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Enhancing quality of life in medical populations: a vision for body image assessment and rehabilitation as standards of care

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Abstract

This article presents a vision and framework for establishing body image assessment and rehabilitation as a standard of care for patients with medical disorders. Making this vision a reality depends upon: (1) a thorough understanding of the body image construct; (2) application of many new forms of body image assessment; (3) refined understanding of body image disorder and dysfunction in the context of medical conditions; and (4) a clear plan to implement and evaluate prevention, rehabilitation, and treatment programs. Applying the many important developments that have occurred in body image theory, assessment, and intervention over the past decade holds promise for enhancing the quality of life of many individuals with medical conditions.

Keywords: Body image; Quality-of-life; Medical conditions; Rehabilitation

Introduction

This article is a clarion call for more research and clinical attention to be given to the often unspoken and neglected body image suffering experienced by many medical patients. As this inaugural issue of *Body Image: An International Journal of Research* makes clear, the study of body image is very deep and broad. However, there is no single more important need in this entire field than to develop extensive programs of research that will help us better understand and ameliorate the body image suffering of the many millions of individuals with medical conditions.

Medical illnesses and treatments result in many body image changes. Any significant illness or medical treatment will change the patterns of attention given to bodily experience and may affect the degree to which we feel safe and comfortable in our own bodies. Pain, loss of physical function, mobility or sensory functioning can all change our psychological experience of our body. Additionally, there are, of course, many possible changes in physical appearance that can occur with medical illness and treatment. Some of these attentional, functional, and aesthetic changes may be temporary, others permanent. However, all of them require some form of body image adaptation—an adaptation that is often poorly understood yet powerful and pervasive enough to significantly undermine the quality of life for many people.

The major premise of this article is that there is a great deal more that can be done to improve our understanding of body image changes occurring in the context of medical disease. Even more importantly, there

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is a much more that can be done to improve patients' quality of life by making body image assessment and rehabilitation standards of care within medical practice.

Contributors to *Body image: A handbook of theory, research and clinical practice* (Cash & Pruzinsky, 2002a) have provided the most comprehensive review to date of body image concerns in medical conditions. Our volume reviews the significance of the assessment of body image in the context of health-related quality of life (Pruzinsky & Cash, 2002). Contributors address the core body image issues occurring in dermatology, (Koo & Yeung, 2002), dental medicine (Kiyak & Reichmuth, 2002), obstetrics and gynecology (Heinberg & Guarda, 2002), urological disorders (Tovian, 2002), endocrinology (Gilmour, 2002), oncology (White, 2002), and rehabilitation medicine (Rybarczyak & Behel, 2002). Also, examined are the body image considerations of patients with HIV/AIDS (Chapman, 2002a, 2002b), individuals with congenital (Rumsey, 2002a, 2002b) and acquired disfiguring conditions (Pruzinsky, 2002), as well as individuals undergoing cosmetic plastic surgery (Sarwer, 2002).

This list of medical contexts in which body image has been fruitfully explored is only suggestive of the full range of medical problems where body image is highly relevant. Body image is certainly pertinent in numerous other contexts: cardiac rehabilitation (Lichtenberger, Ginis, MacKenzie, & McCartney, 2003; Vessey & O'Sullivan, 2000), the experience of body image distortions when under anesthesia (Paqueron et al., 2003), prosthetics (Murray & Fox, 2002), limb-lengthening (Guichet et al., 2003) Parkinson's disease (Caap-Ahlgren & Lannerheim, 2002), transplantation (Fisher, 1986; Limbos, Joyce, Chan, & Kesten, 2000), scoliosis (Weinstein et al., 2003), scleroderma (Benrud-Larson et al., 2003), arthritis (Packham & Hall, 2002), strabismus (Menon, Saha, Tandon, Mehta, & Khokhar, 2002), stroke (Keppel & Crowe, 2000), pectus excavatum (Lawson et al., 2003), and cystic fibrosis (Wenninger, Weiss, Wahn, & Staab, 2003), as well as how body experience relates to the very challenging decisions which must be made in the context of genetic conditions (Chapman, 2002b).

Body image change and adaptation within the context of medical illness must also consider the full range of factors affecting psychological adaptation (e.g., personality variables, social support, etc.). However, my focus here concerns how to integrate the concept of body image into our methods for assessing and rehabilitating patients with medical illness.

Far too often research conducted on body image and medical conditions occurs in isolation from the many important developments occurring in the area of body image research (Pruzinsky & Cash, 2002). In the final paragraph of our 2002 volume we noted that: "The greatest promise for the field [of body image] is for it to become more interdisciplinary" (Cash & Pruzinsky, 2002b; p. 516).

In setting new standards of care for medical patients, we must: (1) refine the conceptual understanding of body image in the context of medical illness; (2) apply the important developments in body image assessment; (3) clarify our knowledge of body image dysfunction and disorder; and (4) develop and implement programs for preventing, rehabilitating, and treating body image suffering.

Conceptual foundations

The study of body image in the context of medical conditions will be greatly enhanced by a clear appreciation for the complexity of the body image construct and multiple theoretical perspectives from which it can be understood.

Conceptual complexity

Three themes illustrate the complexity of body image: (1) it does not just refer to perception of physical appearance; (2) body image experiences are inherently subjective; and (3) body image is not static.

Body image is more than perception of appearance

The history of the body image construct is replete with instances of a failure to fully understand or articulate its complex nature. There is often a naïve assumption that body image simply refers to the sensory perception (e.g., size distortion) of one's physical appearance.

While individual perception of physical appearance, "a picture in one's head", is a critical referent for body image, it falls far short of a comprehensive understanding of body image. To understand body image functioning in general and in the context of

medical conditions in particular, we need to consider individual perception of bodily function, level of competence, as well as bodily sensation and a host of other body-related experiences. For example, does one experience one's body as a safe or predictable source of pleasure and competence, or as unsafe and unpredictable?

Body image is inherently subjective

The most fundamental axiom of body image functioning is that it is an entirely subjective experience reflecting many variables. Such variables can include the nature and degree of body image investment (i.e., the extent to which one's appearance defines one sense of self), somatic sensitivity/awareness (i.e., the nature and degree to which one pays attention to bodily sensation), or body image resilience (i.e., the degree to which one perceives one's body image as "intact" despite aging, illness, or trauma), as well as a host of personality and developmental factors (Cash, 2002a; Krueger, 2002a, 2002b). This inherent subjectivity accounts for the richness and complexity of the construct and for some of the challenges encountered by any researcher or clinician interested in assessing body image.

Body image is not static

Body image is not exclusively a stable, trait-like variable. Body image experiences are also clearly experiences of the moment, influenced by a host of personal and contextual/environmental variables (Cash, 2002b). Furthermore, body image experience must be placed in a developmental context. For example, differences in the body image outcomes have been related to the timing of the onset of medical condition (e.g., Ben-Tovin & Walker, 1995; Varni, Katz, Colegrove, & Dolgin, 1995). Additionally, though we know that women report less appearance anxiety, self-objectification, and habitual body monitoring as they get older (Tiggemann & Lynch, 2001), it is not clear if this is true in the context of medical disease. For example, Rowland (1998) reports that older woman may be just as likely to be concerned about the appearance of her breasts as a younger woman after undergoing surgical treatment for breast cancer. The fact is that we do not have a great deal of information regarding the nature of body image adaptation to disease and its treatment across the life span.

Multiple theoretical perspectives

An appreciation of the complexity of body image is greatly enhanced when we consider the diverse theoretical perspectives from which we can better understand it. Of all available theoretical perspectives, cognitive-behavioral theory (CBT) currently has been given the greatest attention, in part because it provides clear and direct methods for measurement and intervention. There is no question that this model (Cash, 2002a; Cash & Strachan, 2002; see also Veale's article in this issue) can be applied to a range of medical conditions, and can be used to develop effective forms of assessment and intervention. For example, the CBT perspective has been of great value in creating a heuristic model for understanding the body image concerns of oncology patients (White, 2000, 2002). White's (2000, 2002) model is an excellent example of how a general theoretical perspective can be applied to the medical context with suggestions about integration of key concepts—including distinctions between self-schema, body image schema, body image investment, self-ideal discrepancies, as well as the role of cognitive assumptions, automatic thoughts, body image emotions, and compensatory behaviors.

However, there is also a very long tradition of understanding body image and medical conditions from a psychodynamic perspective. In his 1986 two-volume opus, Seymour Fisher reviews many of these studies that shed a unique light on medical conditions. Provocative clinical insights are available through a psychodynamically based understanding of body image response to medical conditions.

Similarly, the sociocultural perspective (Jackson, 2002) has much to offer our understanding of the powerful role of physical appearance with direct implications for those many medical conditions where appearance is altered. There are, of course, other perspectives from which we can view body image, including an information processing approach (Williamson, Stewart, White, & York-Crowe, 2002), identity process theory (Whitbourne & Skultety, 2002), terror management (Goldenberg, McCoy, Pyszczynski, Greenberg, & Solomon, 2000), as well as a neurological vantage point (Kinsbourne, 2002). The latter has implications for understanding such classic body image phenomena of phantom limb and unilateral neglect.

Body image assessment

Important advances have occurred in assessing body image attitudes in adolescents and adults (Thompson, this issue; Thompson & van den Berg, 2002) and children (Gardner, 2002; see Smolak, this issue). These advances are quite applicable to evaluating the body image experiences of medically ill individuals.

Benefits of routine body image assessment in medical contexts

Pruzinsky and Cash (2002) outlined the benefits of improving body image assessment in the context of evaluating health-related quality of life, including: (1) more effective screening for body image distress; (2) specification of body image concerns; (3) refinement of health outcomes.

More effective screening for body image distress

To be of greatest help to the largest number of people in need of care, we must be able to identify individuals who are and are not suffering from body image concerns associated with their medical condition. Currently there is no single way to screen for those patients who may be experiencing body image concerns that significantly undermine their quality of life. Of course, not all individuals with a medical condition will have a severely negative body image response to their illness or their treatment—despite the actual disfigurement or disability that occurs.

In most medical treatment contexts, patients' body image concerns are not explicitly addressed by the attending physician or any member of the treatment team, even in those instances where body image suffering is very likely occurring (e.g., in cases where there is obvious disfigurement or disability). Such benign neglect of this suffering is likely the consequence of physicians being uncomfortable with and/or unskilled at addressing such issues. Methods by which we can effectively screen patients for these concerns are clearly needed.

The Body Image Quality of Life Inventory (BIQLI; Cash & Fleming, 2002a) provides one potential method by which body image screening can occur. The 19-item BIQLI allows individuals to report the body image effects (both positive and negative) on self-concept, feelings of masculinity–femininity, social interactions, emotional experience, overall satisfaction with life as well as sexuality, and a variety of other domains. The items are relatively non-intrusive/reactive and appear pertinent to a wide variety of medical populations. Of course, the instrument is new and its potential scientific value in medical contexts must be determined by further research.

One possible clinical value is that such an assessment provides physicians or other members of the treatment team with a way to initiate discussion of the individual's body image concerns. Giving the BIQLI (or similar measures) to patients as part of their routine pre-consultation paperwork normalizes the body image evaluation (i.e., patients are not singled-out for such an evaluation). Additionally, being able to report one's concerns in writing may be much easier for some patients who may not otherwise address these concerns (Corcoran & Fischer, 2002). Shame and discomfort make many patients reticent to conversationally express their body image concerns.

Instituting routine body image screening procedures also provides the clinician with a standardized method by which to refine their understanding of the full continuum of body image concerns that patients' experience (see Section 4 later in this paper). The BIQLI may be valuable for identifying medical patients who may have body image concerns and it can, therefore, serve as one core measure of a standardized assessment module required for cumulative progress to be made in body image evaluation (Cash & Pruzinsky, 2002b).

Specification of body image concerns

Refinement in body image screening will also result in our being able to specify the exact nature of patient concerns. For example, there has been progress in developing body image measures tailored to specific medical problems, including the creation of the Satisfaction with Appearance Scale (SWAP) designed specifically to evaluate burn survivors (Lawrence et al., 1998) as well as dermatological conditions (Halioua, Beumont, & Lunel, 2000). Measures of body image have also been incorporated into a more comprehensive assessment of many diseases, including the effects of cancer (Sprangers et al., 1998) and end-stage renal disease (Wu et al., 2001). Researchers and clinicians interested in assessing body image in the context

of medical conditions would benefit from reviewing these developments.

Refining health outcomes measurement

A third important advantage of integrating body image assessment into the routine evaluation of medical patients is that such evaluations provide a unique perspective on health outcome. In some medical contexts there may be significant improvements in body image health-related outcomes (e.g., in reconstructive plastic surgery) that are essential to document (Pruzinsky, 2002). This is especially important if we hope to promote changes in health policy that help to ensure coverage for interventions that may be deemed as "only cosmetic" (e.g., surgical construction of an ear for those children who are born without one; Pruzinsky & Cash, 2002).

In other areas of medicine, even treatments that improve functioning or lead to the extension of life may nevertheless have *negative* body image effects. What is clearly needed is for body image to be an outcome variable routinely considered, so that both improvements and declines in body image functioning are documented. Such information can serve many purposes including identifying patients in need of rehabilitation and to provide patients with information as part of the informed consent process. For some patients, learning of the possible negative body image consequences of a treatment may lead to decisions to not undertake such treatments (e.g., in some instances of facial cancers).

Specific measurement issues

To make progress toward improving body image measurement in medical contexts, Pruzinsky and Cash (2002) outlined five specific issues that must be addressed: (1) general versus disease-specific assessment; (2) multidimensional assessment; (3) determining clinical significance; (4) pediatric assessment; and (5) cultural sensitivity.

General versus disease-specific assessment

When measuring the body image effects of medical illness and treatment it is essential to consider to what degree "general" measures of body image functioning are effective in assessing the critical variables and to what degree it is necessary to use and/or develop disease-specific measures (Pruzinsky & Cash, 2002). For example, a researcher or clinician might utilize a well-validated assessment of broad dimensions of body image (e.g., the Multidimensional Body-Self Relations Questionnaire). However, does this excellent measure adequately capture those body image issues related to a specific medical illness? Scientists and professionals must select measures based upon their clinical, empirical, or conceptual knowledge or hypotheses about the medical condition, rather than to choose an assessment merely because it is reputed to be "a good body image measure" (see Thompson, this issue).

This issue of general versus disease-specific assessment is similar to the one addressed in the health quality-of-life literature where it is commonly assumed that a combination of general and disease-specific measures are most likely to be the most effective (Pruzinsky & Cash, 2002). It is most likely that as body image measurement in medical contexts becomes more refined, a combination of general body image measures with illness-specific measures (which may be quite brief) will be the standard assessment protocol.

Multidimensional assessment

There are many different dimensions of body image and many ways to measure them. As stated above, using a psychometrically sound assessment instrument is not helpful if it fails to measure those dimensions of body image central to the medical condition being studied. A good example of this issue is the interesting study of prostrate cancer and sexual functioning conducted by Perez, Skinner, and Meyerowitz (2002), who included assessments of sexual functioning and body image (Derogatis & Melisaratos, 1979). While it is laudable that they measured body image, they reported that their "... findings regarding the importance of body image in predicting emotional distress and quality of life [QoL] are ... difficult to interpret, particularly in light of the fact that radical prostatectomy rarely causes obvious changes in physical appearance, the component of body image assessed here" (Perez et al., 2002, p. 292). That is, these investigators evaluated a dimension of body image (i.e., appearance) not directly relevant to the body image changes occurring for patients undergoing prostatectomy. My point is not to criticize Perez et al. (2002) per se, but I wish to illustrate how otherwise significant research can evince a misunderstanding of the

different dimensions of body image or how they can be assessed.

Determining clinical significance

The critical questions here are: "Do the body image measures we use tap those variables that really make a clinical difference in the lives of the individuals we are evaluating? Are the measures sensitive enough to detect clinically meaningful body image changes pre- and post-illness and/or treatment?" This is a complex topic requiring consideration of many issues including understanding the distinctions between categorical and dimensional forms of classification and how different measures and items within measures are weighted and combined (Pruzinsky & Cash, 2002). With respect to body image assessment in medical conditions, this issue has not even begun to be addressed.

Pediatric assessment

There are many medical conditions that affect children's body image. A Delphi study of European experts in the assessment of pediatric quality of life determined that body image to be one of eight areas essential to evaluate (Herdman et al., 2002). However, pediatric body image assessment is very challenging. This is due, in part, to the relative lack of body image measures for children (Cash & Pruzinsky, 2002a; see Smolak's article in this issue) and to the complexity of evaluating psychological functioning in the context of developmental changes and the changing nature of the illness and treatment process (Chambers & Johnston, 2002). Despite these challenges, it is essential that progress be made in understanding childhood body image adaptation to illness so that we can better understand if there are methods of preventing or ameliorating their body image concerns.

Cultural sensitivity

Clearly important cultural differences in body image experience exist (Altabe & O'Garo, 2002; Celio, Zabinski, & Wilfley, 2002; Kawamura, 2002), as well as consistent evidence for cultural differences in the experience of medical illness (Ma & Henderson, 1999). Given space limitations, the only point that can be made here is that the astute clinician or researcher will be sensitive to the specific cultural factors that may influence an individual's body image experience of their medical illness. The specific cultural meaning assigned to specific types of illness, body parts, body appearance, sexual functioning, etc. may have a dramatic (if often unappreciated) influence on the individuals' body image related quality of life.

Classification of body image concerns

Developing a clearer understanding of the nature and extent of body image dysfunctions and disturbances in the context of medical diseases requires considering many variables. For example, there are clear relationships between body image and social (Cash & Fleming, 2002b) and sexual functioning (Wiederman, 2002) in general and in certain medical conditions (e.g., Andersen & LeGrand, 1991; Gutl, Greimel, Roth, & Winter, 2002; Rice, 2002).

There is a paucity of data regarding the epidemiology of body image concerns within specific patient populations. Part of the problem is that there is no consensual definition regarding what is meant by the term "negative body image" in general (Cash, 2002b) or in relation to specific medical problems. Many health-care professionals have an intuitive grasp of the concept of a continuum of psychological/body image functioning but have not yet explicitly articulated its specific referents. That is, experienced and psychologically astute physicians within specific medical specialties can likely estimate the percentage of patients who experience body image concerns. They also could describe, at least to some degree, their patients' typical body image concerns, as well as those patients with fewer and greater than average body image concerns.

One approach to the determination of patients' severity of body image concerns is to search for how these concerns match prototypic diagnostic criteria in the psychiatric nomenclature (American Psychiatric Association, 2000). For example, in cosmetic surgery and dermatology settings, one asks whether the patient meets criteria for body dysmorphic disorder (in this issue, see Sarwer & Crerand and Veale). In most medical contexts, it is more beneficial not to think of "disorders" but to view the body image concerns on a simple continuum.

Continuum of body image concerns

Adjustment to the body image changes associated with medical conditions can be usefully

conceptualized utilizing a dimensional approach wherein individuals can be described as falling along a continuum of body image concern. One extreme pole of such a continuum would characterize those individuals with "no discernible body image concerns". The opposite pole of the continuum would characterize those individuals who have an "extreme" level of body image concern that significantly disrupts their lives. In the middle of such a continuum would be those individuals who have an "average/normative" level of body image concern.

Individuals classified as evidencing "no discernible body image concerns" are ones who, despite the fact of having a clearly diagnosable medical condition and/or having undergone some form of medical treatment, report that they have no body image concerns. Many different types of individuals may fit at this end of the continuum. One group might be those who are denying, to themselves and others, the concerns that they do in fact have. A second group is those individuals who, despite having significant functional and/or appearance changes as a result of their medical problem, are genuinely not concerned by them. Such individuals could teach us about the positive aspects of body image adaptation. A third group of individuals are those who have transmuted their medical condition into an opportunity to experience an enhancement of life. For example, Eiserman (2000), writing about those individuals who have some form of facial disfigurement, has articulated what he terms "blessings in disguise" that can result from having such a physical difference.

Construction of this continuum of body image concerns in medical illness assumes that there is some body image discomfort experienced by many (but not all) medically ill individuals. Therefore, for persons at the middle of the continuum ("average/normative" level of body image concern), such concerns are not out of the ordinary. Although these individuals are not overwhelmed by their concerns, body image issues have had a moderately negative impact on quality of life. These persons may benefit from body image rehabilitation interventions to prevent or reduce body image distress. Individuals at this "middle/average" level are quite likely to be very heterogeneous in their presentation. That is, while they all may have a "normative" level of body image discomfort, the exact nature of the concern will vary from individual to individual.

Those individuals who are at the "extreme body image concern" end of the continuum explicitly report and/or exhibit a great deal of body image distress that significantly disrupts their life. They are also very likely exhibiting psychopathology that may or may not be body image focused—for example, experiencing clinical levels of depression and/or anxiety, or perhaps even psychotic forms of body image disturbance. Such individuals are clearly recognizable to most health-care professionals who should seek mental health consultation to address the patients' concerns.

Preventing, rehabilitating, and treating body image dysfunctions and disorders

Developing methods for preventing or relieving body image suffering associated with medical disease is the single-most neglected area in the study of body image. I base this conclusion on observations that: (1) there are tens of millions of people with potentially body image-changing medical illnesses; (2) these body image changes result in untold amounts of suffering; and (3) there is a dearth of scholarship (clinical or empirical) regarding how to ameliorate this suffering. Even in those areas where there has been some research documenting the nature and extent of body image concerns there has been little done to address the pressing need for prevention, rehabilitation, or treatment programs. Certainly we should hold no illusions that all body image problems can be prevented or rehabilitated. However, there unquestionably is much more we can do to develop, implement, and evaluate helpful programs for medically ill individuals.

Prevention

Body image prevention programs thus far have focused almost exclusively on individuals at risk for developing eating disorders. Unfortunately, we do not have even the most rudimentary understanding of how to prevent body image suffering in medical populations. However, it is reasonable to speculate that it may be helpful to develop psychoeducational programs that address the prototypical body image concerns that arise in relation to specific diseases. Such programs can help patients learn to adaptively modify their thinking, behaviors, and social environ-

ments (Cash, 1997; Winzelberg, Abascal, & Taylor, 2002; see also Levine & Piran in this issue). The many advantages to psychoeducational programs include the fact that materials utilized in such programs (e.g., videotapes, self-help manuals, etc.) are inexpensive and do not necessarily require the input from a mental health professional (Winzelberg et al., 2002). Such programs are clearly a worthwhile "first step" that can be followed-up with more intensive intervention if needed (Winzelberg et al., 2002).

Such psychoeducational interventions do not need to be exclusively focused on body image concerns, but rather on the full range of issues occurring in the context of a specific medical illness. For example, teaching people how to address concerns regarding sexuality after undergoing ostomy or prostatectomy can include a specific focus on the body image issues that may arise in this context.

Thus far the focus has been on preventing the negative psychosocial sequelae of medical illness. However, it is also helpful to discuss how an understanding of body image variables may also play a role in preventing specific medical problems. For example, there is a growing body of literature documenting the influence of body image variables on exposure to UV light (e.g., via sunbathing, tanning booths), which increases risk of skin cancers (Hillhouse & Turrisi, 2002). That is, some individuals with higher levels of body image investment are more likely to engage in behaviors placing them at increased risk for skin cancer. Similarly, increased body image investment contributes to smoking in some women (King, Matacin, Marcus, Bock, & Tripolone, 2000). Additionally, it is reasonable to speculate that body image variables have a direct relationship with comfort and compliance with cancer screening self-examination programs (e.g., breast and testicular self-examination.).

Rehabilitation versus treatment

The concept of rehabilitation has not been frequently applied to body image. "Treatment" of body image problems can be interpreted as implying that there is some kind of pathology/disorder. However, as noted earlier, negative body image responses to medical illness are often normative responses requiring adaptation in order to return to a previous level of functioning. Here, the concept of rehabilitation is much more apt than treatment and is also a term likely to be much more acceptable to patients.

One method to facilitate rehabilitation of body image functioning in the context of medical illness is to use physical interventions (e.g., exercise). There is some documentation of the efficacy of fitness programs to enhance body image (Martin & Lichtenberger, 2002). Such interventions already have been used in a variety of medical populations including individuals with acquired mobility disabilities (Yuen & Hanson, 2002) and women with breast cancer (Pinto, Clark, Maruyama, & Feder, 2003), but have not been found to be universally helpful (Hider, Wong, Ortiz, Dulku, & Mulherin, 2002). Psychological methods of rehabilitation for medical problems could be readily derived from CBT approaches (Cash & Strachan, 2002) or experiential approaches to body image intervention (Rabinor & Bilich, 2002). The latter might utilize somatic techniques such as massage or the Alexander Technique that have been used successfully in the care of patients with medical disease (e.g., Loewe et al., 2002).

There are, of course, individuals for whom body image treatment would be necessary, particularly for those individuals whose body image concerns greatly impair their quality of life. Exploration of the development of such treatment programs would ideally begin with the already well-developed programs of CBT approaches to treatment (Cash, 2002a; Cash & Strachan, 2002) but could also include use of psychodynamic (Krueger, 2002b) and psychopharmacological (Allen & Hollander, 2002) approaches. No matter what therapeutic approach is taken, it is essential to have consistent empirical documentation that these programs of prevention, rehabilitation or treatment are efficacious.

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