

Article 9

When Body Image Becomes a Disorder

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Introduction

Body Dysmorphic Disorder (BDD), also known as dysmorphophobia is a disorder that may sound unfamiliar, but has actually been in existence for over 100 years, being first reported in medical literature around the year of 1891 (Hill, 2006). According to the *DSM-IV-TR* (American Psychiatric Association [APA], 2000), BDD is classified as a Somatoform Disorder, meaning there is the "presence of physical symptoms that suggest a general medical condition and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder" (p. 485). The disorders that fall under this broad category of 'Somatoform Disorders' include (a) Somatization Disorder, (b) Undifferentiated Somatoform Disorder, (c) Conversion Disorder, (d) Pain Disorder, (e) Hypochondriasis, (f) Body Dysmorphic Disorder, and (g) Somatoform Disorder Not Otherwise Specified (*DSM-IV-TR*, APA, 2000). In short, the above present with physical symptomology which have underlying emotional/psychological roots and no general medical condition can be originated as the cause for the symptoms. The primary indicator for BDD is "a preoccupation with a defect in appearance, the defect is either imagined, or if a slight physical anomaly is present, the individual's concern is markedly excessive" (*DSM-IV-TR*, APA, 2000, p. 507). An individual suffering from BDD usually seeks treatment for a physical problem when in reality the problem is emotionally and psychologically based as a psychiatric disorder. For example, an individual may perceive their nose as rather large, disfigured, and the source of their problems: They believe the way to 'cure' this ailment, is to consult with a cosmetic surgeon for a rhinoplasty (e.g., nose job). However, Phillips, Grant, Siniscalchi, and Albertini (2001) found that 61.4% of individuals with BDD who sought either cosmetic surgery or dermatologic treatments reported no improvement in their perceived flaw and some individuals found the treatment worsened the initial complaint. Figueroa-Hass (2009) reported that BDD "tends to be unrelenting and can lead to social exclusion, major depression, unnecessary surgery, and even suicide" (p. 379).

Prevalence

In a society where ‘looks are everything’, and it’s just not about who or what you know, but more importantly ‘what’ you look like, it is important to discuss the psychiatric disorder Body Dysmorphic Disorder (BDD). Phillips (2005) stated that “many, including health professionals, still aren’t aware that BDD is a known disorder that often responds to psychiatric treatment,” and she found that most mental health professionals in particular, “had never even heard of BDD” (p. 39). However, research studies have continued to find that almost everyone, regardless of one’s sex, is at times dissatisfied with some aspect of his or her appearance (Cash, 1997). Who hasn’t looked in a full length mirror and thought, “I wish I were thinner,” or glared at those favorite pair of ‘skinny jeans’ and thought, “If I only I could still fit in those,” or looked at an old photograph and thought, “Gee, I have I lost that much hair?” For individuals not currently suffering from Body Dysmorphic Disorder, these thoughts are fleeting and do not seem to impair one’s functioning in everyday life. However, for those diagnosed with BDD, these thoughts are played over and over again just like a broken record in one’s head. These repetitive thoughts about a flaw or multiple flaws in one’s appearance may be viewed as minor or nonexistent to an outsider, but to the individual with BDD it causes a lifetime of torture if left untreated, misdiagnosed, or even missed completely.

For those of you whom are wondering, “What is BDD?”; it is actually fairly common, with about 1% of the general population being affected and some estimates state 0.7 to 2.3% (Glaser & Kaminer, 2005; Phillips, 2005; Phillips & Dufresne 2002). Other populations have been identified at increased risk of BDD: 13% of people hospitalized in psychiatric facilities (Phillips, 2005); 2% to 13% of students, both those attending high school or college (Dyl, Kittler, Phillips, & Hunt, 2006; Phillips, 2005); about 12% of those seeking dermatologic treatments (Phillips, 2005; Phillips, Dufresne, Wilkel, & Vittorio, 2000); and anywhere from 6% to 20% of individuals seeking cosmetic surgical procedures (Phillips, 2005; Phillips et al., 2001). Ruffolo, Phillips, Menard, Fay, and Weisberg (2006) further revealed that BDD has a high comorbidity rate with Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, and other variants of Eating Disorder Not Otherwise Specified (EDNOS) with 32.5% of those also meeting criterion for BDD (p. 14). Other comorbid disorders frequently found with BDD also include Major Depressive Disorder with 14% to 42%, Social Phobia at 11% to 12%, and people with Obsessive-Compulsive Disorder is around 3% to 37% (Phillips, 2005, p. 38). BDD does not discriminate and affects men and women of all ethnicities equally.

Symptoms

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000), defines BDD as:

- A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.
- B. The preoccupation causes clinically significant distress or impairment in social, occupational, and other important areas of functioning.
- C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa; p. 510).

Body Dysmorphic Disorder is categorized as a Somatoform Disorder in the *DSM-IV-TR* (APA, 2000). Claiborn and Pedrick (2002) reported that, “clearly, to people with BDD the defects are present and are not slight,” and the individual “may not see their reaction as excessive at all” (p. 10). In addition, the significant distress and impairment in all important areas of functioning can be presented in many forms such as “serious depression, or clinical depression” as well as “suicidal thoughts and attempts” in people who have BDD (Claiborn & Pedrick, 2002, p. 11). There are also various symptoms associated with the preoccupation with the defect in appearance such as excessive grooming rituals, attempts to correct the flaw, measurement of the flaw, repeated viewing of the flaw in a mirror, and the use of camouflaging. Camouflaging takes the form of crafty ways the individual with BDD attempts to hide, cover up, fix, or otherwise try to make the imagined flaw or slight defect in one’s appearance unnoticeable. The more common methods used are baggy clothing, excessive make-up or tanning, hats, and the strategic placement of one’s hair or the use of a body part such as an arm or hand over the imagined flaw.

Causes

In short, the exact cause of BDD appears to be unknown. However, Phillips (2005) discovered in her research that some theories exist in the development of BDD in which the cause is multifaceted from a neurobiological, psychological, and sociocultural standpoint. From the neurobiological model one may view the cause of BDD as a result of a genetic predisposition, malfunctioning of the brain, abnormalities in the structure of the brain, and deficits of the neurotransmitter serotonin, which would increase the susceptibility of one to develop BDD (Phillips, 2005). Some psychological factors may also increase the risk of BDD such as experiencing a major life event, possessing particular personality traits, influence of pubertal changes, or the lack of self-esteem (Phillips, 2005). Additionally, we cannot forget the impact of society’s view of the ‘thin ideal’ and the overall importance of appearance that we are barraged with everyday in the various forms of media we encounter day to day such as film, advertisements, magazines, billboards, song lyrics, etc. (Cororve & Gleaves, 2001; Rosen & Rameriez, 1998; Rosen, Reiter, & Orosan, 1994). In some cases the trigger for the onset of BDD may simply start with “a chance remark about appearance, such as “Why is your face half red and half white?” (Phillips, 2005, p. 181).

Treatments

Just as the ability to understand the development of the disorder should be approached from the multiple areas, the best treatment is one that involves collaboration between the prescribing physician and/or psychiatrist, and the mental health professional which ultimately combines both psychopharmacotherapy and psychotherapy. Keep in mind that just as symptomology is experienced differently from a person to person, the treatment method should also be specialized to each individual’s case. In Phillips’ (2005) book, *The Broken Mirror* (2005), she even indicated the best Selective Serotonin-Reuptake Inhibitors (SSRIs) to use from the generic names to the brand name to the typical dose range (e.g., milligrams per day) in Table 12 (p. 216):

<u>Generic name</u>	<u>Brand name</u>	<u>Typical Dose Range</u>
Citalopram	Celexa	20-60 mg
Escitalopram	Lexapro	10-20 mg
Fluvoxamine	Luvox	100-300 mg
Fluoxetine	Prozac	20-80 mg
Paroxetine	Paxil	20-60 mg
Sertraline	Zoloft	50-200 mg
Clomipramine	Anafranil	100-250 mg

Phillips (2005) reported that patients who respond to SSRIs improve by “spend(ing) less time obsessing, it’s easier to push the thoughts aside, and some people think they actually look better than they used to” (p. 221). In addition it is common to see “anxiety, depression, and suicidal thinking diminish, BDD-related behaviors diminish, and people are better able to cope with their appearance problem” (Phillips, 2005, p. 221). However, even as Phillips (2005) noted in her book, medical research studies examining the treatment outcomes from the use of these different SSRIs are greatly needed to establish the most effective and beneficial medication for BDD.

The second, most researched type of treatment for BDD is Cognitive-Behavioral therapy, often referred to as CBT. When this treatment is broken down, the ‘cognitive’ portion is related to helping the client with BDD “identify, evaluate, and change unrealistic ways of thinking,” and the ‘behavioral’ portion refers to the “problematic behaviors, such as checking and avoidance of social situations” (Phillips, 2005, p. 249). The primary interventions utilized for BDD are (a) response ritual prevention, (b) cognitive restructuring, (c) behavioral experiments, and (d) exposure (Phillips, 2005, p. 249). Response ritual prevention is when a mental health professional assists a person with BDD identify behaviors such as excessive grooming, flaw checking, or reassurance seeking by trying to reduce or eliminate these behaviors. Cognitive restructuring is the ability to identify negative thoughts and faulty beliefs about one’s appearance or flaw to transform these into more realistic beliefs. Behavioral experiments are frequently used as a way to test those hypothetical beliefs (e.g., the what if’s or educated guesses about what will happen), such as “People will run away screaming in terror if I do not have make up on.” A therapist would assist the individual with BDD by examining their hypothesis, and then the therapist and the client would review either the evidence or factual support for and against the hypothesis. Lastly, exposure is when a client is asked to create a graduated hierarchy of exposure to certain events or situations in a hierarchical fashion from 0 (least threatening or anxiety provoking) to 100 (the most threatening or anxiety provoking). For example, zero may equal sitting in the dark in one’s own bedroom; 30 may represent walking by a mirror in a department store; 50 may be looking at some old photographs; 80 could represent going to a department store and asking a sales clerk for help in the dressing room; and 100 could represent going on a blind date with no make-up on. After the hierarchy has been constructed, the goal would be to ‘expose’ the client suffering from BDD to the least anxiety and threatening situations till they feel comfortable all the way up to the most anxiety and stress inducing situations. It is best if you are encountering individuals with BDD that you actively seek further training utilizing CBT with patients with BDD and pursue professional consultation and clinical supervision by someone whom specializes in treating BDD.

Implications for Health Professionals

It has already been mentioned how several people in the general public, health professions, and especially those in the mental health field often do not know about Body Dysmorphic Disorder, the signs and symptoms, diagnostic tools, the prevalence, causes, and effective treatment options. This is a disorder that holds intense shame and humiliation due to the fact that one's perceived flaw or defect in their appearance ruins their life. Imagine approaching your primary care physician and telling him or her, "My appearance is ruining my life," how difficult this may be, and the fear of being labeled as vain or having a trivial anomaly. This is suspect as to why some individuals do not seek treatment. These beliefs cause the sufferer to believe that their condition is one that is 'physical' in nature and can be 'fixed' as a means of dermatologic treatments, cosmetic surgical procedures, or even as severe as self-surgery, instead of a condition that is psychologically based. Since we have already discussed the comorbidity with BDD primarily with individuals diagnosed with Anorexia Nervosa, Social Phobia, OCD, and Major Depressive Disorder, which may ultimately be the secondary symptoms of the primary disorder of BDD, it would be helpful to use some assessment tools related to BDD. The assessment tools related to diagnosing BDD are as follows: the Body Dysmorphic Disorder Examination (BDDE; Phillips, Hollander, Rasmussen, Aronowitz, DeCaria, & Goodman, 2000), Overvalued Ideas Scale (Neziroglu, McKay, Yaryura-Tobias, Stevens, & Todaro, 1999), Yale-Brown Obsessive-Compulsive Scale; Body Dysmorphic Disorder Modification of The Y-BOCS (BDD-Y-BOCS; Rasmussen & Goodman, 2000), Body Dysmorphic Disorder Diagnostic Module (Albertini & Phillips, 1999), and Body Dysmorphic Disorder Questionnaire (BDDQ; Phillips, 2005).

If a practitioner is located in a school or university setting, and they suspect that a client may be suffering from an eating disorder, a mood disorder, or an anxiety disorder, it may also be worth looking into the BDD diagnosis as a possible disorder to rule out. If one does not have easy access to one of these instruments, a series of questions can be simply asked in an initial interview such as:

1. Do you have any concern with your appearance?
2. If so, what area or areas trouble you?
3. How does your appearance impact your everyday life such as school, work, social situations, relationships, etc.?
4. Do you frequently look into mirrors to examine your appearance?
5. If so, how long do you spend looking into mirrors, and how do you feel when you are looking in the mirror?
6. Do you engage in some grooming behaviors that may take up a lengthy period of time?
7. If so, what does your typical grooming day to day behavior look like?

After you have the answers to the above questions, then these answers may further warrant in exploration into the BDD diagnosis. To start, as with any therapy session, it is most important to convey that sense of empathy, acceptance, understanding, and the ability to be nonjudgmental especially for individuals suffering from BDD, a disorder that holds so much humiliation and shame. Although BDD has been around for over 100 years, the disorder is still fairly new in terms of being researched. Thus more

investigation to the causes, implications, and effective treatment options is something that must be explored in future research studies.

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