

Review article

The experiences of individuals with body dysmorphic disorder: A systematic review and thematic synthesis of qualitative research

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ABSTRACT

Body Dysmorphic Disorder (BDD) is a distressing psychological condition where an individual is preoccupied by a perceived issue with their appearance. Qualitative studies enable nuanced aspects of BDD phenomenology to be investigated. The current systematic review used thematic synthesis to integrate the findings from the extant qualitative studies. Searches were run on six databases to identify studies that had sought to describe the experience of individuals with BDD. PRISMA guidance was followed and ten articles were identified for inclusion. The quality of each article was appraised and thematic synthesis was conducted to generate novel and summative themes. Three superordinate themes were created: 'self-objectification and the view of self'; 'control and protecting the self'; and 'sociocultural influences and the impact of others in BDD'. Shame and self-disgust emerged as key experiential elements of BDD. The findings of the review suggest that self-objectification theory and possibly models of self-compassion are theoretically relevant to understanding the experience of individuals presenting with BDD. Current interventions may benefit from consideration of these theoretical models when seeking to improve efficacy.

1. Introduction

Body Dysmorphic Disorder (BDD) is a psychological condition listed in the Diagnostic and Statistical Manual of Mental Disorders where the central feature of the 'disorder' is a preoccupation with a perceived flaw in appearance (5th ed., DSM-5: [American Psychiatric Association, 2013](#)). Emphasis is placed on the perceived flaw being not observable or appearing slight to others, despite the excessive distress caused ([Veale et al., 1996](#)). Hence the condition is sometimes applied where there is an objective visible difference. In such cases there can be some controversy as to whether or not it is the most appropriate formulation of the presenting issue and in any event the use of the term 'slight' places emphasis on the perception of the person making the diagnosis as well as the person with the condition ([Thompson, 2012](#)). According to the International Classification of Diseases (ICD-11: [World Health Organization, 2019](#)) individuals with BDD can also be preoccupied about "ugliness in general" ([World Health Organization, 2019](#)). Regardless of

the precise diagnostic criteria used, it is clear that individuals experiencing BDD symptomatology often experience a significant amount of distress in relation to their appearance and may unduly view themselves to be disgusting, ugly or even deformed ([Feusner, Yaryura-Tobias, & Saxena, 2008](#)). This distress is reflected by individuals with BDD being four times more likely to have increased levels of suicidality and 2.6 times more likely to have attempted suicide than healthy controls, individuals with an eating disorder, OCD or other anxiety disorders ([Angelakis, Gooding, & Panagiotti, 2016](#)).

There are a multitude of safety behaviours that people with BDD may engage in. [Veale \(2004\)](#) categorised these safety behaviours into three domains: avoidance or exiting situations where one feels overwhelmed (such as avoiding mirrors, not attending events), compulsive behaviours (such as mirror gazing or comparing the perceived flaw to other people's features), and hiding the perceived flaw from others (such as by camouflage through clothing or make-up). Whilst these safety behaviours may provide some initial relief, they are time-consuming and are

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counterproductive as they cause more preoccupation and self-consciousness towards the perceived flaw (Veale, 2004). Furthermore, BDD has been reported to be associated with significant functional impairment, including poorer academic performance or dropping out of school (Phillips, et al., 2006), unemployment or if in work BDD symptoms interfered with occupational functioning (Didie, Menard, Stern, & Phillips, 2008) and social avoidance (Ritzert, Brodt, Kelly, Menard, & Phillips, 2020) with more severe BDD associated with poorer psychosocial functioning (Phillips, Quinn, & Stout, 2008).

Studies within the general population have found BDD to have a prevalence rate between 0.5%– 3.2% (Minty & Minty, 2021). As individuals with BDD may lack insight that they have a psychological condition (Eisen, Phillips, Coles, & Rasmussen, 2004), they typically seek treatment to correct the perceived flaw, rather than access psychological support (McCausland, Paparo, & Wootton, 2021). Embarrassment or shame about the perceived flaw may also prevent individuals from seeking psychological or in some cases physical intervention, such as speaking to a medical professional about corrective options (Phillips, 2004). Therefore, the number of individuals experiencing BDD may be underrepresented (Minty & Minty, 2021).

A recent meta-analysis has reported upon adverse childhood experiences (ACEs) and symptoms of BDD. The results suggest a relationship between ACEs and more severe levels of BDD symptoms (Longobardi, Badenes-Ribera, & Fabris, 2022). A large association was found between teasing and BDD symptoms, whereas a low to moderate association was found between BDD symptoms types of abuse, neglect, or bullying (Longobardi et al. 2022).

Whilst muscle dysmorphia is a sub-type of BDD, it may be phenomenologically different from BDD as it has a distinct preoccupation with perceived flaw in body build or/and musculature that is deemed too small or not muscular enough (5th ed., DSM-5: American Psychiatric Association, 2013). Muscle dysmorphia is more prevalent in males (Lechner, Gill, Drees, Hamady, & Ludy, 2019) and due to the pursuit of becoming more muscular, body builders are most likely to be affected when compared to non-bodybuilder resistance trainers (Mitchell, et al., 2017). Further highlighting some of the differences, Phillips (2007) found that when compared to men with BDD, men with muscle dysmorphia were more likely to have substance use difficulties, steroid abuse, have a poorer quality of life and have attempted suicide.

Self-conscious emotions have been posited as playing a role in BDD. For example, body related shame has been recognised as being prominent in BDD (Weingarden, Shaw, Phillips, & Wilhelm, 2018; Veale, 2002). Shame has been posited in part as serving a function to protect the self from perceived social exclusion by bringing into awareness any aspect of the self which could cause one to be rejected (Ryan, 2017). Shame has been separated into external shame and internal shame. External shame has been conceptualised as arising when a person feels that they are being judged negatively by others (Matos, Pinto-Gouveia, Gilbert, & Duarte, 2015). As individuals with BDD believe that their flaw is real and observable, it is suggested that they are at risk of experiencing external shame related to their appearance (Veale, 2004). Theoretically, internal shame has been used to refer to the belief that the self, or an aspect of the self, is “inadequate, flawed or bad” (Gilbert & Procter, 2006, p.354). As such individuals with BDD may experience internal shame due to their perceived flaw (Veale, 2002) and experience thoughts such as being worthless, inferior to others or inadequate (Veale, 2004).

In addition to shame, self-disgust has received recent attention for its role in BDD (McKay & Lo Presti, 2015). The function of the emotion disgust is to protect the self by alerting oneself to any stimuli that could cause disease, infection or illness (Curtis, de Barra, & Aunger, 2011). Previous literature has highlighted how individuals with BDD have higher levels of self-directed disgust compared to those in a control group (Hickey, Neziroglu, & McKay, 2010). Powell et al. (2015) have proposed a model of self-disgust, whereby a part of the self evokes a disgust response. Once a self-disgust schema is formed, the model

suggests that an individual will appraise and process information in line with this schema which will trigger a sense of wanting to repair or change the perceived cause of the reaction (Powell et al., 2015).

As individuals with BDD “evaluate themselves almost exclusively in terms of their appearance” (Veale, Kinderman, Riley, & Lambrou, 2003, p158), objectification theory (Fredrickson & Roberts, 1997) may be usefully deployed to explain some experiences of the individuals with BDD. Objectification theory hypothesises that women internalise the frequent sexually objectifying messages they are subjected to, within male dominated culture and institutions (Fredrickson & Roberts, 1997). Consequently, women may engage in body surveillance, make adverse self-comparisons and feel body-related distress (Fredrickson & Roberts, 1997). Women then develop a tendency to view themselves as an object, placing excessive value on their appearance and may experience body shame if they feel they do not meet particular body standards (Fredrickson & Roberts, 1997). Objectification theory may extend to men due to the sexualised and unrealistic beauty ideals that they are also subjected to through stereotyped media (Heath, Tod, Kannis-Dymand, & Lovell, 2016). However, research suggests that men do not have the same consequences of being sexually objectified by women, with gay males potentially having higher levels of self-objectification than heterosexual males (Calogero, 2012). At present, no studies have investigated the role of self-objectification in men with BDD, although general population studies which explored symptoms of the BDD sub-type muscle dysmorphia disorder and objectification theory had mixed findings in relation to its relevance (Daniel & Bridges, 2010; Davids, Watson, & Gere, 2019; Heath et al., 2016; Oehlhof, Musher-Eizenman, Neufeld, & Hauser, 2009; Hallsworth, Wade, & Tiggemann, 2005).

Whilst not necessarily attributed to the experiences of sexually objectifying messages, self-objectification is incorporated in the Cognitive Model for BDD (Veale, 2004) which highlights the role of ‘processing of self as an aesthetic object’ in the maintenance of BDD. The model proposes that self-objectification starts once “an external representation of the person’s appearance (e.g. looking in a mirror) activates a distorted mental image” (Veale, 2004, p.115). Veale (2004) explained that selective attention impacts the distorted image which influences how the person sees themselves and expects others to see them. It could be suggested that socially constructed ideal beauty standards contribute to people with BDD placing their self-worth on their appearance and becoming more preoccupied with their body including the perceived flaw. As different cultures have different beauty standard ideals, cross-cultural differences may exist in where the perceived flaw is for individuals with BDD (Ayub et al., 2018). Phillips (2004) drew upon case reports and series for patients across different countries and stated that “BDD’s clinical features are generally similar across cultures, but that culture may produce nuances and accents on an apparently invariant, or universal, expression of BDD” (p.13). Phillips (2004) highlighted that in Japan, patients with BDD may have concerns about the appearance of their eyelids and how this area of concern is not identified as often in Western countries.

Social learning theory (Bandura, 1977) has also been suggested to play a role in the development of BDD. Early life experiences and social learning have been recognised as contributing to the beliefs one develops about their own body image (Neziroglu, Khemlani-Patel, & Veale, 2008). Through exposure to messages in the media, interactions with family and peers, bullying and sociocultural factors in early life, individuals vicariously learn the importance of looking a certain way in order to be successful and what an acceptable body is (Tiggemann, 2011). The Cognitive Model for BDD by Veale (2004) highlights how a negative appraisal of one’s body image influences and is influenced by processing of self as an aesthetic object with individuals with BDD often basing their self-worth on the perceived flaw whilst having beliefs around the importance of one’s appearance. Similarities between objectification theory and social learning theory, when applied to body image, have been noted due to women evaluating their bodies following being exposed to “social messages about acceptable and unacceptable

looking bodies” from observation of significant others or media sources (Heath et al., 2016, p.298).

Over recent years, a number of qualitative studies have started to explore the experiences for individuals with BDD. These studies are useful for understanding the specific phenomenology of BDD, and may also help to clarify which psychological theories are most relevant. Whilst qualitative research studies are important for gaining an understanding of the lived experiences for people with BDD and informing the refinement of the theoretical understanding of the condition and its treatment, surprisingly the existing qualitative studies have not yet been appraised or synthesised. As a result, the quality of the existing qualitative studies on BDD is also unknown. Through synthesising the available qualitative literature on the experiences for individuals with BDD, commonalities and differences in experiences of BDD across studies can be explored and new themes and knowledge can be generated which were not be present in the original studies (Drisko, 2019). Therefore, the aim of the current review is to identify and synthesize the available published literature, which has utilised qualitative methods, to investigate the experience for people with BDD.

2. Method

2.1. Protocol

The protocol for this systematic review was registered on PROSPERO (CRD42022345297). The basis for how the current review was written is the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist (Moher et al., 2009).

2.2. Search strategy

The framework PICO (Population, Phenomenon of Interest, Context: Munn, Stern, Aromataris, Lockwood, & Jordan, 2018) was applied to formulate the research question and identify search terms.

The following search terms were then identified and used in the current systematic review: (“body dysmorphic disorder” OR “body dysmorphia” OR “dysmorphophobia” OR “dysmorphia”) AND (“lived experience*” OR “qualitative” OR “qualitative method*” OR “interview*” OR “focus group*” OR “ipa” OR “phenomenological” OR “thematic” OR “template analysis” OR “framework analysis” OR “grounded theory” OR “view” OR “views” OR “experient*” OR “opinion*” OR “attitude*” OR “perce*” OR “belie*”). To optimise the likelihood of identifying suitable literature, the search terms were run on six different databases: APA PsycINFO, CINAHL, Embase, MEDLINE, Scopus and Web of Science. During the searches, the only applied limit was ‘peer reviewed journal’ which could only be applied on APA PsycINFO search. No other limits were used in the search strategy and titles published in any year could be identified.

2.3. Study selection

Studies were eligible for inclusion in the systematic review if they used a qualitative or mixed-methods approach to explore the experiences of people with BDD with extractable quotes from participants, were articles in a peer-reviewed journal and were written in English.

The exclusion criteria for the systematic review was quantitative studies, secondary research studies, conference proceedings, grey literature, book chapters, theses, qualitative studies where no specific methodology or structured process was followed and qualitative studies where quotes from participants were not provided. For homogeneity, studies focusing on the experiences of individuals with muscle dysmorphia disorder were not included, due to differences in their presentation.

The first author completed the primary searches and identified the studies used in the review via discussion with the second author. Discussions were held with the second author where there was a lack of

clarity as to whether a study met criteria. All selected papers were then discussed and agreed as eligible via discussion between both authors. In addition, an independent researcher looked through a selection of records (n = 5), which were accessed for eligibility at the full record stage. There were no discrepancies between studies meeting inclusion criteria as identified by independent researcher or via the authors.

Ancestry and citation searches were run on all peer-reviewed journal articles identified as being eligible for the review, and this process did not identify any additional or missed studies.

2.4. Quality assessment

To assess the quality of the research used in the current review, the Critical Appraisal Skills Programme (CASP) qualitative checklist was used (CASP, 2018) by the first author. The checklist does not produce a scoring system but intends to encourage the reviewer to reflect on the quality and utility of the qualitative studies (CASP, 2018). On the CASP, the rating options for each item of the checklist is ‘yes’, ‘can’t tell’ and ‘no’. To ascertain whether any poorer quality studies influenced the findings from the thematic synthesis, after the descriptive and analytical themes were developed, these studies were extracted, to see if they contributed solely to the development of any themes within the review, with the intention of where this was found to be the case this would be made transparent.

To help assure inter-rater reliability, both authors discussed and reviewed the CASP ratings and an independent researcher completed the CASP qualitative checklist for a selection of studies (n = 2). Any discrepancies between the ratings were reviewed and resolved via re-reading papers and discussion. This process did not reveal any significant discrepancies.

2.5. Data extraction

The following information was extracted from each of the articles: author(s), year of publication, aims of the study, country, participant characteristics, recruitment strategy, data collection, methodology for data analysis and key findings. Please see Table 1 for the information extracted from each paper.

2.6. Data synthesis

The methodology selected to synthesise the findings from the studies identified in the systematic review was thematic synthesis (Thomas & Harden, 2008). Thematic synthesis was selected due to its clear and transparent process for synthesising qualitative data in addition to having an interpretative element which produces themes beyond what is reported in the initial studies (Thomas & Harden, 2008).

The entire findings or results section of each study underwent line-by-line coding. Line-by-line coding was supported using NVivo 12 software (QSR International Pty Ltd, 2018). After coding the first study, these codes were used to create a coding framework, and when coding subsequent papers either a code in the framework was used or if necessary a new one was created. This process resulted in 337 initial codes being created. The codes were then clustered into a hierarchy that represented key themes and associated subordinate elements, resulting in 37 descriptive themes being developed. To refine these themes further, another hierarchy of key themes was made using the 37 descriptive themes. Finally, analytical themes were created by applying the author’s interpretations to these creating three superordinate themes and ten subthemes. This process was led by the first author with each stage being discussed and audited by the second author.

Table 1
Data Extracted from Each Study.

Author (s), (Year), Country	Aims of study	Participants	Recruitment	Data collection and methodology	Data rigour and trustworthiness	Key findings or themes in article
Brohede, Wijma, Wijma, and Blomberg (2016), Sweden	To explore the experiences of people living with BDD	15 participants <ul style="list-style-type: none"> • 6 males and 9 females • aged 19-48, mean age = 30 • either under a clinic for BDD or met BDD screening criteria • comorbidity included: social anxiety disorder (n = 1), BPD (n = 1) and Asperger's & GAD (n = 1) 	Via a specialist clinic or approached following previous involvement with another study	Data collection: Interview (either face-to-face or via telephone) Methodology: Interpretative Description	Rich information on data analysis and how themes were chosen. Bias not mentioned. Transcript validated through second author.	Overarching theme of: 'feeling imprisoned - struggling to become free and no longer feel abnormal' Key themes: 'being absorbed in time-consuming procedures', 'facing tension between one's own ideal and the perceived reality', 'becoming the disorder', 'being restricted in life', 'attempting to reduce one's problems' and 'striving to receive care'
Craythorne, Shaw, and Larkin (2020)* England	A methodological piece to display the artwork and account of a participant from a wider study exploring individual experiences of coping with BDD	1 participant <ul style="list-style-type: none"> • female • aged 27 • identified as living with BDD • lives in North West Europe 	Online recruitment and advertisement in a newsletter for a relevant organisation	Data collection: Artwork and semi-structured interview (via telephone) Methodology: Boden and Eatough's Framework for Analysis of Drawings and IPA	Participants were invited to create a piece of artwork to represent experiences of coping with BDD. These were then sent to the research team and the follow-up interview was scheduled. Interview schedule provided. Coded data was discussed in supervision with the other authors. No mention of reflexivity apart from asking questions based on notes when viewing artwork.	Article focuses only on the themes of 'the fragmented self' and 'towards a reconciliation of the self and body'. Additional themes from the wider study: 'the integration of BDD in one's lifeworld' and 'detachment and distancing of perceived self'
Jassi, Baloch, Thomas-Smith, and Lewis (2020)** England	To explore whether family accommodation occurs in BDD and, if so, how it presents	5 participants <ul style="list-style-type: none"> • 3 females and 2 males • aged 15-18 • under a BDD specialist clinic 	Via a specialist clinic for young people	Data collection: Semi-structured interview Methodology: Thematic Analysis	Explanation of the thematic analysis approach used given. Two researchers analysed the data and discussed themes together. No mention of data saturation.	Key themes: 'involvement in rituals, reassurance seeking and funding for products/procedures', 'facilitating avoidance', 'minimise distress and reduce risk/suicidality' and 'family accommodation as a support'
Morgan-Sowada & Gamboni (2021), USA	To explore the lived experiences of gay men with BDD	10 participants <ul style="list-style-type: none"> • all males who identify as being gay • aged 18-60 • viewed by research team as self-diagnosed with BDD after responding yes to screening questions • live in USA • 6 White, 3 Latino and 1 mixed race participant 	Online recruitment	Data Collection: Online pre-interview survey and telephone interview Methodology: Hermeneutic Phenomenology approach with Thematic Analysis	Pre-interview data and interview analysed, rich information on analysis given, reflexivity, member checking, mentions data saturation.	Key themes: 'degrading and abject influence of BDD', 'culpability of gay culture', 'intersection of BDD and gay culture as a barrier to intimacy', 'toxic masculinity's impact on gay men with BDD'
Oakes et al. (2017), Australia	To explore the lived experiences in relation to BDD behaviours	8 participants <ul style="list-style-type: none"> • 5 females and 3 males • aged 27- 46 • reported a BDD diagnosis • 7 had comorbid conditions at some 	Online recruitment, advertised via psychology clinics and local psychologists, participants of previous studies approached	Data collection: Semi-structured interview via Skype (audio only) Methodology: Inductive Thematic Analysis	Theme refining process explained but no information of initial themes being reduced. Exception to themes included with quote. Only one analyst used,	Key themes: 'routine and repetition', 'safety through control' and 'natural and automatic'

(continued on next page)

Table 1 (continued)

Author (s), (Year), Country	Aims of study	Participants	Recruitment	Data collection and methodology	Data rigour and trustworthiness	Key findings or themes in article
		lifetime point (depression, OCD, social anxiety, bipolar disorder, PTSD, BPD and agoraphobia) <ul style="list-style-type: none"> country of residence: UK (n = 4), USA (n = 2), Australia (n = 1), India (n = 1) 			no mention of data saturation.	
Schnackenberg (2021), England	To develop a constructivist grounded theory for the experiences of young people with BDD including within educational settings	10 participants <ul style="list-style-type: none"> 8 females and 2 males aged 16-25 self-identify or have been diagnosed with BDD 9 White-British, 1 Caribbean participant 2 attending school, 2 attending university, 4 in work, 2 neither employed or in education 	Via a specialist clinic (for young people with eating disorders) and online via relevant organisations	Data collection: Semi-structured interview, also asked to bring an object or artwork to discuss Methodology: Constructivist Grounded Theory	Saturation not discussed. Interview schedule was updated in line with early emerging themes. Detailed description of the analysis provided, sufficient data is supported, recognises own role in bias.	Key themes: 'appearance based identity is informed by and informs relationships in young people's experiences of BDD', 'characteristics of BDD are expressions of shame and low self-worth', 'educational experiences trigger and are affected by BDD'
Silver & Farrants (2016)* England	To educate health care professionals on mirror gazing in BDD, from a wider study on exploring experiences of people with BDD	10 participants <ul style="list-style-type: none"> 7 females and 3 males aged from late teens to mid-30 s all identified having BDD duration of BDD ranged from 4 to 25 years 	Online advertisement, discussed at a self-help group and word of mouth	Data Collection: Semi-structured interview; participants were asked to take photographs and bring in existing ones representing their BDD experience, to record any reflections or feelings this process brought up in a notebook and bring both of these to the interview Methodology: IPA with photo elicitation	No mention of reflexivity or interviewer bias provided but does mention how the study design may have impacted on recruitment. Detailed information on analytic approach provided but no mention of reflexivity, quotes and story match themes, two researchers discussed themes.	The article focuses on the findings from the constituent theme 'omnipotent mirrors trap the self' which falls under superordinate theme of 'the imprisoned self'. Key themes from the wider study: 'the self as an aesthetic object'; 'striving for the 'good enough' self'; 'the confused self' and 'the imprisoned self'.
Silver & Reavey (2010)*** England	To examine in people with BDD narratives of the self across different times in their lives	11 participants <ul style="list-style-type: none"> 7 males and 4 female aged 20-39 diagnosed with BDD or identified as having BDD 9 White British and 2 Asian British 3 middle class, 4 lower middle class, 4 working class 	Self-help group, via a national OCD clinic, word of mouth	Data collection: Participants were asked to bring in photos from different time points in their life, semi-structured interview, artwork then produced Methodology - Narrative Analytical Approach	Brief description of the analytical approach used. Acknowledges that similarities and differences across the narratives were identified and put into a logical story. Does not mention any researcher bias. No mention of reflexivity detailed in the paper.	Themes not explicitly stated in text; around wanting to looking like younger self who was pure and untainted prior to having BDD and discussion of loss in relation to aging
Silver, Reavey, and Finebery (2010)*** England	To identify how people with BDD view themselves and live their lives	11 participants <ul style="list-style-type: none"> 7 females and 4 males aged 20 - 39 have BDD and if have comorbidity, BDD was the primary diagnosis other diagnoses from the 6 participants who attended the clinic - OCD (n = 5), social anxiety disorder (n = 4), depression (n 2), obsessive compulsive 	Via a specialist clinic or a self-help group	Data collection: Semi-structured interview and artwork; participants were asked to bring photographs from different time periods Methodology: Thematic Analysis (including discussion of the drawings and photographs)	No information on data saturation. Authors do not mention keeping a reflective journal (however, not typical in thematic analysis) but there is a reflexivity section in the discussion and authors acknowledge the role of bias in the themes. In depth description of analysis provided, contradictory information taken into account, recognises role of own biases.	Key Themes: 'increased threat perception resulting in disordered interpersonal relationships', 'wish for regularity and symmetry in appearance versus beauty', 'idealisation of childhood self', 'the duty to look good' and 'focus on specific "defective" features rather than "ugliness"'

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Table 1 (continued)

Author (s), (Year), Country	Aims of study	Participants	Recruitment	Data collection and methodology	Data rigour and trustworthiness	Key findings or themes in article
		personality disorder (n = 1), Gilles de la Tourette syndrome (n = 1), trichotillomania (n = 1) <ul style="list-style-type: none"> • BDD began in adolescence (n = 8) • case-note review found clinicians' assessment of BDD severity for 6 participants ranging from mild to moderately severe 				
Stechler & Henton (2022) England	To explore how women with BDD view their experiences of physical intimacy in their current romantic relationships	6 participants <ul style="list-style-type: none"> • all females • aged 21-33 • identify as having BDD, 4 of whom report being diagnosed • currently in a physically intimate relationship • relationship duration: 8 months to seven years • all identify as being heterosexual 	Online advertisement	Data collection: Semi-structured interview (face-to-face) Methodology: IPA	Data analysis process explained, initial coding of transcripts checked by second author and audit trail. Reflexivity discussed.	Key themes: 'the shame in being seen', 'disgust and detachment during intimacy' and 'a flawed self, unworthy of relationships'

* studies reported on narrowed focus of a wider study

** other participants, without BDD, also included as part of the study

*** same study and participants, different qualitative analytical approaches used and discussed

3. Results

3.1. Summary of included papers

Following removal of duplicates, the searches found 3383 records. For information on the process of how studies in the review were selected, please see Fig. 1.

Ten peer-reviewed journal articles were identified in the systematic review which met the inclusion criteria. All studies were published between 2010 and 2022. Two of these studies used the same participants and interview data but analysed the information using different qualitative approaches. Therefore, there were 76 participants who were either receiving psychological support for BDD, had a diagnosis, identified as experiencing it or were screened by the research team as meeting criteria for BDD. One study interviewed clinicians and parents in addition to young people with BDD, however, only the data from the young people with BDD was extracted and included in the current review and thematic synthesis. All studies were conducted in the following countries: Australia, England, Sweden and USA. However, two studies also included participants from other countries (one from India and another from an unidentified country in North West Europe). The ages of the participants across the included studies ranged from 15–60 years old. Co-morbid psychological conditions were only reported in three of the studies.

3.2. Quality appraisal results

All of the studies were generally of good quality, meeting at least 7 of the CASP criteria. Reflexivity is a process used throughout the lifetime of a qualitative research study where the authors consider the impact of their own experiences and views which may influence (both usefully and

unhelpfully) data gathered and conclusions drawn (Patnaik, 2013). Only three studies met the CASP criteria for considering or using reflexivity, five did not meet this criteria and for two studies it could not be ascertained from the information provided. Under the 'rigorous data analysis' criteria, six studies met criteria and for four it could not be ascertained. The reasons for this item not being fully met included a lack of reflexivity in interpretative phenomenological analysis (IPA) studies, data saturation not being discussed in a grounded theory study, no extractable quotes to support the themes and a lack of clarity pertaining to how themes were identified. All but one study met the criteria for the item 'clear statement of findings'. Further information on the CASP ratings can be found in the supplementary file.

3.3. Thematic synthesis

The thematic synthesis of the 10 studies resulted in three superordinate themes; 'self-objectification and the view of self', 'control and protecting the self' and 'sociocultural influences and the impact of others in BDD'. Ten subthemes were identified which fell under these superordinate themes, please see Table 2 for more information. There is overlap between some of the themes which may reflect the intersecting experiences for people with BDD.

3.3.1. Self-objectification and the view of self

The superordinate theme 'self-objectification and the view of self' encompasses how individuals with BDD see themselves. Nine of the studies had at least one theme that fell under this superordinate theme.

3.3.1.1. *Disgusting, ugly, deformed and not correct.* Eight of the studies discussed how participants in their study felt disgusted by their appearance, that they were ugly, deformed or that their perceived flaw

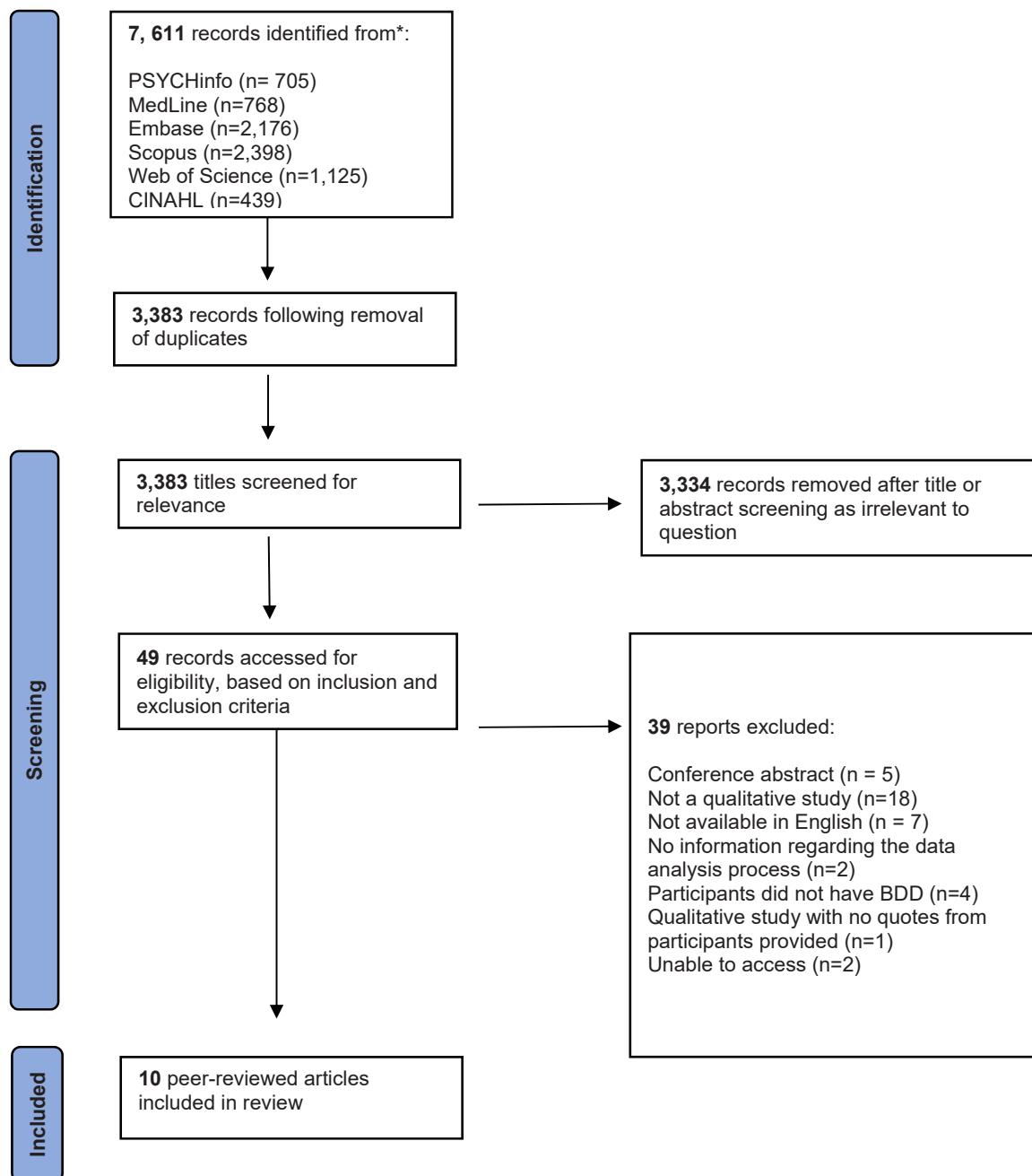


Fig. 1. PRISMA Diagram showing Systematic Review Process for Identifying Qualitative Studies on BDD.

did not look correct or as it should (Brohede et al., 2016; Morgan-Sowada & Gamboni, 2021; Oakes et al., 2017; Schnackenberg, 2021; Silver & Farrants, 2016; Silver & Reavey, 2010; Silver et al., 2010; Stechler & Henton, 2022).

Four studies included data of participants feeling that they did not look human, but a monster or another creature (Brohede et al., 2016; Schnackenberg, 2021; Silver & Farrants, 2016; Silver & Reavey, 2010). A participant in the study by Silver & Farrants (2016) explained “I look like a monster I just don’t feel sort of human” (p.2651). Some of the participants explained that BDD is not about looking beautiful or being vain, but rather not being ugly, as explained by a participant in the study by Brohede et al. (2016) “I never had an ambition to be the most beautiful – I would just like not to be grotesque” (p.194). Another participant, from the study by Schnackenberg (2021) explained “they think it’s something to do with vanity or narcissism or something but, oh, gosh, that couldn’t be further from the truth, I don’t think” (p.210).

Two studies mentioned that apart from the perceived flaw, some of the participants were content with their appearance and only saw the perceived flaw as unattractive (Silver et al., 2010; Silver & Reavey, 2010).

3.3.1.2. Self-worth, identity and success through appearance. Seven of the studies spoke of how some participants based their self-worth or identity on their appearance or perceived flaw (Brohede et al., 2016; Morgan-Sowada & Gamboni, 2021; Schnackenberg, 2021; Silver & Farrants, 2016; Silver et al., 2010; Stechler & Henton, 2022). Four studies discussed the thoughts that individuals with BDD have between their current and ideal self (Brohede et al., 2016; Morgan-Sowada & Gamboni, 2021; Silver & Reavey, 2010; Silver et al., 2010). A few participants spoke of how meeting their appearance ideals would equate to a perfect or successful life, as demonstrated by a participant in the study by Brohede et al. (2016) “I am always admiring beautiful people, like,

Table 2
Superordinate themes and their corresponding subthemes.

Superordinate Theme	Subtheme
Self-objectification and view of the self	Disgusting, ugly, deformed and not correct
	Self-worth, identity and success through appearance
	Self-focus, obsessive thoughts and preoccupied with the perceived flaw
	The fragmented self
Control and protecting the self	Reality of the perceived flaw
	Behaviours in BDD
	Increased sense of threat, judgements from others and the need to fit in
Sociocultural influences and the impact of others in BDD	Consequences of BDD
	Social and cultural factors in BDD
	The role of others in BDD

it's as if I looked like them, my life would be, like, perfect, and I would be able to live a normal life" (p.194).

Two studies reported that participants viewed their childhood self as their ideal self (Silver et al., 2010; Silver & Reavey, 2010). This version of themselves was seen as innocent, pure and attractive. As these positive feelings about the self were before the person had BDD, it may reflect how participants see themselves as dirty, unattractive and sinful in relation to their current appearance.

3.3.1.3. Self-focus, obsessive thoughts and preoccupied with the perceived flaw. Six of the studies very clearly described a sense of obsessive preoccupation with perceived appearance flaws (Brohede et al., 2016; Craythorne et al., 2020; Morgan-Sowada & Gamboni, 2021; Schnackenberg, 2021; Silver & Reavey, 2010; Stechler & Henton, 2022). The preoccupation with the perceived flaw can be all-encompassing, as described by a participant in the study by Morgan-Sowada & Gamboni, 2021) "I was constantly judging and critiquing my body. I was constantly preoccupied with my appearance...the way I looked" (p.7).

The preoccupation with the perceived flaw can result in a critical inner dialogue whereby the individual with BDD berates themselves and scrutinises their bodies. Preoccupation was identified as interfering with intimacy:

I guess kind of ruins it when you're trying to be intimate. Like the body dysmorphia has its little ... [sigh] thing to everything, its input to everything, [...] it doesn't give you peace. It just kind of pecks at you. (Stechler & Henton, 2022, p.7)

3.3.1.4. The fragmented self. Unlike the other subthemes, none of the studies which had quotes under 'the fragmented self' met full criteria on the CASP. Nevertheless, this theme is sufficiently of interest to be included although the CASP findings may indicate greater caution when considering its transferability.

The included studies described how participants may view their body in a fragmented way. For example, Craythorne et al. (2020) spoke of how a participant saw themselves as a collection of different body parts and struggled to see their self as a whole person "I'm not really able to... look at my body in a kind of – integrated way or something" (p.23).

Similarly, when engaging in appearance-related behaviours, such as mirror-checking, participants were reported as having disclosed seeking out specific body parts to check, as described by a participant "then I look at my individual body parts, for example how big my stomach might look, how big my arms might look, how broad my shoulders might look" (Oakes et al., 2017, p.436).

3.3.1.5. Reality of the perceived flaw. Six studies provided data around the reality of the perceived flaw (Brohede et al., 2016; Craythorne et al., 2020; Morgan-Sowada & Gamboni, 2021; Silver & Farrants, 2016; Silver

& Reavey, 2010; Stechler & Henton, 2022). The perceived flaws tended to not be acknowledged by others (Brohede et al., 2016). Some participants in the studies queried whether, or acknowledged that, they were exaggerating their perceived flaws. Some participants recognised that others did not see them the way they saw themselves, which could create confusion:

Um, people see, seem to see this thing, this person which isn't me. It's like my body is like Dorian's Gray's body, then when I look in a picture, I mean in the mirror, or something reflective I then see the true person. But, then what if the thing, which I see, is true isn't true, and what people see in me is the true thing? That's what gets to me. (Silver & Farrants, 2016, p.2652)

Some participants felt that they had the correct image of themselves and were essentially waiting for others to see it too as demonstrated by Stechler and Henton (2022) "what if he saw me for who I, how I really was, like ... what if one day he just woke up and seeing all the flaws that I saw" (p.8).

3.3.2. Control and protecting the self

Individuals with BDD often reported feeling out of control with their appearance and feared being judged and ultimately rejected by others. Individuals would try to protect themselves and regain control through appearance-related behaviours, however, these came with consequences. All studies within the review had at least one subtheme which fell under the superordinate theme 'control and protecting the self'.

3.3.2.1. Behaviours in BDD. Eight of the studies spoke of the behaviours that individuals with BDD engaged in (Brohede et al., 2016; Craythorne et al., 2020; Jassi et al., 2020; Morgan-Sowada & Gamboni, 2021; Oakes et al., 2017; Schnackenberg, 2021; Silver & Farrants, 2016; Stechler & Henton, 2022). These included avoidance from others and being more housebound, camouflage (including wearing make-up), reassurance seeking, comparing themselves to others, covering or avoiding mirrors, avoiding being photographed or seeing themselves in photos, checking their appearance in mirrors, engaging in routines, rituals and trying to change or alter the perceived flaw. The avoidance and use of safety behaviours helped relieve some of the distress for participants and helped them to feel more in control of their symptoms. However, relief provided from the safety behaviours tended to be short-lived and these behaviours could be incredibly time consuming.

An exception to the soothing function of these behaviours was in one participant who compared mirror-gazing to a form of self-harm, purposefully using a mirror to scrutinise her appearance:

On the bad days when you are using a mirror, it, it really is a form of self-harm. It's kind of like, because you are looking at it, you know you know what your faults are going to be, and they are about how disgusting that you are, um and then you just get, you get really sort of like sad as well, because it's like fuck what am I going to do? (Silver & Farrants, 2016, p.2650)

3.3.2.2. Increased sense of threat, judgements from others and the need to fit in. Individuals with BDD appeared to have an increased sense of threat and feared being judged from others, as described by a participant who was "scanning the area and sort of listening to what other kids were saying, and if they were talking about me, or assuming that if they laughed, they were laughing at me" (Schnackenberg, 2021, p.207).

The use of avoidance and safety behaviours helped the individuals with BDD feel more protected. One participant in the study by Brohede et al. (2016) explained "I admit that I have to live, but I refuse to go out into life, I don't want to participate in it because people will just say that I am ugly and disgusting" (p.194).

It seemed as though avoidance and safety behaviours were used to help protect themselves from judgement and the external shame they

were experiencing. The use of avoidance and safety behaviours seemed to reflect an innate need to belong and fit in. Schackenberg (2021) explained how important this was to their participants: “the task of “belonging” in adolescent identity formation came through strongly in every interview. Some participants spoke about social pressure within their peer group being linked to their experience of BDD, including the need to fit in within education settings” (p.207).

3.3.2.3. Consequences of BDD. Every study within the current review and thematic synthesis detailed the severe consequences of BDD. Despite the use of avoidance and safety seeking behaviours to gain control, ultimately the condition took control of the participants’ lives, some of whom felt imprisoned and helpless by the condition. Brohede et al. (2016) explained that for their participants “living with BDD was described as a constant struggle, comparable to constantly carrying a weight or being in a prison and never being free” (p.193).

BDD behaviours were time consuming, participants felt compelled to do them and coupled with the distress of BDD, led many participants to lead a more restricted life. This included missing or dropping out of school, missing work or being unable to, not entering romantic relationships, not enjoying hobbies or interests and not socialising with others. Silver and Farrants (2016) explained that for one of their participants: “despite having ‘buckets of love to give’ she is unable to have a romantic relationship as it would ‘interrupt’ her mirror gazing and ‘interrupt’ her thoughts, which would be ‘overwhelming’ and ‘claustrophobic’. Jane thinks that by not having relationships she is ‘missing out on this whole world of things’, making her feel ‘very very sad’ and ‘very very fucking lonely’.” (p.2654).

Relationships with families, friends and intimate partners were also impacted as a result of the BDD and its behaviours. Jassi et al. (2020) explained that in their study with young people who had BDD, family rows would occur. Brohede et al. (2016) described one participant’s mother being distressed by the condition.

People with BDD would become increasingly isolated as a result of the condition, including not wanting to be seen. Two studies spoke of how BDD impact on friendships due to difficulties socialising (Brohede, 2016; Morgan-Sowada & Casey Gamboni, 2021). Morgan-Sowada and Gamboni, (2021, p.8) quoted a participant who explained “I live 98% [of the time] at home. I don’t want anyone to see me... It’s lonely”. Another of their participants stated “my interests and hobbies no longer bring me joy, and I have been increasingly lonely because I self-isolate” (Morgan-Sowada & Gamboni, 2021, p.8).

For those in romantic relationships, some participants felt unworthy for their partners and as a result, intimacy could be associated with disgust, detachment and anxiety due to seeing their body and it being seen by their partner (Stechler & Henton, 2022). An exception to this was a participant in the study by Stechler & Henton (2022) who felt her partner had habituated to her perceived flaws “I don’t really have a problem with that [...] we’ve been together for so long [...] I’m so comfortable with him that all my flaws [...] I’ve already drawn so much attention to them [...]” (p.7).

3.3.3. Sociocultural influences and the impact of others in BDD

The final superordinate theme focuses on wider sociocultural influences and roles of others in BDD. Seven of the ten studies had sub-themes which fell under this superordinate theme.

3.3.3.1. Social and cultural factors in BDD. Five of the studies acknowledged the role of sociocultural factors in the experiences for individuals with BDD. These included cultural expectations to look a certain way, feeling society judges people for their looks and how family experiences contributed to individuals with BDD placing emphasis on their appearance:

My mum’s side of the family, they tend to be, they are quite vain people, and I feel like I have a lot to live up to. When I did used to go

to family dos, people used to say how the children and the kids in the family, how good looking they all are, and how we look very similar, and I feel like I am damaging that somehow, by not being one of these attractive kids that they have brought up, whereas I used to be the most attractive, I feel like a sort of black sheep now. (Silver & Reavey, 2010, p.1645)

Differences in how genders should look was discussed by participants in three studies, where participants spoke of how men and women should look a certain way. For example, one female participant in the study by Silver and Farrants (2016) described herself as having masculine features alongside other derogatory comments towards themselves. Furthermore, a participant in the study by Silver and Reavey (2010) commented on the pressure within Indian culture of men and women needing to appear a certain way with others commenting on their appearance:

Femininity, and masculinity to a guy, is very important, you know there’s a lot of, importance, especially in my Indian you know, in our family, in our culture, everywhere there are such beautiful ladies, and everyone comments on each other’s looks, constantly, and you have that added pressure. (1641)

Morgan-Sowada and Gamboni (2021) discussed how gay men were impacted by messages of toxic masculinity with conflicting messages about needing to look perfect to fit unrealistic cultural body standards with media portraying gay men looking a particular way. However, they could not look too perfect as this was associated with femininity. A participant in the study by Morgan-Sowada and Gamboni (2021) discussed how his appearance, including his Hispanic heritage, differed to how gay men are portrayed by gay media:

I didn’t look like those blue eyed, blonde boys that everyone was validating. I am Hispanic and skinny with a long nose and I became more hyper aware of what I am not. (164)

Morgan-Sowada and Gamboni (2021) highlighted how gay men may body shame to cope with the unrealistic body standards within the gay community and shame placed on their own body. The study details that when gay men with BDD avoid gay spaces due to feeling unsafe and fear of being judged, they are also losing a community where their sexuality is accepted and celebrated (Morgan-Sowada & Gamboni, 2021).

3.3.3.2. The role of others in BDD. Six studies provided data pertaining to the role of others in BDD (Brohede et al., 2016; Jassi et al., 2020; Schnackenberg, 2021; Silver & Reavey, 2010; Silver et al., 2010). Three studies spoke of individuals being supported for the BDD, two of these studies were with participants who were young people and one study was with adults. This support came from teachers in educational settings, family and close friends.

One study spoke of how family members may be complicit in the BDD behaviours, due to fear of distressing their child or their symptoms worsening:

If we had somewhere to go and if I couldn’t go, before they would have forced me in the car and stuff, now they let me relax, wait a bit, see if I feel better. If I don’t, I just don’t go and one of them stays behind with me (Jassi et al., 2020, p.325)

Shame of discussing BDD with others and being rejected as a result was identified as a barrier to confiding in others about BDD (Brohede et al., 2016). Similarly, a few studies mentioned how participants had poor experiences when disclosing they have BDD. Brohede et al. (2016) stated that some “friends would consider the participants to be superficial, ridiculous, or even crazy and had said ‘get over yourself’” (p.195) and that some of the participants’ partners were not understanding or lost patience. Schnackenberg (2021) discussed how BDD and its behaviours were not always understood by teachers and resulted in the young person being punished such as having a detention and believed

this contributed to feelings of shame. One participant in the study described how teachers “saw it as me not trying ... ‘he’s just bunking the lessons’ ... they started to be a bit mean to me ... it must have seemed like I was just, you know, at home, just messing around.” (Schnackenberg, 2021, p.209).

Comments from other people about their appearance were identified as starting the preoccupation with the perceived flaw for some participants, as described by a participant in the study by Silver and Reavey (2010) “‘look at you, you’ve got quite a big nose’, and that’s when it snapped.” (p.1645). However, the conceptualisation that the condition results from bullying or other trauma was also reported as being a common misconception that could contribute to secondary feelings of shame (Schnackenberg, 2021).

Experiences of accessing healthcare for BDD was discussed in one study. Brohede et al. (2016) discussed how participants had lost faith when accessing support for BDD due to a lack of knowledge and a lack of services set up to support them. However, a diagnosis for BDD elicited hope for some participants that the BDD was treatable in addition to working with professionals familiar with BDD (Brohede et al., 2016).

4. Discussion

The purpose of the current systematic review and thematic synthesis was to identify, appraise and integrate the available published literature of qualitative studies regarding the experiences for individuals with BDD. Our unique review identified ten peer-reviewed journal articles, synthesis of which produced three novel superordinate themes: ‘self-objectification and the view of self’, ‘control and protecting the self’ and ‘sociocultural influences and the impact of others in BDD’.

The current review draws attention to the importance of objectification theory (Fredrickson & Roberts, 1997) in relation to understanding the phenomenology of BDD, where, self-worth was viewed in relation to the perceived flaw and their appearance. In this study, the preoccupation and self-focus around the perceived flaw was all-encompassing for some participants which draws parallels with objectification theory which recognises the strong sense of over identification with internalised societal stereotypes related to expectations about the appearance of the body (Fredrickson & Roberts, 1997). Similarly, seeing the self in a fragmented manner and as a collection of body parts may reflect self-objectification. Further, this review identified how observations or perceptions of significant others may for some also play a part in this process and this is commensurate with expectations of social learning theory.

This review also demonstrates that people living with BDD can experience disgust towards their body and complex feelings of shame associated with both having the condition and the meaning of the perceived flaw itself. This finding compliments research which has already recognised the role of shame (Weingarden et al., 2018) and disgust in BDD (Hickey et al., 2010), although it uniquely demonstrates how this is more evident in the phenomenology of the condition as described in the extant qualitative studies than previously considered.

External shame was also evident within the avoidance and safety behaviours being reported in a perceived attempt to prevent judgement from others. It might be speculated that the participants had developed a self-disgust schema which contributed to an expectation that others would find their perceived flaw disgusting (Powell et al., 2015). The use of avoidance and safety behaviours appeared to have a paradoxical effect, as these behaviours were reported lead to participants experiencing isolation due to not socialising, excluding friends, and not entering romantic relationships. The time-consuming nature of the behaviours reported to be associated with BDD, coupled with the emotional experiences of BDD, was clearly reported as restricting quality of life.

In line with objectification theory (Fredrickson & Roberts, 1997), the findings within this review suggest that sociocultural expectations may contribute to the experiences of individuals with BDD believing that they needed to look a certain way. The nature of this was also

demographic context specific. For example, objectification of gay men within the gay community contributed to participants feeling unsafe in gay spaces (Morgan-Sowada & Gamboni, 2021). Similarly, comments from family members and a belief that one needs to look a certain way due to societal or cultural expectations were evident in some of the other studies (Brohede et al., 2016; Jassi et al., 2020; MorganSowada & Gamboni, 2021; Schnackenberg, 2021; Silver & Reavey., 2010; Silver et al., 2010; Stechler & Henton., 2022).

Given that many people with BDD seek medical procedures and are reluctant receive psychological treatment, interestingly, only one study reported on experience of accessing healthcare (Brohede et al., 2016). This study described participants as having had some difficulty in relation to experiencing health care professionals lacking knowledge of BDD and support services to refer onto, a lack of sensitivity and long waiting times to access support. As BDD is a distressing psychological condition which can be accompanied by a significant reduction in functioning (Phillips, 2004), it is key that individuals have access to the right healthcare at the soonest opportunity, to alleviate their distress.

4.1. Critique of included studies

All the studies included in the review had been published between 2010 and 2022, therefore the experiences of the participants were relatively recent. All studies met at least 7 of the 10 criteria on the CASP and tended to be of a high quality. This may reflect the protocol for the systematic review which only included studies published in peer-reviewed journals. Only three of the ten studies within this review met the criteria for reflexivity. Reflexivity is important in qualitative research to ensure transparency and that authors are aware of their own position when designing the study, interviewing participants and analysing the data (Patnaik, 2013). Therefore, the studies which did not fully meet criteria for reflexivity may be subject to researcher bias and lack the depth that consideration of positionality and personal context can bring. As only two studies within the current review investigated the experiences of young people with BDD, there may be further information specifically regarding young people that the current review and previous literature has not identified. All of the included studies were conducted in Western countries and only one participant was identified as living in a non-Western country. Therefore, the experiences of BDD for people from different countries may well have differences which the current review has not been able to consider.

4.2. Limitations and future directions

The current systematic review and thematic synthesis has some limitations. As only peer-reviewed journal articles were included in the review, there may be grey literature regarding the experiences of individuals with BDD which were not included. Similarly, as only journal articles published in English were included, there may be further literature on experiences of individuals with BDD which is missing, and this may have contributed to the very limited data available on experiences of BDD for participants in non-Western countries. During the searches, two full text articles could not be accessed during the full-text screening stage. Therefore it is unknown whether these two papers would have been suitable for inclusion and if their findings are in line with those from current thematic synthesis.

As participants were interviewed about their experiences of BDD and many people with BDD do not seek help (Phillips, 2004), the current review does not capture the experiences of people living with BDD who might lack insight. Furthermore, as some of the included studies had participants who self-identified as having BDD, rather than having a formal diagnosis, there may be experiential differences for those with a BDD diagnosis that warrant further investigation.

Further qualitative research would be useful to investigate the experiences of young people with BDD and to ascertain the experiences of people with BDD in different cultural contexts. This would include

consideration of the role played by social media which is surprisingly absent in the extant literature. Further whilst some studies were published after the commencement of the 2020 pandemic there was no mention of the role of this in the studies included, and given the known impact of the pandemic on young peoples mental health, this warrants specific investigation in future studies.

Muscle dysmorphic disorder was not included in the current review due to differences in presentation and a lack of studies during preliminary searches, and it might soon be relevant to conduct a specific review in this area. To ascertain whether objectification theory is relevant to men with BDD (Fredrickson & Roberts, 1997), it would be helpful to have further quantitative research, that might for example investigate the relationship between self-objectification in men of differing sexual orientations who have BDD. Indeed further mixed methods research is required to investigate the potential role of wider sociocultural factors such as intersectional appearance pressures (including gendered racism) has on BDD.

4.3. Clinical implications

A number of clinical implications can be generated as a result of the current review. For psychological therapy to be meaningful and appropriate to the clients' needs, clinicians should ensure that any treatment for BDD is culturally relevant and takes into account social factors. As this study highlighted some of the blocks that may present for clients when engaging in psychological therapy for BDD, clinicians could consider adopting a motivational interviewing intervention when this occurs. For example, Oakes et al. (2017) reported that participants in their study had been offered psychoeducation about the reinforcing nature of safety behaviours in BDD and chose to continue them. Similarly, Jassi et al. (2020) highlighted the role of family accommodation in BDD, where individuals or families feel stuck at dropping or colluding with safety behaviours. Motivational interviewing techniques are advised when delivering the NICE recommended treatment Cognitive Behavioural Therapy (CBT) for BDD (National Institute for Health and Care Excellence, 2005; Veale & Neziroglu, 2010). In addition, due to disgust and shame often being reported as part of individuals' experiences with BDD, Compassion Focussed Therapy (CFT) may be helpful as an adjunct or following CBT for BDD (National Institute for Health and Care Excellence, 2005).

Finally, due to the difficulties in relationships for individuals with BDD, services should consider embedding a relational component into treatment for BDD such as fear of entering relationships, intimacy difficulties and remaining connected to friends. Finally, this review suggests that initiatives should be considered to raise awareness of BDD in collaboration with experts by experience. Furthermore, due to a lack of awareness and misunderstandings on BDD in young people, and the fact that BDD typically has its onset in adolescence (Bjornsson, 2017), staff from children and adolescent mental health services should work alongside charities to reduce the risk of self-objectification.

5. Conclusion

BDD is a distressing psychological condition where individuals objectify themselves and are preoccupied with their perceived flaw. Disgust and self-conscious emotions such as internal shame and external shame may be experienced. Safety behaviours where the individual tries to protect themselves from judgement from others tend to be counter-productive. Social and cultural factors may influence the development and maintenance of BDD. Services should ensure they are culturally appropriate, consider outreach initiatives and consider implementing CFT and Motivational Interviewing alongside treatment as usual. The current review suggests a key role for using objectification theory in formulating the onset and maintenance of BDD, although, further research is needed to fully test this assertion and use it to enhance existing interventions.

CRedit authorship contribution statement

Andrew R Thompson: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing.
Kathryn Thomson: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Validation, Writing – original draft, Writing – review & editing.

Declaration of Competing Interest

None.

Data Availability

This is a review article, any information about data extracted as part of the review process can be requested from the corresponding author.

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Declarations of Interest

None.

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