Recognition and Treatment of Muscle Dysmorphia and Related Body Image Disorders

James E. Leone*; Edward J. Sedory†; Kimberly A. Gray*

*Southern Illinois University Carbondale, Carbondale, IL; †University of Virginia, Charlottesville, VA

Objective: To present the reader with various psychobehavioral characteristics of muscle dysmorphia, discuss recognition of the disorder, and describe treatment and referral options.

Data Sources: We conducted a comprehensive review of the relevant literature in CINAHL, MEDLINE, SPORT Discus, EBSCO, PsycINFO, and PubMed. All years from 1985 to the present were searched for the terms muscle dysmorphia, bigorexia, and reverse anorexia.

Data Synthesis: The incidence of muscle dysmorphia is increasing, both in the United States and in other regions of the world, perhaps because awareness and recognition of the condition have increased. Although treatment options are limited, therapy and medication do work. The primary issue is identifying the disorder, because it does not present like other psychobehavioral conditions such as anorexia or bulimia nervosa. Not only do patients see themselves as healthy, most look very healthy from an outward perspective. The causes of muscle dysmorphia are not well understood, which reinforces the need for continued investigation.

Conclusions: Muscle dysmorphia is an emerging phenomenon in society. Pressure on males to appear more muscular and lean has prompted a trend in the area of psychobehavioral disorders often likened to anorexia and bulimia nervosa. Athletes are particularly susceptible to developing body image disorders because of the pressures surrounding sport performance and societal trends promoting masculinity and leanness. Health care professionals need to become more familiar with the common signs and symptoms of muscle dysmorphia, as well as the treatment and referral options, in order to assist in providing appropriate care. In the future, authors should continue to properly measure and document the incidence of muscle dysmorphia in athletic populations, both during and after participation.

Key Words: morbidity, masculinity, psychobehavioral disorders, psychology

Body image disorders such as anorexia nervosa (AN) and bulimia nervosa (BN) have been well documented in the clinical literature. Societal pressures ranging from media advertisement campaigns to sports icons often dictate the way an “ideal” body should look. For several decades, much of the focus on body image disorders has centered on women. In American society, the feminine ideal is to appear thin. Males, however, are encouraged to be muscular and “ripped.” We have witnessed a gradual shift in how males perceive their bodies and a growing trend toward a condition called reverse anorexia or bigorexia. Dysmorphia or dysmorphosis is defined as an anatomical malformation. As attention grows in this area of psychopathology, the clinically appropriate term of muscle dysmorphia (MDM) has come into usage. In cases of reverse anorexia, bigorexia, or muscle dysmorphia, the primary focus is not on how thin a person can get but rather on how large and muscular. The perceived “malformation” is a lack of size or strength. Unfortunately, despite the growing attention, in comparison with AN and BN, few interventional strategies have been explored.

Much like females participating in sports that stress thinness, such as cross-country running, gymnastics, or dance, males with MDM are typically involved in sports stressing size and strength such as football, wrestling, or competitive bodybuilding. Muscle dysmorphia is not limited to the sporting world. As society bombards people at younger ages with images of what the “ideal” body looks like, MDM will likely continue to increase in the general population. One example, from a popular bodybuilding magazine released in November of 2000 included advertisements with headlines such as, “Ashamed of your unwanted hair growth? Stop hair loss now!” and “Get fast results,” in addition to promotions for liposuction and breast implants in men. Mixed messages linking physical fitness with body image insecurities are being sent to America’s youth.

Body image dissatisfaction has been a concern throughout the ages. During medieval times, in efforts to appear more masculine and muscular, men would stuff their shirts with hay or don bulky armor. Whether for survival and intimidation or aesthetics, body dissatisfaction and its sequelae pose a growing social problem.

As athletic trainers, we work in venues in which strength, speed, size, and power are typically valued and encouraged. Although the exact causes are unknown, participation in ath-
one of the first papers addressing MDM, Pope et al. defined discrepancy between the imagined and actual self. In disorder, MDM involves a specific dissatisfaction with muscularity and leanness. A subcategory of body dysmorphic disorder, MDM involves a specific dissatisfaction with muscularity rather than the body as a whole. Formally defined, MDM is a pathologic preoccupation with muscularity and leanness. A subcategory of body dysmorphic disorder, MDM involves a specific dissatisfaction with muscularity rather than the body as a whole. Formally defined, MDM is a pathologic preoccupation with muscularity and leanness. A subcategory of body dysmorphic disorder, MDM involves a specific dissatisfaction with muscularity rather than the body as a whole.

**Table 1. Diagnostic Criteria for Body Dysmorphic Disorder and Muscle Dysmorphic Disorder**

<table>
<thead>
<tr>
<th>Body Dysmorphic Disorder*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.</td>
</tr>
<tr>
<td>2. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.</td>
</tr>
<tr>
<td>3. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa).</td>
</tr>
</tbody>
</table>

**Muscle Dysmorphia**

1. The individual is obsessed with the belief that his or her body should be more lean and muscular. Significant amounts of time devoted to weight lifting and fixation on one’s diet are common.\(^7,18–20\)
2. At least 2 of the following 4 criteria should be met:\(^8,19\)
   a. The uncontrollable focus on pursuing the usual training regimen causes the person to miss out on career, social, and other activities.
   b. Circumstances involving body exposure are preferably avoided; if avoidance is not possible, significant unease and worry occur.\(^19\)
   c. Performance in the work and social arenas is affected by the presumed body deficiencies.
   d. The potentially detrimental effects of the training regimen fail to discourage the individual from pursuing hazardous practices.\(^21\)

3. Unlike anorexia nervosa, in which the person is concerned about being overweight, or other types of body dysmorphic disorder, in which the concern is with other physical aspects, the individual with muscle dysmorphia believes that his or her body is insufficiently small or muscular.\(^7,18,20\)

*Muscle dysmorphia can affect anyone, but it is more prevalent in males than in females.\(^3,8,10,18\) Although numbers are difficult to estimate, as many as 100,000 people or more worldwide meet the formal diagnostic criteria in the general population.\(^3\) Prevalence among athletes has yet to be ascertained through formal clinical studies, with much of the data having been extrapolated from general population numbers. As social influences change and encourage a more muscular physique, children at progressively younger ages are at increased risk for developing body image disorders such as MDM.\(^6\) In one study,\(^3\) adolescent boys were presented with various body types generated on a laptop computer. Each was asked to select a body type based on 3 questions: (1) What would you like your body to look like? (2) What do you think the ideal male body should look like? and (3) What do you think others think your body looks like? The subjects were presented with various body types and asked to select the one that most closely resembled their own. On the first 2 questions, the boys selected body types that were 30 to 40 pounds heavier than the reference image, whereas answers to the third question revealed that they perceived their bodies to be much thinner and weaker looking than they actually were. Some boys even asked if they could make the largest image bigger. These disturbing findings, which have since been supported by other authors,\(^3,6,25,26\) illustrate how changing ideals of body image can distort perceptions at younger ages.\(^6,27\)

This phenomenon is not isolated to the United States; similar results were obtained in Europe and South Africa.\(^24,25,28–30\) With body image so closely related to self-esteem and self-confidence, society may be setting the stage for a generation of boys and girls who are dissatisfied with their bodies, not unappreciated by others but are very real to the person experiencing them. Focus on the flaw is so preoccupying that people often become depressed and obsessed and may even lose relationships or jobs as a result.\(^3,5,12,14,16,17\) Pope et al. noted, “Body dysmorphic disorder is often confused with vanity; this is not the case as most people don’t want to look great, they just want to look acceptable.”\(^3\) For expanded definitions of these disorders, see Table 1.

**WHO DOES MUSCLE DYSMORPHIA AFFECT?**

Muscle dysmorphia can affect anyone, but it is more prevalent in males than in females.\(^3,8,10,18\) Although numbers are difficult to estimate, as many as 100,000 people or more worldwide meet the formal diagnostic criteria in the general population.\(^3\) Prevalence among athletes has yet to be ascertained through formal clinical studies, with much of the data having been extrapolated from general population numbers. As social influences change and encourage a more muscular physique, children at progressively younger ages are at increased risk for developing body image disorders such as MDM.\(^6\) In one study,\(^3\) adolescent boys were presented with various body types generated on a laptop computer. Each was asked to select a body type based on 3 questions: (1) What would you like your body to look like? (2) What do you think the ideal male body should look like? and (3) What do you think others think your body looks like? The subjects were presented with various body types and asked to select the one that most closely resembled their own. On the first 2 questions, the boys selected body types that were 30 to 40 pounds heavier than the reference image, whereas answers to the third question revealed that they perceived their bodies to be much thinner and weaker looking than they actually were. Some boys even asked if they could make the largest image bigger. These disturbing findings, which have since been supported by other authors,\(^3,6,25,26\) illustrate how changing ideals of body image can distort perceptions at younger ages.\(^6,27\)
because they are unattractive, but because society tells them they have to look better. * 

Data describing the effect of MDM on females are also very limited. However, researchers acknowledge that females can be affected by MDM, although the drive for muscularity is less than that seen in males.32

**SIGNS AND RECOGNITION**

Attributing MDM to a single causative factor is difficult, if not short-sighted. Some attribute this disorder to the effect of the media and popular culture,3,6,12,21,25,28 whereas others lean toward individual psychological predisposing factors.1±3,6,9 Phillips and Drummond,12 for example, stated, “current Western culture promotes standards of beauty and success that focus on physical attractiveness and leanness.” Authors in the area of body image dissatisfaction have noted how marketing campaigns once targeting only female body image insecurities are now aimed at males as well.6,20,25,26,28,33 Whatever the causes, MDM is a growing concern, particularly in terms of identifying persons who are most susceptible to its development.3,7,23 Clinical case studies suggest that MDM is most often found in persons who are dissatisfied with their bodies and are heavily involved in weightlifting and other muscle development activities. Because the term “weightlifter” can be applied to most anyone, a clear definition of how MDM relates to the overall concept of “fitness” is still vague.23

To assess the presence of MDM, certain questions can be asked (Table 2).3 There is no particular number of questions used to affirm MDM, nor is there a specific time to ask them; the questions simply serve as a guide to the clinician to connect the pieces of the MDM puzzle. The athletic trainer must ascertain the scope of the situation and select applicable questions.

Questioning athletes presenting with MDM-consistent signs follows the methods used for intervening with AN and BN. The athlete should be approached in a nonconfrontational manner, and concern for his or her well-being should be the major motivation for the intervention. A private setting (ie, outside the athletic training room), such as a private office or other predetermined location, should be used to maintain athlete confidentiality. All 13 questions should be asked of the athlete, and the athletic trainer should note how the athlete’s answers to each question connect to other noticeable traits, such as workout routines, eating habits, and supplement usage. As when the athletic trainer approaches an athlete with possible AN or BN, the questioning serves as a point of confirmation while other signs and symptoms related to the disorder are investigated. If the school does not have an established protocol, several models exist to help develop one (see Resources and Suggested Readings). A flow chart for referral (Figure 2) is an excellent first step. Recognition may not always be clear-cut in the world of athletics. Often, the disorder is masked by the “demands of the sport.” Coaches and staff expect athletes to be physically fit and muscular. If an athlete has a predisposition to MDM, the sport environment may pro-

---

*2-4,6,9,12,21,25,14-17,26-28,31

Figure 1. Contributing psychobehavioral factors for muscle dysmorphia. (Copyright 2004. From Journal of Strength and Conditioning Research; by Lantz CD, Rhea DJ, Cornelius AE. Reprinted by permission of Alliance Communications Group, a division of Allen Press, Inc.)
Being Many with MDM or similar symptoms resort to pro-
damage to their self-esteem and physical and emotional well-
but all such people may be at risk for suffering devastating
at risk for developing MDM will resort to anabolic steroid use,
MDM, several notable morbidities are associated, ranging
physical health, such as androgenic-anabolic steroid use.²
problems producing and selling these products prey on males’ and
li®c usage of sports and nutritional supplements. 34,35 Compa-
substances to satisfy their aspirations.³ Certainly not everyone
body image may turn to anabolic steroids or other dangerous
handle pressures from coaches regarding an unrealistic ideal
excessive time in the
gym and ignoring social commitments, to others that affect
From lifestyle issues, such as spending excessive time in the
disorders, many signs and symptoms exist on the disorder
² 3,4,6-8,10,18-22,25,33,34
viding a breeding ground for the disorder. As with other diseases
and disorders, many signs and symptoms exist on the disorder
continuum. One obvious sign is excessive staring in mirrors.3,5,7,8,10,14,18-22 Some individuals stare in a mirror to pro-
cess aesthetic values and to evaluate overall physical prowess,³,21 whereas others fear that they are “wasting away.”³,19,21,25 Although mortality rates are not high for
MDM, several notable morbidities are associated, ranging from lifestyle issues, such as spending excessive time in the
gym and ignoring social commitments, to others that affect
physical health, such as androgenic-anabolic steroid use.¹
Muscle dysmorphia can have a profound effect on all as-
pects of life, often interfering with normal daily function.⁷ For
example, one man with MDM detailed how he missed the birth
of his first child because he had to finish his 6-hour workout.
Another testified that he lost his prestigious position at a well-
known law firm because he had to adhere to a strict dieting
and eating regimen.³ Other self-destructive behaviors associated
with MDM are shown in Table 3.

**MUSCLE DYSMORPHIA AND SUBSTANCE ABUSE**

**Androgenic-Anabolic Steroids**

Many people who are unable to achieve personal goals or
handle pressures from coaches regarding an unrealistic ideal
body image may turn to anabolic steroids or other dangerous
substances to satisfy their aspirations.³ Certainly not everyone
at risk for developing MDM will resort to anabolic steroid use,
but all such people may be at risk for suffering devastating
damage to their self-esteem and physical and emotional well-
being.³,8 Many with MDM or similar symptoms resort to pro-
lific usage of sports and nutritional supplements.³,34,35 Companies producing and selling these products prey on males’ and females’ insecurities about their bodies.³ Many individuals
take higher doses of these products than recommended, which
may predispose them to a variety of health concerns, such as
renal failure.³,6-8,21,35,36 Pope et al³ noted that “as people at
risk for MDM grow increasingly familiar with the weightlift-
ing and bodybuilder subculture, they will inevitably learn
through this subculture that anabolic steroids can deliver in a
way that no supplement can.”

Athletics alone can provide enough motivation for a person
to start using dangerous doses of supplements, anabolic ste-
roids, or both. Athletes with a poor sense of self and body
image dissatisfaction can and do fall prey to substance abuse
very easily.¹³,18,21,25,34,35

**TABLE 2. Questions the Athletic Trainer Can Ask to Determine Whether Muscle Dysmorphia is Present**³,⁸

<table>
<thead>
<tr>
<th>Social Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often have your relationships with others been affected by your exercise and diet regimens?</td>
</tr>
<tr>
<td>2. Do your concerns about your appearance influence your school or career performance? Do you miss out on opportunities to progress because of your self-consciousness?</td>
</tr>
<tr>
<td>3. Do you frequently miss school or work or avoid social activities because of your appearance concerns?</td>
</tr>
<tr>
<td>4. What measures do you take to avoid showing your body to others? Do you pass up chances to participate in sports because you will have to change clothes in front of people? Do you often wear baggy clothes or hats to hide your body or face?³,19</td>
</tr>
<tr>
<td>5. Do your concerns about your appearance affect your sex life?³,19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What portion of each day do you spend grooming yourself?²,³</td>
</tr>
<tr>
<td>2. How much time is spent daily on exercises with the specific intent of bettering your appearance (eg, abdominal exercises, weightlifting) rather than improving your performance in sport?²,³</td>
</tr>
<tr>
<td>3. How much of your day is taken up with actively worrying about your appearance?⁹</td>
</tr>
<tr>
<td>4. How frequently does your appearance make you feel distraught, depressed, or anxious?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diet and Other Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How commonly do you diet, ingest certain foods (eg, low-fat, low-carbohydrate, or high-protein foods), or take supplements with the explicit aim of enhancing your appearance?</td>
</tr>
<tr>
<td>2. What portion of your salary or other income is devoted to items and practices (eg, exercise equipment or classes, grooming supplies, surgery, special foods or dietary aids) to better your physical appearance?³⁰</td>
</tr>
<tr>
<td>3. Have you at any time taken a drug (lawful or not) to drop pounds or increase muscle mass?</td>
</tr>
<tr>
<td>4. Aside from drugs, have you pursued other methods of enhancing your appearance, such as overexercising or attempting your normal training regimen despite an injury; fasting, purging, or other detrimental nutritional activities; or unproven methods for growing hair, increasing muscle mass, or enlarging the penis?¹⁹</td>
</tr>
</tbody>
</table>

**IMPLICATIONS FOR ATHLETIC TRAINING**

As a whole, athletes are very concerned with their health
and well-being. In some sports, appropriate weight and phys-
sique are qualities that may improve some aspects of athletic
performance. The notion of becoming larger to gain an “edge”
over the competition permeates sports today.³⁷ Ath-
letes involved in sports stressing muscularity, leanness, and
aesthetics may be predisposed to developing MDM. For both
male and female athletes, body weight is another concern. Dis-
satisfaction with body weight can lead to body dysmorphic
disorder or, more specifically, MDM.¹³-³ Overall, athletes are
more critical of their bodies and body weights than are recre-
tional exercisers or nonexercisers.²,¹³ Failure to meet per-
formance standards or expectations may lead to a negative
view of the body, resulting in a greater emphasis on achieving
a certain look or body ideal. This combination of sport per-
formance, body image, and body weight can result in a body
image disorder such as MDM.

As clinicians, we must be well versed in many areas. The
well-being of our athletes needs to be approached in a holistic
manner that includes both the somatic body and the psyche.
The better informed athletic trainers are about recognizing
body image disorders such as AN, BN, disordered eating pat-
Figure 2. Conceptual model for developing an intervention strategy to aid a person with possible muscle dysmorphia or another related body image disorder. *Such as loss of a job, poor athletic performance, relationship problems, or physical harm (ie, substance abuse, injuries, etc). †MDM indicates muscle dysmorphia; ‡, if deemed appropriate.
good health, at least in the short term. The devastating psy-
with AN may be forced to seek treatment because of associ-
ating the help of coaching and support staff to address the
body image, encouraging group or team discussion, and solic-
the person recognize the condition, such as openly discussing
MDM that he or she needs help. Many approaches can help
take a backseat, and the athlete should be approached with the
institution where they will be applied. Accusations must
meet a backseat, and the athlete should be approached with the
utmost respect, understanding, and empathy for an intervention to work. Other approaches include being sensitive
to the condition, nonjudgmental, and empathetic, but also re-
alistic and forthright.3

TREATMENT OPTIONS

To understand treatment options for MDM, it is important
to first address common barriers. Many with MDM do not seek
treatment; thus, the onus is on the health care professional to
identify and intervene at the right time, just as in AN and
BN.1,3,7 The biggest hurdle is convincing the person with MDM that he or she needs help. Many approaches can help
the person recognize the condition, such as openly discussing
body image, encouraging group or team discussion, and solic-
it ing the help of coaching and support staff to address the
topic. The difference between AN and MDM is that people
with AN may be forced to seek treatment because of associ-
ated morbidity, whereas people with MDM usually present in
good health, at least in the short term. The devastating psy-
chological and social consequences often go unrecognized and, thus, untreated.7

Currently, no specific programs have been developed to help
people with MDM, although several general approaches have
made headway. Those who have responded best have been
treated with antidepressant medications such as fluoxetine
(Prozac; Eli Lilly and Co, Indianapolis, IN), alone or in com-
bination with cognitive behavioral therapy.3 Many people who
have milder forms of MDM are not the best candidates for the
aforementioned therapies, because they may seek intervention only when they have a related injury or illness. Reaching those
who suffer from the effects of MDM but do not outwardly
present with frank signs and symptoms is a problem. As with
many athletic-related conditions and injuries, athletic trainers
are on the front lines and need to be well versed in recognizing
the signs and symptoms of MDM, with prevention serving as
the ultimate goal. Athletic trainers can recognize lesser forms
of MDM by simply being familiar with the dispositions of their
athletes as well as with the common signs and symptoms of
MDM.

To properly address MDM, society has to undergo a para-
digm shift in how we approach our bodies and body images.
Traditionally, males are not supposed to be concerned with
looks or vanity, let alone talk about them. Social mores of
forced silence add fuel to a building internal fire.3 Males, par-

ticularly boys, do not want to be viewed as feminine or
weak.3,6

In helping people with MDM, several steps need to be con-
sidered. The individual with MDM has a distortion of his or
her own reality. Nothing is ever good enough, even though
the person may believe that one more cycle of steroids or one
more cosmetic procedure is all that will be needed in order to
look good. This process feeds into itself, perpetuating the psy-
chological need for more.3,4,9,12,13

Encouraging talking about inner feelings and dispelling feel-
ings of isolation are good first steps. Discussing the social
aspects of the disorder with the person can also be useful. For
specific questions, refer to Table 5.

THE ATHLETIC TRAINER’S ROLE

Athletic trainers can use several resources to approach the
issue of MDM (see Tables 2–4). Resources, however, are only
beneficial when those using them are properly educated. The
impetus for this review is to serve that purpose: to heighten
the health care professional’s awareness and knowledge re-
garding the subject matter. Many schools have policies on han-
dling and discussing eating disorders such as AN and
BN.1,14,26 Athletic trainers should encourage their schools to
adopt and implement similar approaches to MDM.

When considering programming to address MDM and other
body image disorders, athletic trainers need not reinvent the
wheel. Programs most likely exist to address AN and BN, so
further programming and education can be added to encom-
pass all athletes and all ranges of sports. Developing informa-
tional pamphlets and offering group discussions, team
meetings, and occasional educational in-service programs can
heighten the athletes’ and coaches’ awareness of the disorder.

Table 3. Self-Destructive Behaviors Associated with Muscle
Dysmorphia

- Disordered eating patterns and/or an eating disorder
- Preoccupation with working out at expense of social commitments
- “Stressful dieting” (ie, very high-protein or low-fat diets)
- Overtraining
- Training despite the presence of injuries or illness
- Abuse of pharmacologic agents (ie, anabolic steroids)
- Excessive use of dietary supplements (ie, creatine)
- Disruption of body image satisfaction
- Obsessive-compulsive rituals

*Reprinted with permission from Dawes and Mankin.7

Table 4. Useful Techniques for the Athletic Trainer Treating an Athlete with Muscle Dysmorphia

- Reassure the athlete that talking about his or her feelings is beneficial.29
- Remind the athlete that others share the same concerns with physical appearance.
- Encourage the athlete to avoid jumping to conclusions about what others may think.29
- Dissuade the athlete from “all or nothing” thinking.
- Reject the idea that the athlete’s negative body image cannot be changed.17
- Discard the notion that the media and advertisements dictate how people should look. Every person is an individual.32
- Support the athlete in focusing on positive and not negative reinforcement.17
industries’ livelihoods come from making people feel insecure about their bodies, whether it is telling females that they need to look thinner or males that they need to be more muscular. Athletic trainers need to reinforce the concept that how one looks on the outside does not define the type of person one is, one’s athletic ability, or the quality of one’s character. We should draw on our forefathers’ wisdom that it is all right to look ordinary.3 Wanting to look good and feel healthy are positive traits, but it is not healthy to compare oneself to the unattainable standards imposed by Western society. If we allow ourselves and our athletes to be taken in by these cultural beliefs about beauty, the process of muscle MDM and related morbidity will self-perpetuate. Raising awareness among athletic trainers and health care professionals will help in addressing this growing public health concern.

ACKNOWLEDGMENTS

We thank John E. Massie, PhD, LAT, ATC; Jodi Johnson, MS, ATC; and Robert Colandreo, DPT, LAT, ATC, CSCS, for revising and editing this manuscript. Gratitude is also extended to Harrison G. Pope Jr, MD, MPH, for his brilliant insight on the topic and conceptualization of this manuscript.

RESOURCES AND SUGGESTED READINGS

Books


Web Sites


Information on body image: http://www.headdocs.com

Legal aspects of body image disorders: http://www.aldenandassoc.com/articles/eating_disorders.htm

Organizations

The Body Image Program (Butler Hospital/Brown University) Contact: Dr. Katherine Phillips, (401) 455-6466 or Katherine_Phillips@brown.edu

Body Image Program

Butler Hospital

345 Blackstone Boulevard

Providence, RI 02906

The Obsessive Compulsive Foundation, Inc

(203) 315-2190

PO Box 9573

New Haven, CT 06535

www.ocfoundation.org

Most of these approaches can be developed in house, incurring minimal expenses. Programming can be as creative or as basic as suits the needs of the school and its athletes. For a comprehensive listing of very useful resources, please consult the Resources and Suggested Readings section of this paper.

CONCLUSIONS

Our goal in writing this article was to raise athletic trainers’ awareness of the psychobehavioral condition known as MDM. The intent is not to pathologize working out, bodybuilding, or fitness. Pope et al3 noted, “If you wash your hands 5 times per day, that’s healthy, if you wash your hands 200 times per day, you very likely have a problem.” Nearly 20 years of research have yielded some basic recommendations for combating MDM. Pope et al3 promoted a fundamental cultural change in the way people view their bodies. Health care professionals have to be able to recognize the signs and symptoms of MDM, select the right type of intervention, and maintain contact with the affected person through follow-up. Helping people to resist the lure of media and advertisements is a fundamental step.3,7 Many of the supermodels (both females and males) we see in everyday life are products of airbrushing or body image drugs such as anabolic steroids.25,28,34,35 Certain industries’ livelihoods come from making people feel insecure about their bodies, whether it is telling females that they need to look thinner or males that they need to be more muscular. Athletic trainers need to reinforce the concept that how one looks on the outside does not define the type of person one is, one’s athletic ability, or the quality of one’s character. We should draw on our forefathers’ wisdom that it is all right to look ordinary.3 Wanting to look good and feel healthy are positive traits, but it is not healthy to compare oneself to the unattainable standards imposed by Western society. If we allow ourselves and our athletes to be taken in by these cultural beliefs about beauty, the process of muscle MDM and related morbidity will self-perpetuate. Raising awareness among athletic trainers and health care professionals will help in addressing this growing public health concern.

ACKNOWLEDGMENTS

We thank John E. Massie, PhD, LAT, ATC; Jodi Johnson, MS, ATC; and Robert Colandreo, DPT, LAT, ATC, CSCS, for revising and editing this manuscript. Gratitude is also extended to Harrison G. Pope Jr, MD, MPH, for his brilliant insight on the topic and conceptualization of this manuscript.

RESOURCES AND SUGGESTED READINGS

Books


Web Sites


Information on body image: http://www.headdocs.com

Legal aspects of body image disorders: http://www.aldenandassoc.com/articles/eating_disorders.htm

Organizations

The Body Image Program (Butler Hospital/Brown University) Contact: Dr. Katherine Phillips, (401) 455-6466 or Katherine_Phillips@brown.edu

Body Image Program

Butler Hospital

345 Blackstone Boulevard

Providence, RI 02906

The Obsessive Compulsive Foundation, Inc

(203) 315-2190

PO Box 9573

New Haven, CT 06535

www.ocfoundation.org

Most of these approaches can be developed in house, incurring minimal expenses. Programming can be as creative or as basic as suits the needs of the school and its athletes. For a comprehensive listing of very useful resources, please consult the Resources and Suggested Readings section of this paper.

CONCLUSIONS

Our goal in writing this article was to raise athletic trainers’ awareness of the psychobehavioral condition known as MDM. The intent is not to pathologize working out, bodybuilding, or fitness. Pope et al3 noted, “If you wash your hands 5 times per day, that’s healthy, if you wash your hands 200 times per day, you very likely have a problem.” Nearly 20 years of research have yielded some basic recommendations for combating MDM. Pope et al3 promoted a fundamental cultural change in the way people view their bodies. Health care professionals have to be able to recognize the signs and symptoms of MDM, select the right type of intervention, and maintain contact with the affected person through follow-up. Helping people to resist the lure of media and advertisements is a fundamental step.3,7 Many of the supermodels (both females and males) we see in everyday life are products of airbrushing or body image drugs such as anabolic steroids.25,28,34,35 Certain industries’ livelihoods come from making people feel insecure about their bodies, whether it is telling females that they need to look thinner or males that they need to be more muscular. Athletic trainers need to reinforce the concept that how one looks on the outside does not define the type of person one is, one’s athletic ability, or the quality of one’s character. We should draw on our forefathers’ wisdom that it is all right to look ordinary.3 Wanting to look good and feel healthy are positive traits, but it is not healthy to compare oneself to the unattainable standards imposed by Western society. If we allow ourselves and our athletes to be taken in by these cultural beliefs about beauty, the process of muscle MDM and related morbidity will self-perpetuate. Raising awareness among athletic trainers and health care professionals will help in addressing this growing public health concern.

ACKNOWLEDGMENTS

We thank John E. Massie, PhD, LAT, ATC; Jodi Johnson, MS, ATC; and Robert Colandreo, DPT, LAT, ATC, CSCS, for revising and editing this manuscript. Gratitude is also extended to Harrison G. Pope Jr, MD, MPH, for his brilliant insight on the topic and conceptualization of this manuscript.

RESOURCES AND SUGGESTED READINGS

Books


Web Sites


Information on body image: http://www.headdocs.com

Legal aspects of body image disorders: http://www.aldenandassoc.com/articles/eating_disorders.htm

Organizations

The Body Image Program (Butler Hospital/Brown University) Contact: Dr. Katherine Phillips, (401) 455-6466 or Katherine_Phillips@brown.edu

Body Image Program

Butler Hospital

345 Blackstone Boulevard

Providence, RI 02906

The Obsessive Compulsive Foundation, Inc

(203) 315-2190

PO Box 9573

New Haven, CT 06535

www.ocfoundation.org

Most of these approaches can be developed in house, incurring minimal expenses. Programming can be as creative or as basic as suits the needs of the school and its athletes. For a comprehensive listing of very useful resources, please consult the Resources and Suggested Readings section of this paper.

CONCLUSIONS

Our goal in writing this article was to raise athletic trainers’ awareness of the psychobehavioral condition known as MDM. The intent is not to pathologize working out, bodybuilding, or fitness. Pope et al3 noted, “If you wash your hands 5 times per day, that’s healthy, if you wash your hands 200 times per day, you very likely have a problem.” Nearly 20 years of research have yielded some basic recommendations for combating MDM. Pope et al3 promoted a fundamental cultural change in the way people view their bodies. Health care professionals have to be able to recognize the signs and symptoms of MDM, select the right type of intervention, and maintain contact with the affected person through follow-up. Helping people to resist the lure of media and advertisements is a fundamental step.3,7 Many of the supermodels (both females and males) we see in everyday life are products of airbrushing or body image drugs such as anabolic steroids.25,28,34,35 Certain industries’ livelihoods come from making people feel insecure about their bodies, whether it is telling females that they need to look thinner or males that they need to be more muscular. Athletic trainers need to reinforce the concept that how one looks on the outside does not define the type of person one is, one’s athletic ability, or the quality of one’s character. We should draw on our forefathers’ wisdom that it is all right to look ordinary.3 Wanting to look good and feel healthy are positive traits, but it is not healthy to compare oneself to the unattainable standards imposed by Western society. If we allow ourselves and our athletes to be taken in by these cultural beliefs about beauty, the process of muscle MDM and related morbidity will self-perpetuate. Raising awareness among athletic trainers and health care professionals will help in addressing this growing public health concern.

ACKNOWLEDGMENTS

We thank John E. Massie, PhD, LAT, ATC; Jodi Johnson, MS, ATC; and Robert Colandreo, DPT, LAT, ATC, CSCS, for revising and editing this manuscript. Gratitude is also extended to Harrison G. Pope Jr, MD, MPH, for his brilliant insight on the topic and conceptualization of this manuscript.
REFERENCES


