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Mirror, mirror on the wall, who is the ugliest of them all? The psychopathology of mirror gazing in body dysmorphic disorder

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Abstract

Patients with Body Dysmorphic Disorder (BDD) may spend many hours in front of a mirror but little is known about the psychopathology or the factors that maintain the behaviour. A self-report mirror gazing questionnaire was used to elicit beliefs and behaviours in front of a mirror. Two groups were compared, which consisted of 55 controls and 52 BDD patients. Results: Prior to gazing, BDD patients are driven by the hope that they will look different; the desire to know exactly how they look; a belief that they will feel worse if they resist gazing and the desire to camouflage themselves. They were more likely to focus their attention on an internal impression or feeling (rather than their external reflection in the mirror) and on specific parts of their appearance. They were also more likely to practise showing the best face to pull in public or to use “mental cosmetic surgery” to change their body image than controls. BDD patients invariably felt worse after mirror gazing and were more likely to use ambiguous surfaces such as the backs of CDs or cutlery for a reflection. Conclusion: Mirror gazing in BDD consists of a series of complex safety behaviours. It does not follow a simple model of anxiety reduction that occurs in the compulsive checking of obsessive–compulsive disorder. The implications for treatment are discussed. © 2001 Elsevier Science Ltd. All rights reserved.

Keywords: Body image; Body Dysmorphic Disorder; Psychopathology; Mirror gazing

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1. Background

This study was prompted by a patient with Body Dysmorphic Disorder (BDD) who reported to one of the authors that he had just spent 6 hours staring at himself in front of a series of mirrors. The obvious questions were what exactly did the behaviour consist of, what was the function of the behaviour and what maintained his behaviour especially when he reported feeling worse after gazing in the mirror?

Mirror gazing occurs in about 80% of patients with BDD while the remainder tend to avoid mirrors sometimes by covering them or removing them to avoid the distress of seeing their own image and the time wasted mirror gazing (Veale, Boocock, Gournay, Dryden, Shah, Willson et al., 1996; Phillips, McElroy, Keck, Pope & Hudson, 1993; Neziroglu & Yaryura-Tobias, 1993). BDD is a hidden disorder, as many patients do not tend to seek help from mental health professionals. When BDD patients do seek help, they may present with symptoms of depression or social phobia and not reveal their main problem unless they are specifically questioned (Veale et al., 1996). Patients are secretive about mirror gazing probably because they think they will be viewed as vain or narcissistic. Patients report however shame about their behaviour and disgust about their appearance. This may account for why mirror gazing is not described in standard textbooks of psychopathology or psychiatry since Morselli first described the condition of “dysmorphophobia” (Jerome, 2001, personal communication). There is some literature on the effects of mirror confrontation in normal controls and psychiatric patients. For example Schwarz & Fjeld (1968) found that subjects who were asked to focus on mirror images for a period of time in a darkened room often experienced gross distortions in their apparent appearance or unusual somatic sensations. Fisher (1970) and Duval & Wicklund (1972) have found that increased self-awareness by the presence of a mirror led healthy individuals to become more self-critical by highlighting their own defects and deviations from the ideal. Lipson & Przybyla (1983) observed students as they walked past a long mirror. For both male and female students, time spent mirror gazing was positively correlated with physical attractiveness. Mirror gazing is sometimes seen in schizophrenia, especially when a patient makes drastic changes in their appearance (for example shaving off one’s hair or the use of striking make-up) (Campo, Frederikx, Nijman & Merckelbach, 1998). Such dramatic changes in appearance are usually part of a command hallucination or a paranoid delusion and may involve significant periods of mirror gazing.

Mirror gazing in BDD has been compared to the compulsive checking of Obsessive Compulsive Disorder (OCD) and BDD has been conceptualised as on the spectrum of obsessive–compulsive disorders (Phillips, McElroy, Hudson & Pope, 1995; Hollander, 1993; Yaryura-Tobias & Neziroglu, 1997). Early experimental analysis on compulsions such as washing and checking found that they were maintained because they “work” by reducing anxiety in the short-term (Hodgson & Rachman, 1972; Roper, Rachman & Hodgson, 1973; Roper & Rachman, 1976). But does mirror gazing in BDD follow the same model as compulsions in OCD? In the authors’ opinion, mirror gazing appears to be much harder for patients to resist than the checking compulsions of OCD. More recent analyses of compulsions reveal a more complex picture of safety or neutralising behaviours, which are distinct from compulsions (Rachman, 1998) and the recognition that compulsions do not always “work” or reduce anxiety. OCD patients also typically use problematic criteria for terminating a compulsion, namely feeling “comfortable” or “absolutely sure” (Richards & Salkovskis, 1995) or the “right feeling” (Yaryura-Tobias & Neziroglu, 1997). It is

not known whether BDD patients use similar criteria. BDD patients might attempt to use such criteria (similar to patients with obsessional slowness) but rarely achieve it and only terminate mirror gazing because they become too frustrated or angry or they have to finish because of an appointment.

Mirror gazing might also occur in obsessional slowness, in which patients perform complex rituals and safety behaviours such as grooming or bathing in a specific order and meticulously. However in such patients, it usually fails to achieve any reduction in anxiety (Rachman, 1974; Veale, 1993). Some patients with obsessional slowness associated with meticulous grooming and shaving described in earlier reports may in retrospect have fitted an additional diagnosis of BDD and have spent some of the time mirror gazing.

In a cognitive behavioural model of BDD, mirror gazing is a crucial factor in maintaining the preoccupation with one's appearance (Veale, Gournay, Dryden, Boocock, Shah, Willson et al., 1996). It increases self-consciousness and selective attention, and may magnify the patient's perception of their perceived defects. It therefore distorts their aesthetic judgement. It is of course vital that patients resist the urge to use mirrors ("response prevention") but it is very difficult for patients to follow such instructions. We need a better understanding of the psychopathology of mirror gazing that we can use in our formulations with patients and new strategies for therapy. These were the aims of this pilot study as well as generating hypotheses for future experimental studies in order to develop a cognitive behavioural model of BDD.

2. Method

52 patients with BDD who reported mirror gazing to be a feature of their problem were recruited to complete a "Mirror gazing questionnaire" described below. All patients fulfilled DSMIV diagnostic criteria for BDD (American Psychiatric Association, 1994). A group of 55 controls were recruited from personal contacts to provide a comparison. The groups were age and sex matched (Table 1). A pilot study revealed that there were two types of mirror gazing — many patients and controls tended to have one session a day which tended to be longer (for example putting on make up or shaving at the beginning of the day). The remainder of the mirror sessions consisted of shorter sessions during the day. Controls were however less likely to report a long session.

2.1. Procedure

Subjects were given a self-report mirror gazing questionnaire. The instructions informed them that we were interested in the feelings that they had in front of a mirror during the past month. The subject was first asked if he or she had a long session in front of a mirror on most days of the past month. A long session was defined as the longest time during the day that the person spends in front of a mirror. An example was given of getting ready for the day. If the respondent said they had at least one long session in front of a mirror, then they were asked a series of questions about a typical long session in front of a mirror. We then repeated the same questions for a typical short session in front of a mirror and gave an example of checking their appearance.

Table 1
Characteristics of BDD patients and controls

	BDD mean (S.D.)	Controls mean (S.D.)	Significance
Age	30.1 (8.6)	33.4 (8.9)	$t=0.093, P<0.09$
Sex (% male)	40.4%	48%	$\chi^2=0.624, P<0.43$
Mean duration of long session (minutes)	72.5 (94.8)	21.3 (19.6)	$F(1, 52)=4.26, P<0.04^*$
Maximum duration of longest session (minutes)	173.8 (205.3)	35.5 (29.3)	$F(1, 56)=6.69, P<0.01^*$
Mean number of short sessions	14.6 (13.6)	3.9 (3.4)	$F(1, 67)=20.3, P<0.00^*$
Mean duration of short sessions (minutes)	4.8 (5.4)	5.5 (12.8)	$F(1, 86)=0.099, P<0.77$
Type of light preferred (natural day-light or artificial) on a Visual Analogue Scale	38.5 (32.4)	41.6 (27.0)	$F(1, 48)=0.11, P<0.75$
External or internal focus of attention (-4 to +4) for long session	-0.49 (2.9)	-2.2 (1.9)	$F(1, 52)=4.37, P<0.04^*$
External or internal focus of attention (-4 to +4) for short sessions	-1.12 (2.7)	-1.15 (2.1)	$F(1, 86)=0.10, P<0.77$
Attention on the whole or specific parts of appearance (0–100 on Visual Analogue Scale) in long session	70.5 (24.3)	44.5 (34.02)	$F(1, 52)=10.03, P<0.03^*$
Distress before long session (1–10)	6.44 (2.3)	1.6 (0.83)	$F(1, 56)=60.8, P<0.00^*$
Distress after long session (1–10)	7.63 (2.2)	2.40 (2.3)	$F(1, 56)=61.3, P<0.00^*$
Distress resisting gaze for long sessions (1–10)	6.82 (2.6)	2.38 (2.5)	$F(1, 49)=29.2, P<0.00^*$

2.2. Length of time mirror gazing

Subjects were asked:

- The average duration of a “long” session in minutes (during the last month).
- The estimated maximum amount of time on any one occasion that he or she had spent in front of a mirror in hours/minutes.
- The average duration (in minutes) and the frequency of a short session in front of a mirror during the last month.

2.3. Motivation before looking in a mirror

Subjects were requested to rate the strength of agreement with the statements for a long session listed in Table 2 *before* looking in front of a mirror on a scale between “1” to “5” (where 1=“strongly disagree”, 2=“disagree”, 3=“neither disagree or agree”, 4=“agree”, 5=“strongly agree”). At the end there was the option of writing down anything else that motivated them to use the mirror. None of the items were reversed. The questions were repeated for short sessions.

Table 2
Motivation for mirror gazing as measured by strength of beliefs (on a scale between 1 and 5)

Beliefs	BDD Mean (S.D.)	Controls Mean (S.D.)	Significance
(1) The hope that I might look different when I first look in the mirror	4.2 (0.9)	1.9 (1.0)	$F(1, 58)=66.8, P<0.00^*$
(2) The hope that I can feel comfortable with my appearance	4.6 (0.8)	3.1 (1.3)	$F(1, 57)=24.9, P<0.00^*$
(3) I have to know what I look like and I can't until I look in the mirror	4.1 (1.0)	2.3 (1.5)	$F(1, 57)=26.6, P<0.001^*$
(4) The belief that I make myself look better or hide myself (e.g. use make up)	4.0 (1.0)	3.0 (0.9)	$F(1, 57)=12.6, P<0.012^*$
(5) I look in the mirror to see how I feel	3.0 (1.2)	2.1 (1.0)	$F(1, 57)=6.7, P<0.00^*$
(6) I have to know for certain how I appear in public	4.7 (0.5)	3.1 (1.1)	$F(1, 57)=65.6, P<0.00^*$
(7) I have to make myself look my best	4.4 (1.0)	3.3 (0.9)	$F(1, 57)=15.5, P<0.00^*$
(8) I believe that if I stare long enough, I might see a different image	3.1 (1.3)	1.2 (0.4)	$F(1, 57)=31.6, P<0.00^*$
(9) If I resist looking in the mirror then I will feel worse	3.7 (1.1)	1.4 (0.7)	$F(1, 56)=52.8, P<0.00^*$
(10) I need to see what I don't like about myself	3.7 (1.1)	2.0 (0.9)	$F(1, 57)=30.3, P<0.00^*$
(11) I need to see what I like about myself	3.2 (1.1)	2.9 (1.1)	$F(1, 57)=1.1, P<0.30$
(12) I can make myself look presentable (e.g. brush my hair, use make-up)	3.7 (1.0)	4.4 (0.5)	$F(1, 57)=5.6, P<0.021^*$

2.4. Focus of attention

Subjects were asked the location of their concentration in front of a mirror for both short and long sessions. They were presented with a 9 point visual analogue scale between “+4” and “-4” (where “-4” represented “I am entirely focused on my reflection in the mirror” and “+4” represented “I am entirely focused on an impression or feeling that I get about myself”).

2.5. Distress before and after looking in front of mirror

Subjects were asked to rate the degree of distress on a visual analogue scale between 1 and 10, where “0” represented “not at all distressed” and “10” was “extremely distressed”. They were asked to rate their distress (a) before they looked in a mirror for a long session, (b) immediately after looking in a mirror and (c) after resisting the urge to look in a mirror. The questions were subsequently repeated for short sessions in front of a mirror. However, a mistake was made in the questionnaire in not rating the degree of distress after resisting the urge for a short session.

2.6. *Behaviour in front of a mirror*

They were asked what activities they did in front of a mirror for long and short sessions and were given a list of options. They were asked to rate the *percentage* of time spent on each activity from the list below and ensure that the total added up to 100.

- (a) Trying to hide my defects or enhance my appearance by the use of make-up;
- (b) Combing or styling my hair;
- (c) Trying to make my skin smooth by picking or squeezing spots;
- (d) Plucking or removing hairs or shaving;
- (e) Comparing what I see in the mirror with an image that I have in my mind;
- (f) Trying to see something different in the mirror;
- (g) Feeling the skin with my fingers;
- (h) Practising the best position to pull or show in public;
- (i) Measuring parts of my face.

At the end there was also the option of listing other behaviours they might do in front of a mirror.

2.7. *Type of light preferred*

Subjects were asked whether the type of light was important for mirror gazing on a visual analogue scale between one extreme of “natural day-light” or at the other extreme of “artificial light”.

2.8. *Types of reflective surfaces*

They were asked if they used a series of mirrors for different profiles or any other reflective surface (for example the backs of CDs) for gazing.

2.9. *Mirror avoidance*

Subjects were asked if they avoided certain types of mirrors and the situations in which this occurred.

2.10. *Statistics*

Data were analysed on SPSS-PC using Anova for parametric and Chi-square for ordinal data.

3. **Results**

The subject characteristics are shown in Table 1. No significant differences were found in age and sex between BDD patients and controls. 44 out of the 52 (84.6%) BDD patients and 16 out of 54 (29.6%) control subjects reported that they had a “long session” in front of the mirror each

day. Of those subjects that reported using a mirror for a long session, BDD patients used a mirror for far longer than controls (Table 1).

45 BDD patients (86.5%) and 43 controls (79.6%) reported that they had one or more “short sessions” in front of a mirror. BDD patients checked mirrors more frequently than controls for the short sessions. However there was no difference between BDD patients and controls for the average duration of each short session (Table 1).

3.1. *Motivation for looking in a mirror*

BDD patients were more likely to endorse all the beliefs listed in Table 2 except that the controls were more interested in making themselves look presentable. The results were the same for short sessions. BDD patients also spontaneously reported that they were more likely to use the mirror if they were feeling depressed. Overall, BDD patients retained some insight into their behaviour. They were more likely than controls to agree with the statements “Looking in a mirror so often and for so long distorts my judgement about how attractive I am” ($F(1, 56)=36.77$ ($P<0.001$)) and “Every mirror I look in I see a different image” ($F(1, 56)=40.19$ ($P<0.001$)).

3.2. *Behaviour in front of mirror*

For long mirror checking sessions, BDD patients did the same proportion of activities (in percentage terms) as controls in front of mirrors for: (a) using make up ($F(1, 58)=0.087$, $P<0.77$), (b) combing or styling their hair ($F(1, 58)=0.70$, $P<0.41$), (c) picking their spots ($F(1, 58)=2.31$, $P<0.13$) and (d) feeling their skin with their fingers ($F(1, 58)=1.66$, $P<0.20$). The controls were more likely to use a mirror for removing hairs or shaving ($F(1, 58)=7.63$, $P<0.008$). BDD patients were more likely: (a) to compare what they see in front of a mirror with an image in their mind of how they think they should ideally look ($F(1, 58)=9.43$, $P<0.003$) or (b) try to see something different in the mirror ($F(1, 58)=4.62$, $P<0.036$).

For short checks BDD patients were more likely than controls to use the mirror: (a) for checking their make-up ($F(1, 85)=4.50$, $P<0.04$), (b) practising the best position or face to pull or show in public ($F(1, 85)=6.21$, $P<0.02$) and (c) compare what they see in front of a mirror with an image in their mind of how they think they would ideally look ($F(1, 85)=14.21$, $P<0.001$). Controls were more likely to use a mirror in a short session for shaving ($F(1, 85)=18.49$, $P<0.001$). BDD patients listed a range of other behaviours that they engaged in whilst in front of the mirror. These included “washing rituals”; “combing my eyebrows”; “studying my eyes, hair and skin to observe the effect of stress on the ageing process”; “pulling my features or squashing my nose to see how I’d look if I had plastic surgery”; “pull ugly faces to prove how disgusting I am” or “I try to permanently fix my image mentally”.

3.3. *Distress before, after or resisting a check*

For both short and long mirror sessions, BDD patients rated themselves retrospectively as significantly more distressed than controls before any gazing (see Table 1). For long mirror sessions, the BDD patients continued to be more distressed than controls after mirror gazing. Lastly

they experienced a greater degree of distress if they resisted gazing in the mirror compared to controls (see Table 1).

The overall difference in distress before and after mirror gazing was calculated for the BDD patients. After a long session in front of the mirror, BDD subjects overall experienced a significant increase in distress of 1.19 (18.5% increase) ($t(1, 41)=2.734, P<0.009$). The overall difference in distress before and after resisting an urge to gaze for a long session was also calculated from the visual analogue scales of the BDD patients. After resisting an urge to gaze, patients reported only a slight but non-significant increase in distress of 0.38 (5.9%) ($t(1, 36)=0.272, P<0.79$). (This is in contrast to the belief prior to mirror gazing that resisting looking in the mirror would make them feel worse — see Table 2.) A number of patients reported significant handicaps from mirror gazing from being very late for appointments to having caused a road traffic accident after gazing in a car mirror.

3.4. *Focus of attention in mirror*

For a long session in front of the mirror BDD patients were more likely than controls to focus their attention on an internal impression or feeling (rather than their external reflection in the mirror) but *not* for a short session. BDD patients were also more likely to focus their attention on specific parts of their appearance during a long session (rather than the whole of their appearance) (see Table 1).

3.5. *Preference for natural light*

No significant difference was found between the BDD patients and controls in their slight preference for natural day-light compared to artificial light on a visual analogue scale (see Table 1).

3.6. *Types of mirrors*

For a long session, BDD patients were more likely to use a series of mirrors with different profiles (22/42, 52.4%) compared to controls (1/15, 6.7%) ($X^2(1, 2)=11.45 P<0.03$). For short checks, both BDD patients and controls admitted to using shop windows. However, BDD patients spontaneously reported using a wide variety of reflective surfaces including car mirrors, windows or bumpers on vehicles, cutlery, fish knives, TV screens, reflective table tops, glass watch faces, washroom taps or the back of CDs.

3.7. *Mirror avoidance*

Some patients reported that they had found mirror gazing too time consuming or distressing and had deliberately avoided all mirrors at certain times. This is similar to the mirror avoidance seen in anorexia nervosa (Norris, 1984). 67% of our BDD patients reported that they selectively avoided only *certain* mirrors compared to 14% of controls (Chi square (1, 2)=11.54, $P<0.001$).

Four types of selective avoidance of mirrors were noted in the BDD patients. The first type of selective avoidance was of looking at a specific “defect” in the mirror. An example of this was

a patient who was preoccupied with the ugliness of his nose, so that he would only use a hand mirror to comb his hair by holding it above the line of his nose so that he avoided seeing his nose. The second type of selective avoidance is of specific mirrors — for example two patients reported avoiding mirrors that they regarded as “bad” or “unsafe” (as they were associated with a bad image and feeling distressed in the past) and only used “good” mirrors. Other patients reported only using mirrors that they trusted as being in the “right” light or if they were tilted correctly as other mirrors or lights were too distressing. The third type of selective avoidance is only using mirrors in private but avoiding mirrors or reflective surfaces in public or social situations to prevent themselves from feeling upset. The fourth type of selective avoidance was to use only a mirror that was obscured — for example one that was cracked, dusty or dirty so that a full reflection could not be seen. Another patient reported looking in a mirror with soap on her face so she did not see her skin. Lastly some patients may flip between avoidance and gazing — for example a patient who picked his skin would remain housebound checking his skin many times during a week to see if his skin had healed. When he was satisfied that he could go outside, he would then avoid mirrors until the urge to check in the mirror and pick his skin would overcome him and the cycle would repeat itself.

4. Conclusions

This is the first experimental study on the psychopathology of mirror gazing in BDD. We have found that BDD patients hold a number of problematic beliefs and behaviours in their mirror use compared to controls. Mirror gazing in BDD does not follow a simple model of a compulsive checking in OCD in terms of a repetitive behaviour for anxiety reduction and is a more complex phenomenon. It is best conceptualised as a series of idiosyncratic and complex safety behaviours, that is designed to prevent a feared outcome and in which the patient is seeking safety (Salkovskis, 1991). The feared outcome may be the internal aversion and disgust about one’s appearance (and in many patients social anxiety and beliefs about rejection).

This study has demonstrated that BDD patients have a number of different motivations and behaviours in their use of mirrors:

(a) BDD patients have an eternal hope that they will look different to their internal body image or feel comfortable with their appearance. This may be intermittently reinforced when a patient feels better about their appearance or not as bad as they thought. However as the gazing becomes more repetitive, the reinforcement schedule may be reduced or depend more on other factors such as mood. However, mirror gazing then becomes counter-productive as it increases distress, self-consciousness, and confirms the negative aesthetic judgement.

(b) BDD patients are uncertain about their body image and demand to know exactly how they look. This may be briefly rewarded whilst staring in the mirror, but once a patient is away from the mirror the focus of attention is on the mental representation of their body image and the uncertainty returns. There is some similarity to OCD patients who check their memory for actions in which each check can increase doubts and uncertainty about an event (Salkovskis, personal communication). The act of mirror gazing also creates further confusion for many patients as they report seeing one or more faces at different times or in different mirrors or

lights. For example, one patient would sometimes see a “good” face, which was associated with being able to go out and function. However most of the time she would see a “bad” face, which meant total avoidance and being housebound. For others being able to see a “good” image was partly under their control if they were able to tilt a favourite mirror in a particular light. Other patients disbelieved what they saw in the mirror — for example one patient who obsessed about his mouth drooping took a photograph of himself daily in a photo-booth. This briefly reassured him that his mouth was not drooping but there remained a marked discrepancy with his body image and how he felt.

(c) BDD patients believe they will feel worse if they resist gazing. However BDD patients subsequently report that mirror gazing increases distress and there is no significant increase in distress after resisting the urge to gaze. Presumably BDD patients do not resist the urge to gaze because other factors such the hope that they look different and knowing exactly how they look are more important in the short-term.

(d) BDD patients are driven by a desire to camouflage their appearance or excessively groom to make themselves look their best or to feel “comfortable”. By contrast controls were motivated to use a mirror for more functional reasons such as making themselves look presentable or shaving. In this regard, grooming or putting on make-up in BDD patients accounts for some of the excessive time during the long sessions and the checks in the short sessions. Some BDD patients are also trying to change their internal body image to see something different. This might be regarded as a type of *mental cosmetic surgery*. For some patients, this may be intermittently reinforced as occasional satisfaction or a memory of a “good” image from the past that they are trying to recreate.

Another interesting difference from controls is the way BDD patients are more likely to report using an “internal impression of how they feel” when they look in the mirror. This may be partly dependent on the length of time spent in front of a mirror, as there were no differences in the focus of attention between BDD patients and controls for short sessions. It implies that when BDD patients look in a mirror for a longer period of time, they are more likely to selectively attend to a mental representation of their body image (rather than an external reflection in a mirror). They may then compare this with their external reflection and idealised body image (or a photo of how they used to look like). The confusion as to how they look is further exacerbated by the ambiguous reflection that they obtain from windows, the backs of CDs or cutlery. It suggests that BDD patients selectively attend to an unstable internal body image and that this further drives the need to mirror gaze to know exactly how they look in a vicious circle. The greater internal focus of attention is also a factor in the “emotional reasoning” and the aesthetic judgement about their appearance. If the patient feels ugly or defective, then he or she reasons that it must be a fact and assume that others can also see them as ugly. Further experimental research is now required on “in vivo” mirror gazing so that the beliefs, focus of attention, mood and behaviours may be analysed immediately prior to and after gazing.

As a result of this study, we have adapted our therapeutic strategies to help BDD patients to stop mirror gazing. We monitor (a) the time taken for the longest mirror session, (b) the frequency of the short mirror sessions. If a patient can reduce the amount of make-up or grooming, then this will tend to reduce significantly the amount of time in front of a mirror and the frequency of the short sessions (when patients tend to check that their camouflage is adequate). However

this is often not possible at an early stage in therapy. It is also worth remembering that when women reduce the amount of excessive camouflage on their face, they may well receive comments from others that they look different. This requires some preparation, as the comments about being different are likely to be distorted to being “ugly” or defective.

Some patients try to cover up or take down mirrors (or previous therapists may have encouraged it). However in our experience this can lead to a different set of problems of mirror avoidance. In this scenario, a patient is likely to still maintain his distorted body image and symptoms of BDD. Furthermore, he or she will be overwhelmed by reflections that they accidentally catch when they pass a mirror. We think it is better that patients learn to use mirrors in a healthy way with negotiated timed limits depending on the activity (for example using a limited amount of make-up). Patients (whether they are gazing or avoiding) are encouraged to develop the following goals:

1. To use mirrors at a slight distance or ones that are large enough to incorporate most of their body;
2. To deliberately focus attention on their reflection in the mirror rather than an internal impression of how they feel;
3. To only use a mirror for an agreed function (e.g. shaving, putting on make-up) for a limited period of time;
4. To use a variety of different mirrors and lights rather sticking to one which they “trust”;
5. To focus attention on the whole of their face or body rather than a specific area;
6. To suspend judgement about one’s appearance and distance oneself from automatic thoughts about being ugly or defective;
7. Not to use mirrors that magnify their reflection;
8. Not to use ambiguous reflections (for example windows, the backs of CDs or cutlery or mirrors that are dusty or cracked);
9. Not to use a mirror when they feel have the urge but to try and delay the response and do other activities until the urge has diminished.

This study has also demonstrated a number of problematic beliefs prior to looking in a mirror. BDD patients tend to assume that “What You See Is What You Get” in front of a mirror. We have found it helpful to engage our BDD patients in a model of “What You See Is What You Construct” as a result of selective attention to specific aspects of their appearance and on an internal representation of their body image. The latter will depend more upon the meaning and value that they attach to the importance of appearance, the ideal that they demand and their mood. We find it helpful to identify the beliefs prior to mirror gazing and the exact behaviours in an individual formulation. When possible, we would try to help the patient to question the usefulness of such beliefs in reaching their goals, and to evaluate more realistic alternatives by behavioural experiments. The approach is difficult to apply when the patient has an idealised value about the importance of appearance, which has become identified with the self (Veale, 2000, in submission). In this regard, it may be helpful to take another pragmatic approach by performing a cost–benefit analysis on the advantages and disadvantages of the value about the importance of appearance, perfectionism or social acceptance by the use of reverse role-plays (Newell & Shrubbs, 1994). As a last resort when all other strategies fail, the therapist might introduce the idea of a “response

cost” in which the patient nominates their most hated organisation and agrees to pay a sum of money to it for each check in the mirror but this requires a very compliant patient.

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