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Advances in Psychotherapy –
Evidence-Based Practice

Body Dysmorphic Disorder

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Description

1.1 Terminology

Body dysmorphic disorder (BDD), previously considered a somatoform disorder, was incorporated into the newly established *obsessive-compulsive and related disorders* (OCRDs) in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). This category consists of disorders characterized by intrusive thoughts (obsessions) or repetitive behaviors (compulsions) (see Section 1.3).

1.2 History

BDD (referred to then as "dysmorphophobia") first appeared in the DSM in the 3rd edition (DSM-III; American Psychiatric Association, 1980) as an "atypical somatoform disorder." Diagnostic criteria were not included, resulting in minimal attention in the psychiatric literature.

With the publication of the DSM-III-R (American Psychiatric Association, 1987), BDD was established with diagnostic criteria as a "somatoform disorder," and the term was changed to "body dysmorphic disorder." No changes occurred in the publication of DSM-IV and DSM-IV-TR. The current DSM-5 diagnostic criteria are more detailed, reflecting the increase in recognition and research. The criteria include specifiers including insight levels.

BDD first appeared in the psychiatric literature in 1891, with the publication of a paper by an Italian psychiatrist Enrico Morselli. He coined the term "dysmorphophobia," noting the desperation and intensity of the fear and thoughts (Morselli, 1891). Other European psychiatrists, including Pierre Janet, Emil Kraepelin, and most famously Sigmund Freud, have published case histories of BDD patients. Freud's Wolf Man was a Russian aristocrat who had a preoccupation with the shape of his nose, accompanied by frequent mirror checking. He carried a small mirror in his pocket, checked for pores, and powdered his nose multiple times a day. His nickname came from recurrent dreams of wolves staring at him. He was later treated by one of Freud's protégées, Ruth Brunswick, who published a paper in 1928 describing his symptoms in detail (Brunswick, 1928).

The disorder was largely unknown until the *OCD spectrum* of related disorders became a model for conceptualization and treatment, leading to the official classification of obsessive-compulsive and related disorders in 2013.

2.2.2 Learning Theory

Learning theory is based on how individuals learn thoughts and behaviors and how they are maintained. Models have focused more on maintenance and triggers than on etiology. Veale (2004; Veale et al., 1996) and Neziroglu (2004) have proposed cognitive behavior models specific to BDD that incorporate several themes of Cash's cognitive learning social model of body image disturbance (Cash, 1997, 2002). The Cash model describes how societal, interpersonal, physical, and personality attributes all contribute to the development of body image perception. This perception, and the emotional consequences that come along with it, are strongly maintained through negative reinforcement. There are two different bases from which cognitive behavior theory can spring. Neziroglu and colleagues have emphasized a cognitive behavior model based on social learning and relational frame theory (Neziroglu, Roberts, & Yaryura-Tobias, 2004; Neziroglu, Khemlani-Patel, & Veale, 2008). Veale and colleagues, however, have proposed a model based on the self as an aesthetic object (Baldock & Veale, 2017; Veale, 2004).

2.2.3 Cognitive Behavior Model Based on Social Learning

Biological Predisposition

In Figure 1, "biological predisposition" refers to the diathesis-stress model in which an individual has to have a certain biological predisposition to developing a disorder. These factors can be neuroanatomical or neurochemical, or reflect genetic vulnerabilities.

Childhood Operant Conditioning

In Figure 1, "operant conditioning" refers to what a child experiences early on in life, which can play a crucial role in the development of BDD. When interviewing individuals with a BDD diagnosis, Neziroglu and colleagues found that appearance was highly reinforced during these early, salient periods (Neziroglu et al., 2009). If not reinforced during childhood, many of these individuals were reinforced at some point during their adolescence, for attention to their appearance, either to a particular body part or their general attractiveness. This reinforcement process solidifies the belief that appearance is the most important personal characteristic to the exclusion of behavior.

A CBT model explains the etiology and maintenance of BDD with neurobiological predisposition and environmental factors, including social learning and reinforcement.

The value system in which we examine physical attractiveness can stem from early, traumatic experiences, such as emotional and sexual abuse (Didie et al., 2006; Neziroglu et al., 2006) and bullying (Neziroglu et al., 2018). These traumatic events normalize the experience of negative affect. Later in life, this normalcy is replicated and reintroduced as the person observes their body (Cash et al., 1986; Osman et al., 2004; Rieves & Cash, 1996; Veale, 2004; Zimmerman & Mattia, 1999).

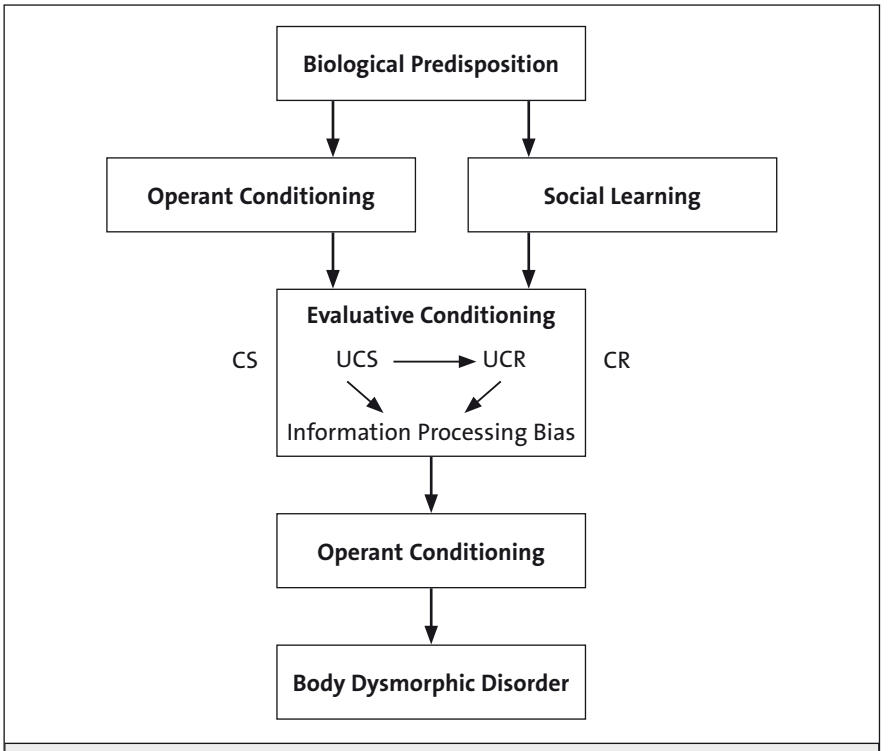

Figure 1
Cognitive therapy model based on evaluative and operant conditioning. Refer to the text for explanations of the different stages in the model. CR = conditioned response; CS = conditioned stimulus; UCR = unconditioned response; UCS = unconditioned stimulus.

Social Learning

In Figure 1, "social learning" refers to observing the reinforcement of beliefs and behaviors in other people, whether positive or negative, which can result in *vicarious learning* (Bandura, 1977). Vicarious learning of the importance of attractiveness can be affected by the sociocultural environment, with social media, social status, cultural body ideals, and the quest for physical perfection all playing a role. This vicarious learning can also be affected by one's closest social circles, such as immediate family and friends. In familial circles, the largest influential effect on learning is made through direct comments about eating, weight, and the body generally, rather than parental modeling of maladaptive behavior (Levine & Smolak, 2002).

Symptom Development Through Classical and Evaluative Conditioning

In Figure 1, just as classical conditioning utilizes physiological responses to reinforce or extinguish behavior, evaluative conditioning relies on the feelings toward a stimulus, such as liking or disliking, to fulfill the same function. Evaluative conditioning uses classical conditioning terminology to describe the pairing of two stimuli (unconditioned and conditioned) that results in a change of valence towards the stimuli (conditioned response).

tation a source of avoidance and distress? Gather details on a workday versus a weekend to help identify sources of distress and dysfunction. The typical day is used in two ways: as an initial diagnostic and severity measure and then later to gather specific behaviors and avoidance to help build a hierarchy. Hierarchy development will be discussed in Chapter 4 as a hierarchy method (see Developing a Hierarchy, in Section 4.1.4: Cognitive Behavior Therapy for BDD).

3.3 Factors That Influence Treatment

Treatment planning is most effective when consideration is given to the client's clinical presentation, cultural background, demographics, and previous treatment history.

3.3.1 Overvalued Ideation

Overvalued ideation (OVI) is likely the most challenging and interfering variable in treatment engagement and early assessment is highly recommended. Patients are unlikely to engage in treatment if they believe their suffering is a consequence of their physical flaws. Developing a shared conceptualization of the disorder as described below is necessary with high OVI. Treatment will progress at a slower pace allowing adequate time for rapport building, cognitive therapy, motivational interviewing, and psychiatric interventions. Exposure and response prevention exercises are less likely to result in the intended shift in learning. Patients with high OVI may not understand the purpose of the exposure exercise or come away from the experience with distorted conclusions. Previous beliefs may be solidified rather than challenged, so ERP should be delayed or adjusted to account for the degree of OVI. Chapter 4 provides specific suggestions on how to prepare the client for these exercises (see Section 4.1.4).

3.3.2 Demographic Variables

Age

BDD symptoms are similar across the life span and cognitive behavioral treatment is an effective strategy for all age groups. Clinicians may need to adjust the treatment to address stage of life stressors, such as declining physical health and loss in elderly patients. Body image focus may also be congruent with aging factors, such as hair loss and skin changes.

Describe BDD as a preoccupation with appearance rather than as an imagined defect

Gender

BDD is found equally in both genders and treatment does not have to be adjusted based on gender alone. Body parts of concern may vary between genders, with men being more likely to be dissatisfied with body build. Symptoms overall are similar between the genders.

case of the existence of appearance flaws, depending on the degree of overvalued ideation. Assessing overvalued ideation as CT progresses may provide a benchmark for treatment planning.

As in standard CT protocols, patients should record their automatic thoughts in a thought record and be guided to identify cognitive distortions. Cognitive distortions are the patterns of unhelpful cognitive errors or biases in thinking. As patients record their automatic thoughts multiple times, these distortions become more evident. Appendix 4 provides some examples of BDD-related cognitive distortions.

Levels of Beliefs in Cognitive Therapy

CT can be thought of concentric circles with automatic thoughts on the surface, followed by intermediate beliefs, and core beliefs in the center. To achieve the best chance of long-term cognitive shift toward balanced thinking, it is recommended that clinicians identify, challenge, and replace unhealthy intermediate and core beliefs. Intermediate beliefs are defined as rules and assumptions that apply across situations. Core beliefs are defined by Beck (1976) as "deeply held beliefs about self, others, and the world." Automatic thoughts are the surface level thoughts that get activated in day-to-day life situations.

Examples of Automatic Thoughts

"My nose is big."
"I have a lot of pimples."

Examples of Intermediate Beliefs

"If my appearance is flawed, then I am flawed."
"If I am unattractive, then life is not worth living."
"The more attractive you are, the better your life."
"Attractive people get ahead in life."
"I will not get a partner, because of the way I look."
"Life is not worth living if I can't get surgery."
"One of the most important things in life is attractiveness."
"To keep your partner, you should always stay youthful and attractive."
"I would give a million dollars not to have that flaw."
"If I'm muscular, then people will love me."
"People with good skin are happier and have a better life."

Examples of Core Beliefs

About Self	*About Others*	*About the World*
"I'm inadequate."	"Others can't be trusted."	"The world is a dangerous place."
"I'm unlovable."	"People are out to get me."	
"I'm worthless."		
"I'm abnormal."		

Challenging Intermediate and Core Beliefs

Identifying core beliefs can be done in a few different ways. Clinicians and patients can review completed automatic thought records to identify patterns and clues about deeper beliefs. Another common method is called the *downward arrow technique* in which the clinician asks the patient questions about

impairment at onset of treatment can guide a relapse prevention plan. A step-down schedule can be helpful, with sessions first on a twice a month basis and then a monthly basis until the patient has successfully managed a variety of environmental triggers and life circumstances. If the patient decides to discontinue medication during this time, ongoing therapy should be continued. Family involvement in developing a collaborative relapse prevention plan is also important, as loved ones may be the first to notice any slight reemergence of symptoms, and they can facilitate booster sessions as needed. Relapse prevention strategies have led to better maintenance and continued improvement when compared with no further treatment (McKay, 1999; McKay et al., 1997).

4.5 Problems Carrying Out the Treatments

Engagement and adherence are frequent treatment obstacles. In the case of BDD, clinicians, more often than not, need to weave in alternate treatment methods and anticipate a longer time frame to achieve progress. Techniques such as goal clarification, MI, and family engagement are not optional strategies, as they might be in other disorders. Those techniques should not be rushed in the initial stages of treatment. Often, even patients with better insight will waver in treatment adherence or may struggle with suicidal ideation.

The following is a list of the most common obstacles to the treatment of BDD: (1) high overvalued ideation leading to lack of desire to engage in treatment, (2) suicidal risk, (3) pursuing cosmetic surgery simultaneously with psychological treatment, (4) nonadherence to treatment, (5) family accommodation, and (6) therapist variables.

Interventions for many of these complications have already been covered in the previous sections of this chapter, as they are more often the norm than the exception in this population. High overvalued ideation can be addressed via CT, incorporation of values-based strategies, focusing on patients' suffering and distress about appearance, and therapists' flexibility in treatment delivery.

Suicidality and the desire for cosmetic surgery are addressed below, as both place inordinate pressure on the clinician to manage these critical factors with a patient who is not engaging in treatment in order to address the very problem leading to these high-risk behaviors.

4.5.1 Addressing Desire for Cosmetic Surgery

The desire and active pursuit of cosmetic surgery often places a time-sensitive burden on the clinician to intervene and stop the behavior. Family members are often unable to halt the process or are caught up in unhealthy ways. Patients may enter treatment with a prior decision to pursue cosmetic surgery. At times, family members will have agreed to pay for surgery in exchange for a trial of therapy, assuming therapy will obviate the need for the surgery. The patient's motivation, in these cases, may be to tolerate therapy long enough to satisfy their family's expectations, without a genuine intention to engage

5

Case Vignettes

This chapter will provide case examples to illustrate the variety of clinical presentations in body dysmorphic disorder (BDD). Vignettes will include detailed assessments modeling the recommended steps given in Chapter 4, followed by a synopsis of treatment.

5.1 Case Vignette 1: Post Accident Preoccupation With Nose

Janice, aged 49, was a married high school teacher with a 17-year-old son. She sought treatment for BDD after an unfortunate accident in her home. Her clinical history consisted of a mild preoccupation with skin after developing acne in her teenage years. She sought dermatological treatment at age 17 and recalled anxiety and some social avoidance during college. After 6 months of weekly therapy and a trial of medication, Janice went on to attend graduate school and successfully worked full time. During her pregnancy, she developed acne again which led to excessive preoccupation, mild depression, and mirror checking. She responded well to therapy and a second trial of medication after giving birth to her child. Her clinical history was uneventful after the birth of her son. She cited mild concerns about her overall appearance that did not interfere with functioning.

Approximately 9 months ago, Janice accidently bruised her nose on a kitchen cabinet door resulting in swelling and discomfort for many weeks. She subsequently became convinced that her nose had healed in an irregular manner, looking larger and crooked. Her concern escalated to a daily preoccupation resulting in multiple hours in front of a mirror, depression, difficulty getting out of bed on weekends, and avoidance of social activities. She expressed anger and self-blame for injuring her nose. Janice sought multiple appointments with her physician who told her that she had fully healed. She had been researching cosmetic surgeons for a second opinion, believing an expert could easily observe the damage. Janice recently began a trial of antidepressant medication after struggling for months.

Janice was ambivalent toward a BDD diagnosis since she believed that her problem was based on real damage and not an "imagined" flaw. She had read about the diagnosis and did not believe it applied to her circumstances. She reported recent depression and hopelessness. Janice believed that the accident had taken away her youth and beauty. Janice had a supportive husband and family, and she denied any significant environmental stressors. She did

Maintenance and Relapse Prevention Plan

The most important reasons I want to maintain my gains

The rational coping statements that help me the most

Treatment techniques and coping strategies that help me the most

My support system: Whom can I turn to for support and how can others help me?

What are my triggers? (what makes my BDD worse – e.g., staying home, not getting enough sleep)

What are some warning signs that my BDD is worsening? (e.g., I start to isolate, I mirror check in the evening)

Self-guided exposure exercises to continue practicing (what is my specific plan on how often, when, and where I will practice)