

# Body Dysmorphic Disorder: Identifying and Treating an Invisible Problem

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## Abstract

Body dysmorphic disorder (BDD), previously classified as a somatoform disorder, has recently been reconceptualised as related to obsessive-compulsive disorder. BDD is similar to obsessive-compulsive disorder in terms of having obsessions (body image) and compulsions (checking behaviours related to appearance). People with BDD can spend hours each day checking their appearance in the mirror because they believe they are ugly or disfigured, when in fact they look normal. BDD is surprisingly common and has about five times the prevalence of anorexia nervosa, yet is underdiagnosed. However, the research indicates that, once recognised, cognitive behaviour therapy, with an emphasis on exposure and response prevention, is an effective treatment.

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Body dysmorphic disorder (BDD) is a mental disorder characterised by a preoccupation with an imagined defect in physical appearance, or excessive concern for a slight physical abnormality. BDD-type symptoms were first formally documented in 1886 when it was referred to as 'dysmorphophobia' to reflect its phobic-like nature. Since then, it has been recognised using different names and conceptualisations. BDD diagnosis has again been reconceptualised in the *DSM-5* (American Psychiatric Association, 2013), where it is classified within the newly formed obsessive-compulsive and related disorders category. This reclassification reflects its similarities to obsessive-compulsive disorder (OCD) in terms of aetiology, symptomatology, and treatment response (Buchanan, Rossell, & Castle, 2011).

BDD is a relatively common disorder, with a reported prevalence rate in Australia of approximately 2.3% (Bartsch, 2007). This makes BDD more common than schizophrenia and anorexia nervosa combined, yet it remains under-recognised. The reasons BDD is an "invisible disorder" are many, including the private and social phobic nature of BDD sufferers, as well as the strongly held belief that they possess a physical defect rather than a psychological one. Unfortunately, this results in few individuals with BDD seeking or receiving appropriate treatment.

## Cosmetic Procedures

Before a BDD patient ends up in a clinical psychologist's office, it is likely that they have first consulted with dermatologists and cosmetic surgeons in an effort to 'fix' their perceived defect. In fact, one study showed 76% of BDD patients sought procedures like rhinoplasty, breast implants, or botox before getting mental health treatment (Phillips, Grant, Siniscalchi, & Albertini, 2001). A major problem with cosmetic surgery is that the vast majority of BDD patients (83% in some research; e.g., Phillips et al., 2001) experience either no improvement, or a worsening of symptoms after surgery, and most are dissatisfied with the

procedure. This differs from people without BDD who are generally satisfied with cosmetic procedures and even report psychological benefits on follow-up (Rankin, Borah, Perry, & Wey, 1998). This information is important to clinical psychologists whose advice may be sought in regard to someone's suitability for surgery. The data is clear: BDD is a contraindication to cosmetic surgery.

## Presentation

Individuals with BDD are greatly in need of care from clinical psychologists. Without treatment, psychosocial outcomes are unfavourable, with many experiencing prolonged unemployment, severe social isolation, and suicidal ideation, with approximately 25% of individuals with BDD attempting suicide (Buhlmann et al., 2010). Perhaps another reason that BDD is underdiagnosed is that many individuals with primary BDD also fulfil the criteria for other mental disorders, including social phobia (Coles et al., 2006), major depression (Phillips, Didie, & Menard, 2007), and, most commonly, OCD (Stewart, Stack, & Wilhelm, 2008). Routinely and directly asking new patients about body image concerns is important in order to identify BDD in clinical practice, as few people with the disorder disclose their concerns without prompting.

In contrast to other disorders relating to body image (such as anorexia nervosa), the prevalence of BDD is similar in men and women. However, there are consistent gender differences in the body parts of concern (Rief, Buhlmann, Wilhelm, Borkenhagen, & Braehler, 2006). Women tend to focus on skin, legs, and breast size while men are concerned with baldness, body hair, genitals, and build. Muscle dysmorphia (or, more informally, bigorexia) is a subtype of BDD recognised in *DSM-5*. It mostly afflicts men, and is characterised by concerns about muscularity. Those who suffer from muscle dysmorphia tend to hold delusions that they are "skinny" or "too small" and will often spend hours at the gym building muscle and comparing themselves unfavourably to other men.

The prevalence of BDD seems to be consistent across cultures, with people in different cultures dissatisfied

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with different body parts (Rief et al., 2006). The similarity in gender and culture prevalence rates suggest that the onset of BDD is separate from culture, while the differences in body part manifestations of BDD reflect different societal values.

### Causes

The onset of BDD is usually during adolescence, with patients recounting hypersensitivity about their physical appearance for all, or much of, their lives, leading them to remember and fixate upon teasing instances (Phillips, Menard, Fay, & Weisberg, 2005). The majority of BDD patients remember teasing during their adolescence when they 'realised' that they were ugly, and they attach considerable self-meaning to these memories. In fact, the therapeutic use of 'imagery rescripting', allowing imaginary exposure to this event, is often used in treatment of BDD (Veale & Neziroglu, 2010). Revisiting this traumatic memory provides an opportunity to reflect on the resultant unhelpful and perpetuating thought processes.

A comprehensive model of the causes of BDD includes biological and genetic susceptibility upon which adverse life events interact with cognitive abnormalities and lead to maladaptive learned behaviours (Buchanan et al., 2011). A large portion of the aetiology of BDD is likely to be genetic. This was well demonstrated in a large twin study ( $n = 2,148$ ) (Monzani et al., 2012) showing that BDD and OCD traits were largely accounted for by genetic influences common to both phenotypes (64%). It is likely that genetics causes neurobiological differences in the brain that predispose some individuals to develop BDD (Buchanan et al., 2013). Recent neuroimaging research has indicated a key difference in the amygdala and limbic system, the emotion centres of the brain (Buchanan et al., 2014).

### Diagnosis

Many people with BDD have very low insight and difficulty accepting that their perceived defect in appearance is psychological, rather than truly physical. This creates an opportunity to use the formal diagnosis as the starting point in the therapeutic process. In fact, many individuals with BDD may experience significant relief when they receive a diagnosis of BDD because it provides the first glimmer of hope that their perceived defect may, in fact, not be real.

Diagnostic evaluation, according to *DSM-5*, should place emphasis upon assessing the compulsions associated with BDD (see Figure 1). These may include, for example, repeatedly checking one's hair line to make sure balding is not occurring, or spending hours applying and reapplying makeup to cover a few blemishes. Because of the new conceptualisation, simply being obsessed with a perceived defect is no longer sufficient for a diagnosis. Thus, when determining a diagnosis, and trying to differentiate subclinical body image concerns from BDD, an emphasis on the *time spent* engaged in compulsive behaviour is important. As in OCD, the ability of the patient to resist compulsions, and the disruption caused by compulsions, is a key component in determining the level of dysfunction.

### Cognitive Behaviour Therapy (CBT)

Most published studies of CBT for BDD have included cognitive restructuring, exposure (e.g., to avoided social situations), and response prevention (e.g., not seeking reassurance) that are tailored specifically to BDD symptoms (Veale & Neziroglu, 2010). Additional strategies used in combination with these approaches include perceptual retraining with mirrors, habit reversal for BDD-related skin picking or hair plucking, cognitive approaches that target core beliefs, incorporation of behavioural experiments into exposure exercises, and motivational interviewing (Phillips & Rogers, 2011).

In essence, a clinical psychologist who has experience working within an exposure and response prevention framework for OCD can transfer many of these skills to working with BDD. BDD patients, however, tend to have markedly lower insight compared to individuals with OCD. Useful resources have recently been published by the Centre for Clinical Interventions (2013) and are freely available through their website.

CBT targets the mechanisms that maintain the preoccupation with appearance, avoidance behaviours that prevent the patient from habituating to the sight of his or her appearance, and checking behaviour that may provide immediate relief, but, in the long run, keeps the person's attention focused on aspects of appearance that elicit anxiety. It is important to note that the aim of treatment is not to convince patients they look normal, as this will be ineffective given BDD's delusional nature. The emphasis is on reducing the disruption caused by their faulty body image beliefs.

The good news is that CBT treatment is effective. Two comprehensive reviews of treatment efficacy for BDD have been conducted: a Cochrane Review (Ipser, Sander, & Stein, 2009), and a Treatment Practice Guideline for OCD and BDD from the United Kingdom's National Institute for Health and Clinical Excellence (2005). Both these reviews recommended CBT and selective serotonin reuptake inhibitors as first line treatments, though acknowledged that more research is needed.

An evaluation of randomised control trials, published in 2009, included three separate psychotherapy studies (83 participants) (Ipser et al., 2009). The largest of these studies compared 12-week intensive CBT with a waiting list comparison group and found significant improvements, with 81.5% of participants receiving CBT no longer meeting diagnostic criteria post-treatment. Another meta-analysis showed that CBT treatment was significantly more effective than medication after 16 weeks of treatment (Williams, Hadjistavropoulos, & Sharpe, 2006). Longer term follow-up showed that the course of BDD for many individuals was chronic no matter what treatment was received. Phillips, Menard, Quinn, Didie, and Stout (2013) investigated remission rates over 4 years and found that full remission or partial remission of BDD symptoms occurred in 55% of cases.

While most individuals will receive significant benefits from treatment, experience suggests that some patients will continue to struggle. They may seek

psychological treatment and ostensibly accept the BDD diagnosis, while simultaneously investigating or undergoing cosmetic procedures to fix their perceived defect. This level of duplicity is not uncommon, and patients may spend thousands of dollars undergoing risky cosmetic procedures while commitment to therapy can be challenging. Motivational interviewing skills are, therefore, important to keep BDD patients on track, and an emphasis on management of symptoms, rather than a cure, may be more important for those with chronic BDD.

### Conclusion

Correctly identifying and diagnosing BDD is the first challenge for clinical psychologists, given that few individuals with BDD have the insight to identify having BDD themselves. Forging professional connections between dermatologists and cosmetic surgeons represents a key opportunity for clinical psychologists to protect and advocate for this vulnerable patient group. Once BDD is identified and someone commits to treatment, however, research shows that outcomes are good. CBT represents the most effective treatment option for people with this debilitating disorder.

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