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A Narrative Approach to Body Dysmorphic Disorder

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Narrative therapy is proposed as an effective treatment for body dysmorphic disorder. A case example illustrates the clinical application. Implications for the theory and practice of body dysmorphic disorder are considered.

Body dysmorphic disorder (BDD) is a complex clinical syndrome that each year affects approximately 2% of the population in the United States (Phillips, 2005a). According to the *Diagnostic and Statistic Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000), BDD is described as a preoccupation with an imagined defect or slight physical defect in appearance that results in significant distress or impairment in important areas of functioning. Clients with BDD experience a variety of problems and symptoms, including poor self-image, depression, anxiety, avoidance of social situations, and seeking repeated cosmetic surgery for the perceived appearance defect (APA; Renshaw, 2003). Various etiologic theories for BDD have been set forth, including cognitive-behavioral (Sarwer, Gibbons, & Crerand, 2004), neurobiological (Hadley, Newcorn, & Hollander, 2002; Phillips, 2005b), and sociocultural (Phillips, 2005a; Rivera & Borda, 2001). It has been suggested that the most effective treatment approaches for BDD include cognitive-behavioral and antidepressant medication administration (Phillips, 2005a, 2005b; Sarwer et al.).

In this article, we propose that narrative therapy provides an effective framework to treat BDD. An increasing number of counseling, family therapy, and psychotherapy models have emphasized a narrative

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approach to conceptualizing problems and change. The pioneering narrative model was developed at the Dulwich Therapy Center in Australia (White, 1995, 1997, 2000, 2004; White & Epston, 1990). For purposes of this article, *narrative therapy* hereafter refers to the model developed at the Dulwich Therapy Center. Influenced by postmodernism (Lyotard, 1984) and the philosophy of Foucault (1987), narrative therapy conceptualizes clients' problems as restraining narratives that are influenced by one's culture (White & Epston). The change process in narrative therapy involves helping clients replace their restraining narratives with more preferred stories about their problems and lives (White, 2000; White & Epston).

We have found narrative therapy to be a fitting model for BDD for several reasons. First, this approach speaks to the sociocultural factors that are presumed to influence clients with BDD (Phillips, 2005a). Second, narrative therapy has already been successfully applied to anorexia nervosa (Maisel, Epston, & Borden, 2004; Nylund, 2002), a disorder that has features similar to and/or is often comorbid with BDD (Grant, Kim, & Eckert, 2002). Third, narrative therapy is an empowering, focused, and strength-based model and, therefore, holds promise as a potentially effective approach for working with clients with BDD. Narrative therapy offers an alternative to the prevailing cognitive-behavioral therapy approaches to BDD that tend to emphasize faculty cognitions and create resistance during the change process (cf. Phillips; White & Epston, 1990). Moreover, Sinclair (2006) has suggested that "narrative therapy . . . invites clients to reflect on the influence of culture and, thus, represents an important contribution for helping women with body related concerns" (p. 64). To date, however, no narrative therapy application specific to BDD has been found in the literature. Due to the relatively high incidence of BDD, we expect that most mental health counselors will at some time encounter clients who suffer from this condition. Accordingly, it is important for mental health counselors to develop effective treatment strategies for BDD. In this article, we describe our application of narrative therapy to BDD in hopes of providing mental health counselors with a basis from which to intervene.

The organization of this article is as follows. First, we describe BDD along with a consideration of various issues pertaining to this disorder, including comorbidity, etiology, and treatment. Next, we describe the theory and practice of narrative therapy. Then, we provide a case example that illustrates the application of narrative therapy to work with individuals diagnosed with this disorder. Finally, we discuss implications pertaining to the theory and practice of narrative therapy in relation to BDD.

BODY DYSMORPHIC DISORDER

BDD is classified in the *DSM-IV-TR* as a somatoform disorder (APA, 2000). The *DSM-IV-TR* criteria for BDD are as follows: (a) "preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive"; (b) "the preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning"; and (c) "the preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa)" (APA, p. 510). BDD is often occasioned by maladaptive behaviors such as frequent checking of the perceived defect in mirrors; avoidance of reflective surfaces; social inhibition; frequent consultation with dermatologists, cosmetic surgeons, or performing dangerous self-surgeries; and suicide (APA). BDD usually first appears during adolescence and the disorder does not appear to be gender specific (APA; Phillips & Diaz, 1997). The prevalence rate of BDD has not been firmly established with studies ranging from 0.7% to 13% of the populations investigated (Neziroglu, Roberts, & Yaryura-Tobias, 2004).

Research suggests that BDD is frequently comorbid with mental disorders such as anorexia nervosa (Grant et al., 2002), major depressive disorder (Phillips, Siniscalchi, & McElroy, 2004), obsessive compulsive disorder (OCD) (Allen & Hollander, 2004), personality disorders (Phillips & McElroy, 2000), and social phobia (Wilhelm, Otto, Zucker, & Pollack, 1997). For example, in a study of 41 clients diagnosed with anorexia nervosa, 16 clients (39%) were diagnosed with comorbid BDD unrelated to weight concerns (Grant et al.). The literature has also underscored similarities between BDD and anxiety disorders, especially OCD and social phobia (Allen & Hollander). It has been suggested that BDD and OCD share similar features, including perfectionism, compulsivity, and avoidance (Allen & Hollander). These similarities have contributed to debates and controversies regarding the current *DSM-IV-TR* classification of BDD as a somatoform disorder (e.g., Grant & Phillips, 2004; Mackley, 2005). For example, Mackley has suggested that it might be more fitting, then, to classify BDD as a subtype of OCD.

Several etiological theories and corresponding treatments for BDD have been developed, including cognitive-behavioral, neurobiological, and sociocultural. Cognitive-behavioral theory holds that people with BDD have self-defeating thoughts, cognitive distortions, and catastrophizing beliefs regarding appearance and self (Buhlmann & Wilhelm, 2004; Sarwer et al., 2004). From a cognitive-behavioral perspective, it is presumed that such thoughts and beliefs are etiologically related to BDD.

Cognitive-behavioral therapy for BDD includes various techniques such as behavioral exposure, cognitive restructuring, and response prevention (Sarwer et al.). Neurobiological theories hold that BDD is related to brain abnormalities (Hadley et al., 2002). Medication administration and, in particular, selective serotonin reuptake inhibitors such as fluoxetine and clomipramine have been found to be effective in the treatment of BDD symptoms (Phillips, 2005b). It has been also suggested that combining cognitive-behavioral therapy with medication is an effective intervention for BDD (Phillips, 2005a, 2005b; Sarwer et al.).

Recently, sociocultural theory has become a developing area for BDD (Phillips, 2005a; Rivera & Borda, 2001). According to sociocultural theory, people with BDD experience appearance-related pressures as a result of societal and cultural influences. Theorists in various disciplines have discussed the roles that society and culture play in shaping the attitudes of women about beauty and self (e.g., Bartky, 1990; Cherin, 1981; Foucault, 1987; McKinley & Hyde, 1996; Sinclair, 2006; Wolf, 2002). Sinclair has suggested that "the feminine body is socially constructed as an object, to be looked at . . . . [and thereby] coaxes many women to view and treat themselves as objects" (pp. 50–51). Only recently has attention shifted to the role that sociocultural factors play in influencing men with BDD (Olivardia, 2001; Pope, Olivardia, Gruber, & Borowiecki, 1999). Olivardia has noted that "boys and men are exposed to . . . an array of images in the media . . . extolling the desirability of the muscular, fit body. Many such bodies are unattainable for the average male, however" (p. 256). Although sociocultural theory has been considered as an etiologic factor in BDD, there seems to be a dearth of clinical models that set forth clear treatment guidelines that correspond to this body of knowledge. We suggest that narrative therapy, by virtue of its emphasis on the role of restraining sociocultural influences, is particularly well suited for BDD.

NARRATIVE THERAPY

Narrative therapy is a clinical model that is informed by postmodernism, a broad intellectual movement developed in various disciplines that rejects modernist conceptions of truth, certainty, and objectivity (Lyotard, 1984). In particular, narrative therapy has been influenced by social constructionism, a strand of postmodernism that holds that knowledge is constitutive, intersubjective, and language-based (cf. Berger & Luckman, 1967; Derrida, 1989; Foucault, 1987). Narrative therapy is unique by way of its application of Foucault's sociocultural philosophy. Foucault has suggested that individuals internalize oppressive ideas in cultural, political, and social contexts. Thus, in narrative therapy clinical

problems are conceptualized as restraining narratives that are influenced by one's culture and society (White & Epston, 1990). These restraining narratives are referred to in narrative therapy as *dominant stories*. In narrative therapy, the change process involves helping clients replace their dominant stories with more empowering stories about their lives (White, 2000; White & Epston).

Narrative therapy usually involves four stages. The first stage is mapping the influence of the problem. The second stage involves identifying unique outcomes. The third stage is restorying. The fourth stage includes tasks, interventions, letter writing, and other narrative exercises (Guterman & Rudes, 2005a; Monk, Winslade, Crocket, & Epston, 1996; White, 1995, 1997, 2000, 2004; White & Epston, 1990).

Mapping the influences of the problem is a questioning process designed to begin externalizing the problem (White, 2004; White & Epston, 1990). According to White and Epston, externalizing the problem is "an approach . . . that encourages a person to objectify and, at times, to personify the problems that they experience as oppressive" (p. 38). An example of such questioning might include, "How is the problem affecting the picture you have of yourself?" By identifying the many ways the problem has affected the client's life across different domains (e.g., work, relationships, daily functioning), clients are encouraged to view themselves as separate from the problem. In effect, clients are encouraged to see that they are not the problem, to identify times when they have overcome the problem (i.e., unique outcomes), and to begin challenging or restorying the dominant story that has thus far oppressed them. Another purpose of mapping the influences of the problem is to increase a sense of agency for the client by recognizing opportunities for identifying unique outcomes later during the clinical process. After the client has identified various influences through the mapping process, the mental health counselor can go back to these influences and inquire about unique exceptions later as described below. In the case of the problem of anger, for example, the counselor might inquire about unique exceptions to the client's angry responses at work, in the client's relationships with family members, and with regard to his or her health.

After mapping the influence of the problem, clients are helped to identify unique outcomes. A *unique outcome* refers to any thought, behavior, feeling, event—*anything*—that contradicts or is at odds with the dominant story (White, 1995, 1997; White & Epston, 1990). Mental health counselors use interventive questions to help clients identify unique outcomes; for example, "How were you able to not let the problem influence you in this situation?" or "What did you do to overcome the problem in this situation?" Recall that the influences that were identified during the map-

ping process (described above) can be used later as a basis to identify unique outcomes. For example, if a client were to report an influence related to worry about financial issues, the counselor might ask the client a series of questions aimed at identifying unique outcomes in relation to the worry. After identifying unique outcomes, clients are helped to ascribe significant meaning to these instances through *restorying*, a therapeutic process designed to help clients create a sense of empowerment, self-efficacy, and hope (Monk et al., 1996; Guterman & Rudes, 2005a; White, 2000). Restorying might, for example, involve the counselor asking the client, "What does this (i.e., the unique outcome) say about you and your ability to have influence over this problem?" or "What qualities in a person does it require to deal with this problem?" Narrative therapy also frequently employs tasks, interventions, letter writing, and other narrative exercises. Clients might be encouraged to put a name to their problem (e.g., a client's anger might be named the 'angry monster'). In such a case, the client might be asked to write a letter to the angry monster. The letter might take the form of the client's expression of determination to not allow the angry monster to become overpowering and oppressive (Guterman & Rudes, 2005a).

Narrative therapy has been applied to a variety of problems, including eating disorders (Maisel et al., 2004), encopresis (White & Epston, 1990), sexual abuse (Draucker, 2003), and coping with medical illness (Eeltink, Duffy, & Sperry, 2004). Narrative therapy has also been used with different client populations, including children (Smith & Nylund, 2000), couples and families (White & Epston), and larger systems (Winslade & Monk, 1998). The following case example illustrates the application of narrative therapy to BDD.

CASE EXAMPLE

Monique, a 26-year-old European American Jewish female, was self-referred for mental health counseling. The client was an only child. She was single, heterosexual, never married, and had no children. She was employed as a receptionist at a real estate mortgage company. The client reported no prior history of mental health treatment. At the time of the initial evaluation, she reported multiple problems and symptoms. The client described the presenting problem as coping with depression related to the death one month ago of her dog, a Shih Tzu named Bobbie. Her dog died after suffering for a prolonged period from intestinal cancer. The client described her dog as her one and only friend in the world.

The client also reported that, for as long as she could remember, she held the belief that she was extremely ugly. She stated that ever since she

was a young child she felt that her nose and mouth were "hideous" and "grotesque." Although Monique's nose and mouth might have been considered less than ideal to some people in her culture, her concern was markedly excessive and contributed to a lifelong pattern of clinically significant distress and impairment in various aspects of her life. The client stated that for all of her life she had felt depressed and had a poor self-image because of her perceived ugly nose and mouth. She avoided social activities. She seldom, if ever, went out on dates, and she was not sexually active. The client would not even consider cosmetic surgery to resolve her perceived appearance defect. She explained that her mother unexpectedly died during hysterectomy surgery ten years ago and since then she had a fear of surgery and therefore would not consider this as an option.

On the basis of the clinical presentation, it was determined that the client currently met the *DSM-IV-TR* criteria for BDD (APA, 2000) and, moreover, had met these criteria for years. The psychosocial history and mental status examination also indicated that the client had a history of a comorbid dysthymic disorder. The client reported that she had recently consulted with her primary care physician for her depressive symptoms and was prescribed the antidepressant fluoxetine.

During the first session, the client also disclosed that for about the past seven years she had experienced persistent vaginal burning and was unable to resolve this problem despite seeking treatment from numerous physicians, including multiple gynecologists. According to the client, the medical community ruled out common causes for this symptom, including yeast infection, sexually transmitted disease, vaginitis, and cancer. She became discouraged when a gynecologist recently suggested that the vaginal burning may be something that she just might have to live with.

Toward the end of the first session, the mental health counselor instituted the phase of mapping the influences of the problem. This process of questioning helped the client understand how each of the stressors had impacted her life. This phase of treatment was aimed at externalizing the problem whereby clients are encouraged to begin seeing that they are not the problem; the problem is the problem (White, 2004; White & Epston, 1990). Monique began to understand how her perceived body defect and more recently the loss of her dog had contributed to a life of isolation. As a result of her poor self-image and concomitant anxiety and depression, she had not been on a date and had not had sexual relations in over 10 years. She reported that she felt lost since the death of her dog and was now desperate to get help for fear that she might attempt suicide if she did not make drastic changes in her life. Although Monique identified multiple problems—the loss of her dog, the perceived defect in her appearance, the vaginal burning, and other problems—each seemed

related to a common theme, a shared narrative, a dominant story about herself. This dominant story was articulated as a result of an exchange that ensued between her and the mental health counselor. As a result of this exchange, a complex, somewhat fragile yet articulate story was exposed: "My self worth is defined by how I or others evaluate the desirability of my external bodily features," "My external appearance defines me as a human being," and "Because I consider my nose and mouth to be ugly, then I am an ugly person and have no right to search for my personal happiness." At the end of the first session, the mental health counselor complimented Monique for taking the initiative to seek help. The counselor also suggested that she had experienced numerous and severe stressors that had impacted her life in significant ways.

At the start of the second session, the mental health counselor summarized what had been discussed during the first session and then shifted to the second stage of narrative therapy, identifying unique outcomes. The counselor used the influences that had been identified during the previous phase of narrative therapy (through mapping the influences of the problem) to assist Monique in identifying unique outcomes. Several unique outcomes emerged. In particular, she described an occasion two months prior when she had a chance encounter with a group of strangers at a restaurant near her residence. One day she went to the restaurant and sat alone at a table. A group of three people sitting at the table next to her—two women and a man—initiated a conversation with her. Then, one of the women invited her to join them which she did. During the session, the client recalled that she had a wonderful time socializing with these people. When they finished their meals, they exchanged phone numbers and promised to stay in touch but never did. According to Monique, this experience represented a time when she did not allow the dominant story to stop her from pursuing happiness. When she interacted with these people at the restaurant it never occurred to her that, "I am too ugly to be with these people" or "I should not be having a good time because I am not good enough!" These expressions, which contradicted her dominant story, contributed to the development of a restorying experience for the client.

At the end of the second session, the mental health counselor moved to the next phase of narrative therapy, restorying. During this phase, the client was helped to ascribe meaning to this unique outcome. In particular, the mental health counselor asked her to consider two questions between sessions: (a) "What does your having socialized with that group of people in the restaurant that day say about you and your ability to resolve this problem?" and (b) "How does this experience at the restau-

rant influence how you now see yourself?" At the start of the third session, the counselor followed up on these two questions. The client responded by stating that she now recognized that some people seem to show an interest in her despite her perceived defects in appearance. She also came to recognize that she has a desire to develop more social connections with people. The restorying process, in turn, led to Monique identifying more unique outcomes related to her isolation, including various contexts when she had initiated or otherwise engaged in some form of meaningful social interactions.

The client then identified a unique outcome related to her complaint of persistent vaginal burning. She disclosed that the burning sensation subsided or was significantly diminished during those times when she had masturbated and for several days after. Monique reported that she considered her masturbation to be relatively infrequent, about once monthly, yet she always experienced relief from the burning as a result. When questioned about this, Monique began to entertain the possibility that the relief she had derived might be a sign that the burning was more indicative of her sexual desire or, as she put it, being "horny." A stimulating discussion ensued in the counseling session and a new and preferred understanding of sexuality vis-à-vis herself emerged.

Over the course of the next few sessions, the mental health counselor encouraged Monique to engage in the task of identifying additional unique outcomes related to her problems and continue the restorying process. As the counseling progressed, the client's focus shifted away from an emphasis on problem talk and more on her goals, purposes, and intentions. Gradually, she began to resolve her grief over the death of her dog Bobbie. From the counseling, she also came to see that her relationship with her dog provided important lessons for how she might approach a new understanding of herself. She stated that she had always had unconditional acceptance for her dog, something that she had never had for herself. But in another sense, she felt that, on the basis of her bodily defects, she and Bobbie were both "dogs." Hence, it was not far fetched for her to accept herself just as she accepted her dog despite her perceived appearance defects. This realization culminated in the client reauthoring an alternative version of herself—a counterplot, if you will—to the dominant story that had oppressed her for so long.

In ensuing weeks, Monique's coping skills were markedly improved as well as her overall functioning. She reported that she was now intent on working toward her personal happiness. Within two months of starting counseling, she was dating on a regular basis. Within three months, she had a steady boyfriend with whom she was having satisfying sexual

relations. The client surprised the mental health counselor one day when she came to the session with a new dog, another Shih Tzu that she named Maggie.

CONCLUDING REMARKS

From our clinical experiences, we have found narrative therapy to be an effective treatment for BDD. Similar to how narrative therapy has been applied to other specific clinical problems and populations, we suggest that it can also be effectively applied to BDD. It is also suggested that a narrative approach to mental health counseling addresses the sociocultural factors that are presumed to influence clients with BDD. Moreover, we have suggested that narrative therapy provides mental health counselors a clinical framework to help clients with BDD resolve their problems in an effective and efficient manner. We suggest that future studies be designed to assess outcome effectiveness related to narrative therapy applications to BDD. Such studies would contribute to establishing evidence-based research in the area of narrative approaches to BDD and for narrative therapy in general.

We also suggest that mental health counselors adopt eclectic strategies within their narrative approaches to BDD. In recent years, an increasing literature in mental health counseling has addressed the potential merits and limitations of eclecticism (e.g., Ginter, 1988, Guterman & Rudes, 2005a; Harris, 1991; Hershenson, Power, & Seligman, 1989; Kelly, 1988; McBride & Martin, 1990; Nance & Meyers, 1991; Weinrach, 1991). Guterman and Rudes (2005a) have already called for a strategic approach to eclecticism that allows for the use of divergent theories and techniques within a narrative change process. In particular, Guterman and Rudes (2005a) provided a case example that uses cognitive-behavioral techniques within narrative therapy. Guterman and Rudes (2005a) have suggested that "a narrative approach to strategic eclecticism . . . speaks to the need for convergence between the modernist and postmodernist perspectives and . . . an increased understanding of other therapeutic models" (p. 3). We suggest that such an eclectic approach, namely, incorporating cognitive-behavioral techniques within a narrative approach to BDD, underscores the complementary aspects of these models by addressing both their limitations and strengths (cf. Guterman & Rudes, 2005b).

An eclectic approach to narrative therapy for BDD also speaks to the importance of addressing the diversity of clients in a multicultural society. It is crucial for mental health counselors to gain an understanding of how the worldviews of clients from different cultures inform, influence, and

impact the nature and prevalence of BDD. Moreover, the phenomena that mental health counselors in the United States traditionally associate with BDD (i.e., the *DSM-IV-TR* diagnostic criteria for BDD) might, in other cultures, be reflective of alternative explanations or understandings. The *DSM-IV-TR* includes an outline for cultural formulations designed to assist counselors in assessing the impact of clients' cultural contexts and, also, a glossary of 25 culture-bound syndromes for use with diverse clients. For example, the term *koro* refers to a culture-bound syndrome that may be related to BDD (APA, 2000). According to the *DSM-IV-TR*, koro "occurs primarily in Southeast Asia . . . [and] is characterized by the preoccupation that the penis (or labia, nipples, or breast in women) is shrinking or retracting and will disappear into the abdomen" (APA, p. 510). In contrast to BDD, koro is usually brief in duration, has different associated features (e.g., primarily acute anxiety and fear of death), and responds well to reassurance. It has been suggested that the glossary of culture-bound syndromes in the *DSM-IV-TR* is limited to the extent to which it accounts for differences that exist between and within a variety of cultures (Guarnaccia & Rogler, 1999). Gerstein and Ægisdóttir (2005) have noted that "a U.S. model of counseling might not appropriately and accurately reflect the cultural norms, values, and behaviors of another country, and it might even violate these constructs" (p. 96). We suggest that more attention be given to how cultural factors shape the clinical realities that mental health counselors traditionally associate with BDD.

Finally, although we have described a narrative approach specific to BDD, we have also effectively used this approach for related problems that are experienced by many clients, including perfectionism, poor self-image, and social isolation. Accordingly, we suggest that narrative therapy holds promise as an effective treatment for image related issues that fall along a continuum of severity and type. We invite theorists, researchers, and practitioners in mental health counseling to contribute to this important area of study.

REFERENCES

Allen, A., & Hollander, E. (2004). Similarities and differences between body dysmorphic disorder and other disorders. *Psychiatric Annals*, *34*, 927–933.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, D.C.: Author.

Bartky, S. L. (1990). *Femininity and domination: Studies in the phenomenology of oppression*. New York: Routledge.

Berger, P., & Luckmann, T. (1967). *The social construction of reality*. Garden City, NY: Doubleday.

Buhlmann, U., & Wilhelm, S. (2004). Cognitive factors in body dysmorphic disorder. *Psychiatric Annals*, *34*, 922–926.

Cherin, K. (1981). *The obsession: Reflections on the tyranny of slenderness*. New York: Harper and Row.

Derrida, J. (1989). *Deconstruction and philosophy: The texts of Jaques Derrida* (J. Sallis, Trans.). Chicago: University of Chicago Press.

Draucker, C.B. (2003). *Perspectives in psychiatric care*, *39*, 7–16.

Eeltink, C., Duffy, M., & Sperry, L. (2004). Restorying the illness experience in multiple sclerosis. *The Family Journal: Counseling and Therapy for Couples and Families*, *12*, 282–286.

Foucault, M. (1987). *Power/knowledge: Selected interviews and writings, 1972–1977* (C. Gordon, Trans.). New York: Pantheon Books.

Gerstein, L., & Ægisdóttir, S. (2005). A trip around the world: A counseling travelogue! *Journal of Mental Health Counseling*, *27*, 95–103.

Ginter, E. J. (1988). Stagnation in eclecticism: The need to recommit to a journey. *Journal of Mental Health Counseling*, *10*, 3–8.

Grant, J.E., Kim, S.W., & Eckert, E.D. (2002). Body dysmorphic disorder in patients with anorexia nervosa: Prevalence, clinical features and delusionality of body image. *International Journal of Eating Disorders*, *32*, 291–300.

Grant, J.E., & Phillips, K.A. (2004). Is anorexia nervosa a subtype of body dysmorphic disorder? Probably not, but read on...*Harvard Review of Psychiatry*, *12*(2), 23–126.

Guarnaccia, P. J., & Rogler, L. H. (1999). Research on culturebound syndromes: New directions. *The American Journal of Psychiatry*, *156*, 1322–1327.

Guterman, J.T., & Rudes, J. (2005a). A narrative approach to strategic eclecticism. *Journal of Mental Health Counseling*, *27*, 1–12.

Guterman, J.T., & Rudes, J. (2005b). A solution-focused approach to rational-emotive behavior therapy: Toward a theoretical integration. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, *23*(3), 223–244.

Hadley, S.J., Newcorn, J.H., & Hollander, E. (2002). The neurobiology and psychopharmacology of body dysmorphic disorder. In D.J. Castle, K.A. Phillips, E.W. Petersfield (Eds.), *Disorders of body image* (pp. 139–155). Hampshire, UK: Biomedical Publishing, Ltd.

Harris, G. A. (1991). Eclecticism, again. *Journal of Mental Health Counseling*, *13*, 427–431.

Hershenson, D. B., Power, P. W., & Seligman, L. (1989). Counseling theory as a projective test. *Journal of Mental Health Counseling*, *11*, 273–279.

Kelly, K. R. (1988). Defending eclecticism: The unity of informed choice. *Journal of Mental Health Counseling*, *10*, 210–213.

Lyotard, J. (1984). The postmodern condition: A report on knowledge (B. Massumi, Trans.). Minneapolis: University of Minnesota Press.

Mackley, C. (2005). Body dysmorphic disorder. *Dermatologic Surgery*, *31*, 553–558.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: Norton.

Mcbride, M. C., & Martin, G. E. (1990). A framework for eclecticism: The importance of theory to mental health counseling. *Journal of Mental Health Counseling*, *12*, 495–505.

McKinley, N.M., & Hyde, J.S. (1996). The objectified body consciousness scale. *Psychology of Women Quarterly*, *20*, 181–215.

Monk, G., Winslade, J., Crocket, K., & Epston, D. (1996). *Narrative therapy in practice*. San Francisco, CA: Jossey-Bass.

Nance, D. W., & Meyers, P. (1991). Continuing the eclectic journey. *Journal of Mental Health Counseling*, *13*, 119–130.

Neziroglu, F., Roberts, M., & Yaryura-Tobias, J.A (2004). behavioral model for body dysmorphic disorder. *Psychiatric Annals*, *34*, 915–920.

Nylund, D. (2002). Poetic means to anti-anorexic ends. *Journal of Systemic Therapies*, *21*(4),18–34.

Olivardia, R. (2001). Mirror, mirror on the wall, who's the largest of them all? The features and phenomenology of muscle dysmorphia. *Harvard Review of Psychiatry*, *9*, 254–259.

Phillips, K.A. (2005a). *The broken mirror: Understanding and treating body dysmorphic disorder*. New York: Oxford University Press.

Phillips, K.A. (2005b). Placebo-controlled study of pimozide augmentation of fluoxetine in body dysmorphic disorder. *American Journal of Psychiatry*, *162*(2), 377–379.

Phillips, K.A., & Diaz, S.F. (1997). Gender differences in body dysmorphic disorder. *Journal of Nervous and Mental Disease*, *185*, 570–577.

Phillips, K.A., & McElroy, S.L. (2000). Personality disorders and traits in patients with body dysmorphic disorder. *Comprehensive Psychiatry*, *41*, 229–236.

Phillips, K.A., Siniscalchi, J.M., & McElroy, S.L. (2004). Depression, anxiety, anger, and somatic symptoms in patients with body dysmorphic disorder. *Psychiatric Quarterly*, *75*, 309–320.

Pope, H.G., Jr, Olivardia, R, Gruber A, & Borowiecki J. (1999). Evolving ideals of male body image as seen through action toys. *International Journal of Eating Disorders*, *26*, 65–72.

Renshaw, D. (2003). Body dymorphia, the plastic surgeon, and the counselor. *The Family Journal: Counseling and Therapy for Couples and Families*, *11*, 264–267.

Rivera, R.P., & Borda, T. (2001). The etiology of body dysmorphic disorder, *Psychiatric Annals*, *31*(9), 559–563.

Sarwer, D.B., Gibbons, L.M., & Crerand, C.E. (2004). Treating body dysmorphic disorder with cognitive-behavior therapy. *Psychiatric Annals*, *34*, 934-941.

Smith, C., & Nylund, D.K. (Eds.). (2000). *Narrative therapies with children and adolescents*. New York: Guilford.

Sinclair, S. L. (2006). Object lessons: A theoretical and empirical study of objectified body consciousness in women. *Journal of Mental Health Counseling*, *28*, 48–68.

Weinrach, S.G. (1991). Selecting a counseling theory while scratching your head: A rational-emotive therapist's personal journey. *Journal of Mental Health Counseling*, *13*, 367–378.

White, M. (1995). *Re-authoring lives: Interview and essays*. Adelaide, South Australia: Dulwich Centre Publications.

White, M. (1997). *Narratives of therapists' lives*. Adelaide, South Australia: Dulwich Centre Publications.

White, M. (2000). *Reflections on narrative practice*. Adelaide, South Australia: Dulwich Centre Publications.

White, M. (2004). *Narrative practice and exotic lives: Resurrecting diversity in everyday life*. Adelaide, South Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Wilhelm, S., Otto, M.W., Zucker, B.G., & Pollack, M.H. (1997). Prevalence of body dysmorphic disorder in patients with anxiety disorders. *Journal of Anxiety Disorders*, *11*, 499–502.

Winslade, J.M., & Monk, G.D. (1998). *Narrative counseling in schools*. Thousand Oaks, CA: Corwin Press.

Wolf, N. (2002). *The beauty myth: How images of beauty are used against women*. New York: Harper Perrenial.