causes distress in areas of the individual's life as seen by "impaired social functioning, notably poor quality of life, and a high rage of suicidal ideation" (Dyl et al., 2006, p. 370).

These physical changes and thoughts centering around the changes may be the main reasons why the onset of BDD is often in adolescence. Some adolescents have a difficult time adjusting to these changes and "BDD might be an abnormal response to these changes" (Neziroglu, & Khemlani-Patel, n.d.). Hopefully, adolescents are given information and enough support to understand the changes happening within them, but many are not and are at risk for developing BDD.

A study by Dyl et al. (2006, p. 371) which assessed the occurrence of BDD, eating disorders, and other clinically significant body image concerns in 208 adolescents, stated that pubertal changes, increases in body weight, and other "life transitions are associated with increased rates of body dissatisfaction." Dyl et al. (2006) also gathered that the developmental literature does not place body image as an important factor on the impact on adolescents' transitions and development as it should.

Thompson and Smolak (2001) reviewed a study and also found higher body dissatisfaction rates among adolescents. The study (Thompson & Smolak, 2001) found that 55% of girls and 35% of boys ages 8-10 were unhappy with their body size. Thompson and Smolak also stated that body dissatisfaction is not culturally bound. About 30 to 50% of children and adolescents from a variety of countries are dieting and/or unhappy with their weight.

However, Choate (2005) found otherwise. Choate (2005) found a huge cultural difference particularly when comparing African American females to White female adolescents. Only 9.1% of adolescent White females considered themselves as either attractive or very attractive as compared to 40% of Black adolescent females (Choate, 2005). Musser (cited in Choate, 2005, p. 323) stated that Black women also "do not limit their view of ideal body types to a narrow range of weights and shapes but often report larger ideal body shapes." Choate (2005, p. 323) also stated that Black women are more likely to have the ability to question the media's portrayal of the ideal thin body as well as "internalization of negative stereotypes."

According to the study by Dyl et al. (2006), BDD looks a little different in adolescents than it does in adults, mainly due to the physical changes that adolescents

experience. These differences include adolescents' BDD features including concern about body shape and weight versus the focus on specific body parts as seen in adults with BDD (Dyl et al., 2006). Dyl et al. (2006) also went on to predict that adolescents with BDD would be more likely to experience increased levels of depression, anxiety, and suicide.

A study by Albertini and Phillips (1999) interviewed 33 cases of children and adolescents, all of whom were identified as meeting DSM-IV criteria for BDD. The study stated that like BDD in adults, BDD in children and adolescents may lead to decreased functioning. This decreased functioning specifically pertaining to children and adolescents included quitting sports and other activities, poor grades, school absences, quitting high school, and social withdrawal, of which any of these may negatively have an impact on development of that particular individual (Albertini & Phillips, 1999).

Prevalence

Disorders such as anorexia and depression are widely recognized by most individuals. BDD is not as well known. Even among professionals, awareness of the disorder is low (Gilbert & Miles, 2002). BDD is one a disorder that is among the lesser well-known (Phillips, 2005). Phillips (2005, p.38) stated that, "Health care professional usually miss BDD." BDD is a more secretive disorder and is often under-diagnosed (Rief et al., 2006). Dyl et al. (2006), found that only 1 of 14 participants with BDD or what was most likely to be known as BDD as actually diagnosed with BDD. Even though adolescence is when BDD typically first occurs, it is often not diagnosed right away, usually 10 to 15 years pass before its diagnosis (Veale, 2004).

Not only is BDD under-diagnosed, but is may also be misdiagnosed (Phillips, 2005). As mentioned previously, BDD has similarities with a number of other disorders (Phillips, 2005). Many of symptoms of BDD look the same as they do in other disorders, but BDD is easier to recognize if there is an understanding of its similarities with other disorders, such as OCD, depression, and social phobia, among others (Phillips, 2005). Phillips (2005, p.46) stated that "many people with BDD are depressed" and coexistence with other disorders is very likely.

There is a sense of shame that individuals with BDD feel and so many do not reveal their symptoms to anyone. Therefore, many individuals with BDD go undiagnosed. Rief et al. (2006, p. 878) identified that "although 13% of psychiatric inpatients had BDD, all of these patients reported that they would not reveal the disorder to their physician unless specifically asked." Veale (2004) stated that individuals were more likely to tell their doctors that they have various symptoms of depression and social anxiety if they were not specifically asked about symptoms of BDD.

Phillips (2005) stated that some reasons individuals with BDD do not disclose the disorder included worrying that their concerns were superficial, vain, and that others will focus on their defect even more than before once it is specifically pointed out. Phillips (2005) also stated that many individuals with BDD are afraid that they will merely get reassurance that they look fine if they mention it to others and thus feel that their emotional distress is not being acknowledged or comprehended. Grant et al. (cited in Dyl et al., 2006) found that 13 of the 16 participants in their study thought of BDD as their largest problem, but shame kept them from disclosing any of their symptoms to their

doctor unless asked. Despite the fact that many patients go undiagnosed, BDD is still "relatively common" (Phillips, Coles, et al., 2005, p. 717).

The study mentioned previously by Rief et al. (2006) was a population-based survey aimed at assessing the prevalence of BDD. The results of the study included that about 10% of the general population was preoccupied with at least one body part that was seen as a defect to the particular individual, but the belief was not held by other people known to the individual. However, when other DSM-IV criteria were also introduced, the prevalence rate ended up being 1 to 7%. Other studies have also identified similar prevalence rates. Claiborn and Pedrick (2002) stated that BDD occurs in about 1 to 2% of the general population. These percentages equate to about 1 in every 100 adults in the general population (Phillips, 2005). Phillips (2005) stated that a study of 122 people in Minnesota who were in the psychiatric inpatient unit in a hospital, discovered that 13% had BDD. It was found that BDD was more common than a number of various disorders such as OCD, schizophrenia, social phobia, and eating disorders, among many others (Phillips, 2005).

Studies specifically pertaining to adolescents and young adults show even higher rates of BDD, from more than 2% in high school students to up to 13% in college students (Phillips, 2005). The average age in which BDD first appears is before the age of 18 in 70% of BDD cases (Albertini & Phillips, 1999). Many studies have documented the higher rates of BDD among adolescents as compared to adults. A study by Grant et al. (cited in Dyl et al., 2006) found that 14.3% of adolescents in a study of 122 participants met DSM-IV criteria for BDD. Phillips (2005) stated that BDD can occur in up to 13% of students, which equates to 1 in every 8 students.

BDD does not appear to have boundaries in terms of gender, culture, and ethnicity, with some exceptions. BDD is found in men as often as it is in females (Neysa Jane BDD Fund, n.d.b). Choate (2005) stated that despite the fact that body dissatisfaction was at first considered to affect mainly Caucasian women, research has shown that this issue has occurred in any culture or ethnicity, in which the Western standard of beauty has been adopted.

Suicide Implications

BDD impacts many areas of an individual's life. However, the most serious aspect of BDD is its suicidal implications. Suicidal ideation can precede suicide acts (Lai & Mcbride-Chang, 2001). There are many things involved in suicidal ideation, but factors of particular importance in adolescents include depression, poor self-esteem, hopelessness, and poor school performance, among others (Lai & Mcbride-Chang, 2001). Phillips (cited in Veale, 2004, p. 114), found "a degree of distress" in patients with BDD "that is worse than that of depression, diabetes, or bipolar disorder." With this amount of distress present, for many individuals with BDD, suicide may seem like the only way out of their situation.

In an observational study by Phillips and Menard (2006), the authors observed and interviewed 200 subjects who met BDD criteria and then did a follow up interview that assessed suicide attempts. Two of the subjects involved in the study committed suicide. The study found that prior suicide attempt rates for those with BDD were from 22 to 24% (Phillips & Menard, 2006). The study also found that the mean annual rate of suicidal ideation among participants, which consisted of thoughts and ideas of suicide in individuals with BDD and not actual suicide attempts, was 10 to 25 times higher for those

with BDD than in the general U.S. population (Phillips & Menard, 2006). The study also found that individuals with BDD have numerous suicide risk factors, including poor self-esteem and high amounts of anxiety, depression, and hostility (Phillips & Menard, 2006).

Another study by Phillips, Coles, et al. (2005) also found high rates of suicide among individuals with BDD. Phillips, Coles, et al. (2005) assessed suicide ideation and behavior among 200 individuals with BDD in a longitudinal study. The study identified 78% of its participants to have a history of suicidal ideation, and over half stated that BDD was the main reason for the suicidal thoughts (Phillips, Coles, et al., 2005). The study also pointed out various risk factors for suicide completion in those with BDD. Some of these risk factors included having poor social supports, poor self-esteem, high levels of depression, anxiety, hostility, impulsivity, and shame and humiliation, as well as high rates of eating disorders and substance abuse (Phillips, Coles, et al., 2005).

A study by Dyl et al. (2006) examined BDD and suicide specifically in the adolescent population. The study included 208 adolescents, ages 12 to 17 whom were admitted to an inpatient unit of a psychiatric children's hospital. The study (Dyl et al., 2006) used various self-report measures, such as the Body Dysmorphic Questionnaire (BDDQ) and the Suicide Probability Scale (SPS). Four different categories were formed based on participants' answers on the BDDQ. These categories included: BDD, shape/weight concerns (SWC), eating disorders (ED), and no BDD/or any of the other categories. The four groups were found to differ significantly on suicide levels (Dyl et al., 2006). The BDD and shape/weight concerns groups had significantly higher levels of suicide than the no BDD or other categories. The study also showed a relationship

between weight-related concerns and increased psychopathology, including suicide, among adolescents (Dyl et al., 2006).

School Counselor Perspectives

Much of the research on body dissatisfaction and BDD is found in many professional journals, but most of the journals are from the psychiatry field. Other journals that specifically relate to school counseling, such as journals like *Professional School Counseling*, do not refer specifically to BDD as a disorder. However, the school counseling literature does refer to body dissatisfaction and negative body image versus the actual disorder of BDD and has a more school related perspective.

Gabel and Kearney (1998) explored body dissatisfaction and its prevalence and impact with youth. The study found that there was a positive correlation between an adolescent girl's age and measurements and body dissatisfaction. As age and measurements increased, body dissatisfaction also increased. In this study, a huge contributor to youth's obsession with thinking was the media, but in particular media aimed at children and teens. Articles pertaining to outward appearance continually were found in magazines targeted for adolescents, such as *Teen*, and *Seventeen*, etc. Teens were not only bombarded with images of the ideal body, they also received mixed messages about health and physical attractiveness.

There is a lot of concern in regards to the increase in the prevalence of body dissatisfaction in schoolchildren. Gabel and Kearney (1998) stated that dieting is frequent among school aged children. Pugliese et al. (as cited in Gabel & Kearney 1998) found a group of 14 children to have growth and sexual development delayed because of fears of getting fat. The fear among the children increased the amount of skipped meals and

decreased the number of calories ingested from 32% to 91% of the total calorie recommendation pertaining to each of the children's age. Another study by Gustafson-Larson and Terry (as cited in Gabel & Kearney, 1998) also showed the increased concern of negative body image among young children. The study included 457 fourth grade students who were attending rural schools in central Iowa. The study showed that over 60% of the participants very often or sometimes wanted to be thinner, had worries about being fat, and weighed themselves everyday (Gabel & Kearney, 1998).

Gabel and Kearney (1998) also found that body dissatisfaction was very high among adolescents, especially in females. As many as 70% of high school girls were found to be dissatisfied with their bodies and wanted to decrease their body weight (Gabel & Kearney, 1998). Even though body dissatisfaction was common among females, males were also preoccupied with their weight. Due to the increase in dieting adolescents and those dissatisfied with their body, it is important to have preventative measures "before dieting and excessive weight concerns develop into a clinically defined eating disorder" (Gabel & Kearney, 1998, p. 33).

A study by Stout and Frame (2004) reported that negative body image is not exclusively a female issue. "As more boys become attuned to the male ideal presented to them in society, they also become more adept at identifying the shortcomings in themselves and, when that process becomes too painful, they begin to point out the physical shortcomings in others (Stout & Frame, 2004, p. 177)." Also, when boys do not match the image presented to them from the media, they feel pushed to meet that ideal image.

A study by Akos and Levitt (2002) also had perspectives on body dissatisfaction. The study stated that as students' bodies change and mature and preadolescents become increasingly close in their relationships with one another, differences in appearances are noticed much more than before. Developing a healthy body image is very important for preadolescents. The study also stated that developing a healthy body image is difficult due to the surrounding pressure in Western society to maintain a set standard of appearance. Both middle school boys and girls attach feelings with physical change. A study by Folk, Pedersen, and Cullari (as cited in Akos & Levitt, 2002) stated that there was a strong relationship between body satisfaction and self-concept in sixth grade boys. The study also stated that during sometime in their adolescence, girls tend to feel fat, get anxious about their weight, or develop conflicting feelings towards food.

Overall, the school counseling perspective cites the huge impact of the media's portrayal of an ideal body on students' overall body satisfaction (Gabel & Kearney, 1998). Most school counseling literature does not specifically refer to BDD. The literature uses terms like body dissatisfaction and negative body image instead. Overall, there is a high prevalence of body dissatisfaction among children and adolescents, which is of concern to school counselors.

Chapter 3: Summary, Critical Analysis, and Recommendations

This chapter will summarize the research findings from the previous chapter, as well as give a critical analysis of the information on BDD. This chapter will end with recommendations to improve research for future use as well as recommendations for professionals working with adolescents.

Summary

Body dysmorphic disorder (BDD) is a mental disorder recognized by the DSM-IV. It is relatively unheard of, although research on the disorder has exploded in the last 20 years. BDD can be somewhat difficult to recognize because many of its symptoms can vary from one individual to the next. In one individual, BDD may be a fixation on "ugliness" of the nose, whereas in another individual it may be preoccupation with the skin. Some of the key features in all involve preoccupation with some imagined defect so much so that various aspects of the individual's life are affected. For those suffering from BDD, it is more than the "body blues." BDD involves the "most extreme form of body shame" (Gilbert & Miles, 2002, p. 267). About one quarter of individuals with BDD think about their perceived flaw about 1 to 3 hours per day and about another quarter of those individuals think about it for 3 to 8 hours per day (Olivardia, 2004).

Although some cases of BDD are more severe, there are a lot of individuals with BDD who are actually living somewhat "normal" lives and are functioning on the surface quite well (Phillips, 2005). Even though individuals with BDD appear to be "normal," various areas each individual's lives are affected. Dyl et al. (2006, p. 370) stated that for individuals with BDD, there is a "notably poor quality of life." Individuals with BDD

often avoid a variety of social situations as well as close relationships (Gilbert & Miles, 2002).

Understanding what BDD is and knowing symptoms of the disorder are important because of its relation to high suicide rates. One study also found that the mean annual rate of suicidal ideation among individuals with BDD was 10 to 25 times higher than that of the general population (Phillips & Menard, 2006). Dyl et al. (2006) showed a relationship between weight related concerns and increased psychopathology, including suicide, among adolescents (Dyl et al., 2006). A study by Phillips, Coles, et al. (2005) identified 78% of its participants to have a history of suicidal ideation, and over half stated that BDD was the main reason for the suicidal thoughts. Other studies such as the 12 month follow up one by Phillips, Pagano, Menard, and Stout (2006) agree with these high rates. Seventy percent of individuals with BDD are identified as having a history of suicidal ideation (Phillips, Pagano, et al., 2006).

It is especially important to understand adolescents and what is going on in their lives because the prevalence rates of BDD in adolescents is considerably higher as compared to adults. Claiborn and Pedrick (2002) stated that BDD occurs in about 1 to 2% of the general population. Studies specifically pertaining to adolescents and young adults show even higher rates of BDD, from more than 2% in high school students to up to 13% in college students (Phillips, 2005). The average age in which BDD first appears is before the age of 18 in 70% of BDD cases (Albertini & Phillips, 1999).

Prevalence of BDD in adolescents is higher than in adults mainly because adolescence is a time of change. Rayner (1978, p. 105) identified adolescence as a "normal crisis of life." Rayner (1978) also stated that adolescence consists of the

psychological changes that occur due to puberty and includes changes in expectations, such as taking on more adult-like responsibility. Changes both physically and mentally leave a lot of room for various thoughts and challenges. It is hard to completely understand why all of these changes are occurring, so adolescents often come up with their own conclusions. BDD shows some of these more negative conclusions. A study by Dyl et al. (2006) also showed a relationship between weight related concerns and increased psychopathology, including suicide, among adolescents. Thompson and Smolak (2001) reviewed a study and also found higher body dissatisfaction rates among adolescents. Their study (Thompson & Smolak, 2001) found that 55% of girls and 35% of boys ages 8-10 were unhappy with their body size.

Critical Analysis

The definition of BDD can be somewhat confusing. Although BDD is identified under somotoform disorders, there are many other categories in which BDD seems like it could be classified under in the DSM-IV. The main source of confusion is that of whether BDD should be identified under somatoform disorders, under anxiety disorders, or under psychotic disorders. It seems that BDD tends to possess attributes of all of the previously listed categories of disorders. The Journal of Psychiatric Research agrees with BDD being a somewhat confusing disorder, stating that DSM-IV's classification of BDD has many conflicting components (Phillips, Menard, et al., 2006).

BDD's definition is not the only confusing component of the disorder. There is also an overwhelming amount of associated features or behaviors. There is a large array of features that range from physical to mental characteristics. These behaviors are also

tied to the life of an individual with BDD and cause that particular individual significant distress.

In addition to BDD's confusing definition and overwhelming amount of associated features found in the current literature, much of the current research also contains small sample sizes. Most of the studies in existence today have relatively smaller sample sizes that usually consist of about 250 participants or less. One of the associated issues related to having larger sample sizes is the under-diagnosis of the disorder. If individuals who actually have BDD are not being diagnosed, it is hard to have a large sample size involving participants with BDD.

Many of the studies involved with BDD use 200 subjects or fewer. For example, a study by Phillips, Menard, and Fay (2006) looked only at 200 individuals with BDD. Phillips, Menard, and Fay's study (2006) was aimed at examining gender similarities and differences in individuals with BDD. Although both similarities and differences were found, more similarities than differences were observed (Phillips, Menard, & Fay, 2006). A larger sample size may lend to higher amounts of differences, if they do in fact exist. Another critique in regards to sample size in the study by Phillips, Menard, and Fay (2006) is that the study contained twice as many men than women. The validity of the study by Phillips, Menard, and Fay (2006) may be threatened because the sample selection is not equally representative of both genders.

Another study by Phillips, Menard, et al. (2005) also is an example of research on BDD that consists of a sample size of 250 or less. Other limitations of this particular study included that it did not directly make a comparison between individuals with BDD and individuals in the general community and also with individuals with other disorders.

Another limitation of the study is that the suicide data was gathered retrospectively. The study also did not look at completed suicide.

The majority of studies about BDD mostly include 250 or less subjects; however, there are exceptions. A study by Rief et al. (2006) included 2552 participants. This was a population based survey that aimed to assess the prevalence of BDD in the general population. The study, due to its large number of participants, also had the most stable confidence levels to date in regards to prevalence of BDD symptoms in the general population.

The study by Rief et al. (2006) also aimed at selecting individuals with the basis of being representative of the entire population. A lot of the other studies were done with patients in psychiatric wards, which makes the subject selection more narrowed and based on convenience. However, this study did consist mainly of European Caucasians. More generalization could be made if a more culturally diverse sample was used.

Other areas of research involving BDD that have not been explored are its occurrence and impact in the schools. One study from a medical perspective that was conducted in a psychiatric ward was the study by Dyl et al. (2006), which consisted of 208 admitted adolescent inpatients in a psychiatric ward. One limitation of this particular study was that the symptoms of BDD were identified by adolescents' descriptions of them and thus it was based on self report measures (Dyl et al., 2006). Another limitation of the study was that the BDDQ was used, which has been known to be highly sensitive and specific and therefore, "some BDD diagnoses may have been false positives (Dyl et al., 2006, p. 379)." However, it is important to consider that self report is critical for diagnosis of BDD.

Current research, although recently prolific, is still in its infancy. In general, more research involving BDD needs to be generated. Not only is more research in general needed in the area of BDD, but research especially related to adolescents is needed because of the fact that BDD's onset usually occurs during this time. Some studies have utilized adolescents as subjects. For example, the study by Albertini & Phillips (1999) interviewed 33 subjects using the structured clinical interview for DSM-III-R (SCID). All were children and adolescents (aged 17 year or younger). The purpose of the study was to gain information on demographics of the participants as well as on associated mental illnesses. One limitation of this study was that its results were not compared with information from adults. So, the study was not able to make comparisons between adolescents with BDD and adults with BDD. Because BDD can look different in adolescence than in adulthood, more studies specifically pertaining to adolescents would be helpful.

Much of the research that specifically includes individuals with BDD, and even research just merely using the term BDD, has been conducted in the hospital setting, whereas in the journals specifically relating to schools and counseling, the term BDD is rarely used. This is partly due to the fact that school counselors do not diagnose any student with BDD. But it is also due to the manner in which school counselors view students. School counselors take a more developmental and holistic approach instead of a diagnostic and treatment viewpoint. So, school counselors can look for some of the early signs of BDD, which possibly include body dissatisfaction. More importantly, school counselors can take preventative measures through education and curriculum. If school counselors do see some of the associated features, they can make referrals if

deemed necessary. Body dissatisfaction is also a more user-friendly term in the schools because it is more likely that other professionals in the school know what body dissatisfaction is versus BDD.

Recommendations for Research

It would be helpful if in the future, consensus was built in regards to the definition of BDD. Olivardia (2004, p. 542) pointed out that BDD is "one of the most misunderstood diagnoses in the DSM-IV." However, it is also important to take into consideration that in general, the DSM-IV has boundary problems in regards to overlapping symptoms among disorders (Brown et al., 2001). If future research could either find the best fitting category to classify BDD under or come up with an entirely new category just for BDD that possibly combines some of the current ones, BDD would be that much more recognizable and easy to understand.

In addition to a larger body of research, larger sample sizes would be another recommendation for future research. Also, most of the research that has been conducted has been in a psychiatric inpatient setting. It would be helpful for professionals who work with adolescents in a non-hospital setting to have research pertaining to these particular settings. Future research could also include more studies that have adolescent participants because of the fact that BDD's onset usually occurs in adolescence. It would also be helpful if future research not only had studies with adolescents, but compared BDD in adolescents to BDD found in adults. This would be helpful to see if there are significant differences between the two populations.

Future research could use larger and more diverse samples, and more research in general is needed because research on BDD is still in its infancy. Future research on

BDD could also delve into unexplored areas such as impact and occurrence in the schools, among others.

Recommendations for School Counselors and Other Professionals Working with Adolescents

One of the most important recommendations for professionals working with adolescents in any setting is to have knowledge of the existence of BDD and to have a general understanding of the disorder. Many school-based professionals who work with adolescents will not diagnose individuals who have BDD, but being aware of the disorder so that appropriate referrals can be made is important. This is especially important due to the relatively high suicide rates that coincide with BDD.

This is also an important disorder to be aware of because of the implications for children and adolescents. These implications include decreased functioning, such as quitting sports and other activities; poor grades; school absences; quitting high school; and social withdrawal. Any of these may negatively have an impact on development of that particular individual (Albertini & Phillips, 1999). Also, because BDD is relatively new and research is continually being conducted, it is important for professionals to stay current with the most current research.

Because of the high suicide rates in individuals with BDD, it is also important not only to be aware of symptoms of BDD, but also be aware of its association with suicide. There are many things involved in suicidal ideation, but factors of particular importance in adolescents include depression, poor self-esteem, hopelessness, and poor school performance, among others (Lai & Mcbride-Chang, 2001).

Professionals working with adolescents should know symptoms or behaviors associated with BDD. Gilbert and Miles (2002, p. 270) stated that behaviors of individuals with BDD included things such as feeling the contours of their skin repeatedly, taking photos or videos of themselves, measuring their perceived defect, wearing makeup 24 hours per day, excessive cleansing of the skin, excessive grooming of the hair, beauty treatments, skin picking, asking others to "verify the existence of the defect," and facial exercises to increase muscle tone. In some individuals with BDD, the disorder is often endured or escaped with the use of alcohol, illegal substances, or safety behaviors such as those found in individuals with a social phobia in order to cope (Veale, 2004). Also, the most common behavior noticed in individuals with BDD is mirror checking or using other reflective areas, which 73 percent of sufferers perform (Olivardia, 2004).

As a school counselor or other professional working with adolescents, some key things to look for in individuals that may have BDD, as the Neysa Jane BDD Fund (n.d.a) stated, include being very concerned about the way parts of an individual's body looks, being preoccupied with the way one looks, thinking about appearance for at least an hour everyday, being affected by appearance concerns, avoiding things because of appearance concerns, and finally, experiencing stress or emotional pain because of appearance concerns.

It is important not only for counselors to know the signs of BDD, but also to use a more proactive approach in preventing body dissatisfaction and poor body image. As Akos and Levitt (2002, p. 138) stated, school counselors are very important in aiding in the development of adolescents because they "may be the only adults who are sensitive to

the integration of the various aspects of development." In many schools, the way students feel about their appearance and the teaching of healthy body image are mainly left to physical education and health educators (Akos & Levitt, 2002). With school counselors' knowledge of development, a preventative approach can be utilized in order to educate students about healthy body image instead of waiting until symptoms of BDD appear. As Choate (2005, p. 320) stated, in the counseling profession, there is an "emphasis on wellness and holistic approaches that build on the positive resources of clients."

There are many ways to be proactive in preventing BDD for school counselors and other professionals. As Choate (2005) stated, one major influence on body dissatisfaction, especially in adolescence, peer modeling. For school counselors, this is pertinent information because by educating one student, there is the possibility that many can be affected if even just one student is educated about positive body image and about BDD.

Counselors can also emphasize the fact that beauty is much more than an individual's outward appearance through curriculum (Choate, 2005). These "other" beauty indicators can include things like confidence, attitude, ethnic pride, among other characteristics (Choate, 2005). Other proactive methods that counselors can use include teaching coping skills for individuals so that if and when they are teased about their body weight, they know what they can do to handle the situation and their feelings (Gabel & Kearney, 1998).

Another way to be more proactive is to host a parent night and present material on BDD. Because BDD is a relatively new disorder, it is most likely that a lot of parents

have not heard of the disorder as well. To be truly preventative, it would be important for counselors to provide information on developing a positive body image in students and then to also include information on BDD (the extreme end of negative body image). Because counselors are always concerned with a more holistic approach, bringing the parents on board would achieve an even higher level of prevention because parents could monitor their children/adolescents at home for signs/symptoms and talk to them or refer to them to the school counselor.

Counselors can also educate students and parents about resisting the cultural standards of beauty (Choate, 2005). Choate (2005, p. 323) stated that in examining an African American community, having strong ties to the community and strong peer support contributed to the development of "body image resilience." Choate (2005) also stated that the family support is related to an increased positive body image.

There are other specific protective and preventative factors of which school counselors should be aware. These include things such as encouraging the participation in athletics, because as Mussell (as cited in Choate, 2005) stated, there is a positive association with positive body image and participation in sports. Of course, not all students are sports or athletics oriented. So, an alternative to athletic participation could be exercise in general. When exercise is specifically for health versus for the purpose of increasing outward appearances, body satisfaction improves (Choate, 2005). Another specific way to help prevent BDD is educating students about the stereotypes that exist in the media. "Women who have conscious awareness of socio-cultural messages regarding weight and shape are more likely to be buffered from their potentially negative effects" (Choate, 2005, p. 325).

Another area that professionals should be aware of, is treatment options and how to make referrals to qualified professionals. When BDD symptoms are recognized in an individual, it is especially important for school counselors and other professionals who do not have the credentials to make a diagnosis, to be able to refer them to the appropriate agency and/or give them necessary information about the disorder. One excellent source for information is the Neysa Jane BDD foundation, Inc. Other sources that can be used and/or given to the individual with possible BDD include a "the BDD workbook", the book the Broken Mirror, and the Obsessive Compulsive Foundation (Neysa Jane BDD Fund, n.d.c).

Another way to help students and/or clients/patients is to use a screener such as the Body Dysmorphic Disorder questionnaire (BDDQ) and to use that in the referral process (Phillips, 2005, p.41). The school nurse could possibly do this because they have training in administering screeners to students. This is controversial, though, in regards to who would give such a screener and if it is appropriate to do so in schools. It is important to remember for professionals without a medical degree that diagnosis is not the goal, because qualifications to do so are not met. But being able to recognize the symptoms and understanding BDD will enable the professional to help the individual get more intensive help.

A final important recommendation for counselors is to take a personal assessment of one's own views on body dissatisfaction as well to develop some self care skills. First, before any of the aforementioned in the previous paragraphs can be implemented, it is important for counselors to take an overview of their own personal views of body image and dissatisfaction (Gabel & Kearney, 1998). As Gabel and Kearney (1998, p. 33) stated,

"A healthy acceptance of one's body is necessary before developing a program for students." Not only should counselors take a personal inventory of their own beliefs, but also of their self care. In any helping field it is important to take care of one's self to better serve others more effectively.

There is much work for school counselors to do in the area of BDD/body dissatisfaction. It is important to take a preventative approach. This can be achieved through curriculum and hosting parent nights that aim at developing healthy body images in students. Counselors should also take into account their own feelings of their body. It is important for school counselors to be aware of this disorder and its impact on an individual's life.

Overall, research on BDD is still in its infancy. Needed is future research that includes larger studies, more studies specifically pertaining to adolescents, and studies that are done in other environments besides the psychiatric setting. Because of BDD's prevalence, especially due to the fact that onset occurs usually during adolescence, it is important for school counselors to be educated and to take a preventative approach.

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