What is Body Dysmorphic Disorder (BDD)?

1) A preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.

2) The preoccupation is causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

3) The preoccupation is not better accounted for by another mental disorder

• Insight is typically low in most BDD patients.

Classified under “Obsessive-Compulsive and Related Disorders” in the DSM-5
Common Areas of Concern

- Hair
- Nose
- Skin
- Eyes
- Overall face or head
- Breasts
- Teeth

Other Areas of Concern

- Ears
- Buttocks
- Arms
- Chin
- Lips
- Penis Size
- Body build (Muscle Dysmorphia)
Other BDD concerns

- “Not masculine enough”
- “Not feminine enough”
- “Look like an alien”
- “Look abnormal”

Areas of Concern

- 40% concerned with 1 body part or set of parts
- 37% concerned with 1 part then add new parts
- 21% concerned with 1 part which may get replaced by other parts
Obsessions: Cognitive Aspects of BDD

- Obsess about body part
- 10%: < 1 hour per day
- 25%: 1-3 hours per day
- 25%: 3-8 hours per day
- 40%: More than 8 hours per day
- Feel little to no control over their thoughts

Cognitive Distortions of BDD

- All or nothing thinking
- Unfair comparisons to ideals, others, images
- Filtering (magnifying negative, minimizing positive)
- Blaming appearance for all difficulties and disappointments
- Mind reading
- Misfortune telling
- Personalization (referential thinking), (catch 22)
- Shoulds
Compulsions Associated with BDD

- Mirror checking (88%)
  - Hope to look different
  - Use certain “trusted” mirrors
  - Anxiety if do not check
  - “Mental cosmetic surgery”
  - Attend to internal feelings rather than concrete image
  - Lose track of time
  - Almost always feels worse after checking
  - Use of ambiguous reflections

- Mirror avoidance (35%)

Compulsions Associated with BDD

- Camouflaging (90%)
- Excessive grooming/beautification (47%)
- Skin Picking (32%)
- Reassurance Seeking (51%)
- Compare to others/Scrutinizing others appearance (90%)
- Exercise
- Distraction

*Behaviors often exacerbate BDD symptoms and can even create a defect/flaw*
Cosmetic Surgery and BDD

• Studies have shown that anywhere from 50%-77% of BDD patients have sought out cosmetic procedures (mostly dermatological)

• Studies have found that 7%-33% of cosmetic surgery patients had BDD

• Assumptions: Lives will “fall into place”, “everyone will like me”, “have total confidence”, “will be anxiety free”

Cosmetic Surgery and BDD

• Studies show that 76%-83% of BDD patients are just as dissatisfied or more dissatisfied

• Many who are satisfied grow dissatisfied with other parts

• Can develop “polysurgery addiction”

• Patients can become hostile toward surgeons

• Excessive surgeries can result in actual defects or flaws or “plastic” look

• Surgeons taking more notice of BDD
Impairment in Functioning

- Social Impairment (98%)
- Occupational/academic impairment (83%)
- Hospitalization (46%)
- Housebound (30%) (Become nocturnal)
- Suicide attempts (23%)
- Drop out of school (18%)
- Relational Impairment (30%) (marital, family, peers)

With BDD, appearance is not simply a relative matter of style

People with BDD often change their social and professional lifestyles to avoid appearing in public.

People with BDD spend excessive time trying to look presentable, which can affect daily schedules

Westwood Institute for Anxiety Disorders, 2019
Prevalence of BDD

- 1-2% of the U.S. general population (3.2 to 6.5 million people)

- In about 70% of the cases, the onset of BDD occurs before the age of 18.

Veale, 2000; Westwood Institute for Anxiety Disorders, 2019

The Under-Diagnosis of BDD

- The notorious secretiveness of BDD patients (shame)

- Housebound

- Likelihood to seek non-psychiatric help instead (e.g. medical or cosmetic procedures)

- Inadequate training and experience of internists, dermatologists, plastic surgeons, and even psychologists in spotting and redirecting a BDD patient.
  - One study reported that 25 patients with BDD had underwent a total of 46 cosmetic procedures before they were diagnosed with BDD

Veale, 2000; Westwood Institute for Anxiety Disorders, 2019
Comorbid Disorders

- Major depression disorder (most common)
- OCD
- Social anxiety disorder (social phobia)
- Delusional disorder
- Substance-related disorders
- Eating disorders

Muscle Dysmorphia

- Preoccupation that one is not big or muscular enough
- Obsessional thinking (report more than 5 hours per day) marked with distress

APA, 2013; Westwood Institute for Anxiety Disorders, 2019
Muscle Dysmorphia

• Associated Behaviors:
  - Long hours weight lifting or exercising
  - Mirror/Reflective Surfaces Checking
  - Reassurance Seeking
  - Measuring oneself
  - Camouflaging
  - Comparing to others
  - Avoidance
  - Excessive attention and rigidity in regards to diet
  - Engaging in behaviors despite adverse consequences or injury

Muscle Dysmorphia

• Impairs social and occupational functioning

• Associated with depression (58%), eating disorders (29%) and anxiety disorders (29%)

• Significantly different from comparison weightlifters
Anabolic Steroid Use

- 3-4 million people from 13-50 use anabolic steroids
- 1 million satisfy criteria for dependence
- 22% of users begin before the age of 20.
- Studies of high school boys find anywhere from 1.4% to 6% have used steroids

“Orthorexia”

- Obsessing about eating healthy
- Purity, natural, Food quality emphasized
- Minimize or eliminate preservatives, additives
- Strive to eat “clean”
- Often vegan or vegetarian, raw foods
- Hardly eat outside the home
“Orthorexia”

• Adhere to routines (e.g. eat every 2 hours)
• Couples with excessive exercise
• Constantly thinking about food
• Spend hours in food preparation, storage, shopping, reading
• Value healthy eating to detriment of other life activities
• Not always motivated by thinness or esthetics

Eating Disorders in Men

• 1 in 4 people with eating disorders (25%) are male
• 1 in 20 eating disorder patients (.05%) are male
• At least 10-15 million males are affected by eating disorders
• Subclinical eating disordered behaviors are nearly as common among males as they are among females
BDD and Eating Disorders

Anorexia Nervosa

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health)

- Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).

- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

- Restricting or Binge Eating/Purging Type
Binge Eating Disorder

• Recurrent episodes of binge eating characterized by both of the following:

  – Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

  – A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

Binge Eating Disorder

• Episodes are associated with three or more of the following:

  – Eating much more rapidly than normal
  – Eating until feeling uncomfortably full
  – Eating large amounts of food when not feeling physically hungry
  – Eating alone because of feeling embarrassed by how much one is eating
  – Feeling disgusted with oneself, depressed or very guilty afterward
  – Marked distress regarding binge eating is present
  – Binge eating occurs, on average, at least once a week for three months
**Bulimia Nervosa**

- Recurrent episodes of binge eating

- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.

- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.

- Self-evaluation is unduly influenced by body shape and weight.

**Eating Disorders**

- 30 million people suffer from eating disorders

- 20 million women, 10 million males

- 15%-20% mortality rate (suicide, medical complications)

- Various causes (Genetic, biological, social-cultural, personality, environment, trauma, comorbid disorders)

- Only 10-15% of women with eating disorders seek treatment

- Even smaller % of males with eating disorders seek treatment

- Recovery is possible
Negative Body Image

- They are concerned with negative body image that cause significant emotional distress and impair functioning

- Differences:
  - In BDD, the main concerns are specific body parts
  - In ED, the main concerns are general shape and weight concerns

- Individuals with BDD and AN in particular have both shown to have abnormal visual processing (Madsen et al, 2013)

Perfectionistic Tendencies

- Both BDD and ED are associated with higher perfectionistic concerns compared to healthy controls (Buhlmann et al, 2008).

- Frequently perform checking behaviors, including mirror gazing, weighing self, seeking reassurance, measuring body parts (APA, 2013)
Avoidant Behaviors

- Both BDD and ED are characterized by avoidant behaviors, such as in public spaces and in relationships with other people

- Compared with ED, those with BDD have reported more avoidance (Rosen and Ramirez, 1998)

Comorbid BDD and ED

- Females with BDD are more likely to have a comorbid ED (APA, 2013)

  - 32.5% of BDD patients had a comorbid lifetime ED
    - 9.0% with AN
    - 6.5% with BN
    - 17.5% with ED not otherwise specified
  - Compared with BDD only group, comorbid BDD and ED had higher rates of hospitalization for psychiatric problems, psychotherapy sessions, and medications
Treatment Implications

- In treatment, all disorders must be taken into consideration

- Treatment obstacles and hurdles in all:
  - 1) Delusion component
  - 2) Mood changes

- It is necessary to work with a bio-medical and psychiatric team, especially with EDs

Treatment Goal

- “Resizing” the defect = not giving in to the feeling that gives patients a wrong signal.

  - Deeply rooted self-esteem issues of body image that are present and work against the development of proper insight and correct perspective.

  - “Surgery” on self-image
Treatment Modalities

- Psychoeducation
- Nutritional Management
- Cognitive-Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Acceptance and Commitment Therapy (ACT)
- Psychopharmacology

Psychoeducation

- Increase insight into the disorder

- Mindful awareness training to help patients identify emotions/situations (cues) that lead them to perform ritualistic behaviors

- Family education
Nutritional Management

- Stabilizing eating behaviors is a priority to ensure medical status is restored within the normal level

Cognitive-Behavioral Therapy (CBT)

- Addresses distorted and negative cognitive processes by challenging them and replacing them with more accurate and realistic thinking patterns
- Effective combination of CBT and medication
- Exposure and Response Prevention (ERP)
Dialectical Behavioral Therapy (DBT)

- Mindfulness
- Distress Tolerance
- Interpersonal Effectiveness
- Emotion Regulation

Acceptance and Commitment Therapy (ACT)

- Cognitive defusion
- Allowing unwanted thoughts and feelings to come and go without struggling with them.
- Awareness of the here and now
- Values: Discovering what is most important to oneself
- Committed action: Setting goals according to values and carrying them out responsibly, in the service of a meaningful life.
Psychopharmacology

- Studies have indicated that SSRI’s are effective for patients with BDD and/or bulimia
- Higher doses and longer treatment trials than depression
- Improvement varies
- No approved medication for anorexia.

Case Study

- 45-year old female BDD patient.
- Classic treatment refractory case.
  - Had not responded to several prior treatments for OCD and BDD or to a variety of SRIs.
- Had 17 plastic surgeries prior to getting treatment
- Patient scored 32 on the Yale-Brown Obsessive – Compulsive Scale for Body Dysmorphic Disorder (BDD-YBOCS).
Case Study

• Patient established rituals in an effort to protect herself from aging and becoming ugly.
  • Performed 20 to 30 facial wraps a day.
  • Washed her face 40 times daily.
  • Scrutinized the symmetry of her body parts.
  • Put cosmetics on in a particular ritualized order.
  • Frequently looked into mirrors seeking reassurance that she was attractive.
  • Rituals required more than 8 hours a day.

• She missed her 35th birthday party and appeared at the location 32 hours late, because she was absorbed in perfecting her face.

Westwood Institute for Anxiety Disorders, 2019

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Case Study

• Patient was gradually exposed to the distorted mirrors.

• Patient was instructed to:
  • Wear mismatching jewelry and clothes
  • Apply makeup on one eye but not the other

• The distorted mirrors grossly exaggerated her perceived imperfections.

Westwood Institute for Anxiety Disorders, 2019
Case Study

• At the termination of treatment scores on the Yale-Brown Obsessive-Compulsive Scale for Body Dysmorphic Disorder had decreased from 32 to 10.

• At 5-year follow-up, patient had not undergone any further surgeries.

Case Study: “Kevin”:
BDD, MD and ED

• History of Anorexia Nervosa
• Less concerned about fatness
• Weight loss triggered by genital size
• Dissatisfied with thin body
• Began binge eating and weightlifting obsessively
• Could never be big enough
• Came to therapy after losing job and long-term girlfriend
Case Study: “Kevin”:
BDD, MD and ED

- First focused on normalized eating
- Reducing compulsions
- ERPs
- Psychotherapy around masculinity and self esteem
- ACT
- Assertiveness Skills
- SSRI’s helped with “sticky” thoughts

Body Dysmorphic Disorder, Eating Disorders and Muscle Dysmorphia

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