COMPLEXITIES OF TREATING OCD DISORDERS: BDD

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Differential Diagnosis with OCD

- Perfectionism & Symmetry
  - **OCD:** Of objects, environment, even hair on body
  - **BDD:** Of body size, shape
  - Core fears different:
    - BDD: unattractive, rejection, loneliness, rejection
    - OCD: magical thinking, right feeling
- Co-morbidity: About 28% of BDD have OCD

Differential Diagnosis with Anorexia

- **Both have body image & perceptual disturbances**
  - Focus on weight & stomach/thighs in AN
  - Focus typically on facial features in BDD
- **Often co-morbid**
  - Weight/medical stabilization first
  - Body image behaviors & cognitions similar
- **Disordered eating vs. eating disorder**
  - In BDD, restricted diet to improve body part (muscle dysmorphia excessive protein intake) or avoiding specific foods (greasy food to prevent acne)
- 32% of BDD have an eating disorder

Differential Diagnosis with Excoriation Diorder (Skin Picking)

- **Similarities:** Picking behavior, visually cued, causes urges and distress, need to remove bump/sensory cues

- Differences: Primary motivation varies
  - **Skin picking:** urges and relief, habitual, self soothing
  - **BDD**: Targeted to perceived skin imperfections

- Over time in BDD, the picking acquires secondary functions similar to Excoriation Disorder.
  - Treat both aspects of the behavior

Common Struggles in BDD

- Engagement
- Cosmetic Surgery
- Suicide risk
- Altering CT and ERP

Case Example: Late Onset

- **Late Onset:** 45 year old BDD onset after accident. Bumped nose on kitchen cabinet.
  - Flaw is real not imagined. Seeking cosmetic surgery, leave from work, depression. Accident took away her feelings of youth & beauty.

Case Example: Co-morbid AN & BDD:

- 26 year old female with restrictive eating with medical complications of bone loss. Weight restored (-5 lbs). Mirror checking, avoidance of certain clothing, other perfectionism.
- Primary body parts weight, stomach, thighs. Secondary focus on face symmetry & hair.
- Body Image Beliefs
  - Letting go of my weight is evidence that I'm not in control. Weighing more = failure, My weight is ok for others but not me.

Engagement Tips

- Flexibility on location and delivery of therapy.
- Avoid debate over existence of the perceived flaw in appearance.
- Focus on interference of the preoccupation.

Addressing Desire For Cosmetic Surgery in Treatment

- Incorporate family into sessions; family therapy.
- Share the research outcome for surgery in those with body image dissatisfaction.
- Bargain for time in therapy; delay surgery; therapy to address the anxiety and depression that body image causes first.
- If you're going to do the surgery, let's work on realistic expectations & improve mood to be better prepared.
- In early stages of therapy, be open to conversations about surgery; "Tell me more about why you want to seek surgery? What are your goals?"
- Catch ambivalence in patient and explore it.
- Pre-surgery expectations *impact* post-surgery satisfaction.
- Accompany patient to consultations with cosmetic surgeons.

Order of Treatment Strategies

1. Assessment
    1. suicidality initially and regularly
    2. Assess previous history of treatment in detail
2. Engagement
    1. Psychoeducation
    2. Motivational Interviewing
3. Address depression first if it is interfering with treatment engagement
4. Cognitive therapy
5. Perceptual and Mirror Re-training
6. ERP is more gradual with focus on functionality & quality of life
7. Adjunctive techniques including ACT & DBT to target emotion dysregulation, engagement, values
8. Address overall quality of life; life goals social skills strengthening

Tips for Cognitive Therapy for BDD

- Do not dispute the existence of the perceived flaw
- Focus instead on distress, **over importance** of appearance and **value** of appearance
- Target mind reading and selective bias of information
- Do not indicate that you see the flaw or state that "it's not too bad" or "many people have similar flaws" or" it's only noticeable if someone pays close attention to your face."
- Do not engage in reassurance giving that the patient is attractive or normal looking
- Be cautious in accepting worst case scenario ("If the flaw existed, then could you live your life?"); especially in the early stages of therapy

Exposure and Response Prevention for BDD vs. OCD

- Do not exaggerate perceived flaw until last stages of treatment, *if at all (keep OVI in mind)*
- Monitor suicidal ideation
- Minimal to no humor *(different than OCD)*
- More shame & depression to ERP
- Design exposures that increase patient's quality of life and functionality
- Discuss goal before an ERP & discuss conclusions after an exposure *(What did you learn from that experience?)*

Treatment Beyond CBT

- Symptoms that persist despite evidence based CBT treatment.
  - Perfectionism
  - Rejection sensitivity
  - Detailed focused visual processing
  - Shame & self-criticism
  - Self focused attention/attention biases
- What other empirically supported treatments can be applied to BDD?
  - DBT, ACT, Compassion Focused Therapy, Meta-cognitive techniques (attentional training, task concentration)