National Register of Health Service Psychologists

CLINICAL WEBINARS

FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

Recognizing and Treating Body Dysmorphic Disorder

Sony Khemlani-Patel, Ph.D.

Bio Behavioral Institute
Great Neck, New York

Webinar Tips for Attendees

Please review our webinar guidelines for frequently asked questions:
www.nationalregister.org/webinar-tips/

1 CE Credit, Instructional Level: Intermediate
1 Contact Hour (New York Board of Psychology)

The National Register is approved by the American Psychological Association to sponsor continuing education for psychologists.
The National Register maintains responsibility for this program and its content.

The National Register of Health Service Psychologists is recognized by the New York State Education Department's State Board for Psychology as an approved provider of continuing education for licensed psychologists #PSY-0010.

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

Sony Khemlani-Patel, PhD

Sony Khemlani-Patel, PhD, is the Clinical Director at the Bio Behavioral Institute in Great Neck, NY, where she has specialized in the evidence-based treatment of OCD and related disorders for 25 years. She is on the Scientific and Clinical Advisory Board of the International OCD Foundation (IOCDF) and Vice President of OCD-New York, which is the NY State Affiliate of the IOCDF. Dr. Khemlani has co-authored three books, the most recent published in 2022 called “Body Dysmorphic Disorder,” in the Advanced Psychotherapy Series with Hogrefe Publishing. She is also on the Faculty of the International OCD Foundation’s Behavior Therapy Training Institute, which provides evidenced-based OCD training for clinicians around the country.

NATIONAL REGISTER
OF HEALTH SERVICE PSYCHOLOGISTS

Disclosures/Conflicts of Interest

- Book Royalties from Hogrefe Press and New Harbinger Publications
- Sub-investigator on a Pharmaceutical Clinical Trial with Biohaven Pharmaceuticals

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

Learning Objectives

1. Describe the phenomenology and clinical features of BDD
2. Discuss how to diagnose BDD and how to differentiate it from other similar conditions
3. List treatment options for BDD

Body Image vs. Appearance

Body Image

- The mental picture we have about ourselves.
  - Cognitions
  - Emotions
  - Perception
  - Behaviors
- Consider sociocultural & personal historical influences.

Appearance

- Our actual observable physical features.
- Size, shape, form, proportion

While appearance may *not* change, one's body image *can* change

DSM-5 Criteria

- Classified under Obsessive-Compulsive and Related Disorders.
- Marked by a preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- At one point during the disorder, the individual has performed repetitive behaviors or mental acts in response to appearance concerns.
- The appearance preoccupation is ***not*** better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders (5th ed.), *American Psychiatric Association*, Arlington, VA.

Specifiers

- Insight
  - Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., “I look ugly” or “I look deformed”).
    - With good or fair insight
    - With poor insight
    - With absent insight/delusional beliefs

- Muscle Dysmorphia
  - The individual is preoccupied with the idea that their body build is too small or insufficiently muscular.
  - Specifier used even if individual is concerned about other body parts.

Defining Overvalued Ideation

- Poor Insight
- Inability to recognize ideas as irrational or extreme.
- Belief that obsessional fears are realistic and compulsive rituals prevent disastrous consequences.
- OVI is a continuum of thought pathology from normal to delusional.

BDD is Largely Under-Diagnosed

- Lack of awareness & familiarity by clinicians.
- Misdiagnosis as social anxiety, OCD, mood disorders.
- Frequent seeking of non-psychiatric services.
- Secretiveness, shame
- Trivialization

Demographics & Prevalence

- BDD affects 1.7% to 2.9% of the general U.S. population.
- Average age of onset is early teens.
- Generally 1:1 gender distribution with a slightly higher propensity in females.
- BDD is found in appearance enhancing medical practices.
  - 5% to 7% in cosmetic surgery
  - 8.5-15% in dermatological practices
  - 20.7% in Rhinoplasty clinics
- BDD in mental health
  - 8% of people with depression
  - More than 12% of people seeking mental health treatment

BDD: The Severity of the Disorder

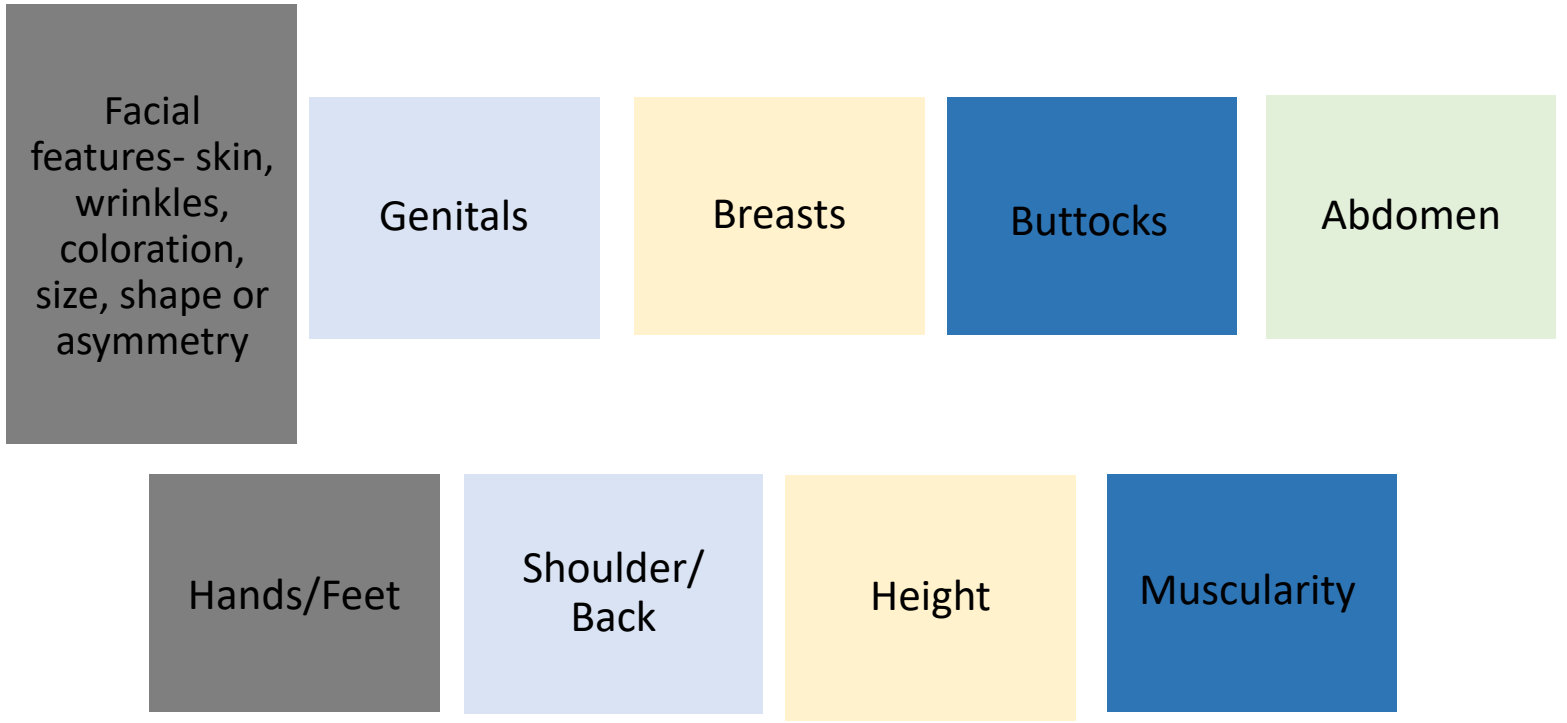
- 29% Suicide Attempt Rate
- 45-70% Suicidal Ideation
- 36-58 % Hospitalization
- 32-40% Homebound
- 42% Full-time employment/student
- 70% Single

Perugi, et al., (1997); Phillips. et al., (2006); Phillips, et al., (1994); Phillips, McElroy, Keck, Hudson, & Pope, (1994).

Etiology

- Consider sociocultural influences
- Personal historical factors
  - History of bullying, teasing, abuse
  - Beauty standards & familial values on perfection.
- Neurobiological factors
  - **Neurochemistry:** SSRIs mediate some symptoms
  - **Visual Processing –** Detailed vs. holistic processing
  - **Neural Circuitry** – Front-striatal and temporo-limbic systems
  - **Genetics - ** 8% of those diagnosed with BDD have a relative with BDD

Common Areas Of Concern in BDD



Intrusive Thoughts in BDD

- Persistent and intrusive thoughts about one's body part of concern.
- Intrusive visual images of one's body parts of concern.
- Strong desire to know what the body parts of concern look like or what others perceive.

Associated Behaviors of BDD

Safety & avoidance

Camouflaging/

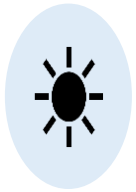
Positioning body part

Mirror checking/ avoidance

Reassurance seeking – does flaw exist or do I look attractive?

Skin picking/hair pulling

Excessive grooming



Tanning

Comparisons Social & Self

Cosmetic surgery

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

Avoidance Behaviors

- Social situations
- Dating/work
- Bright lighting
- Medical appointments
- Outdoor activities
- Sweating
- Restrictive eating (for reasons other than weight loss)

Common Comorbidities in BDD

BDD in OCD
10%
OCD in BDD
27.5%

BDD in Social Anxiety
11-12%
Social Anxiety in BDD
30-40%

Suicidal Ideation
89%
Suicide Attempts
24-28%

Substance Abuse
29.5%

Major Depressive Disorder in BDD
53 - 81%

Eating Disorders in BDD
32.5%

Personality Disorders in BDD
57%

Differential Diagnoses: OCD vs. BDD

Similarities

- Persistent and recurring obsessive thoughts.
- Repetitive, compulsive behavior.
- Preoccupations with symmetry and perfection.
- Respond to similar treatment and medication.

Differences

- Content of the obsessive thoughts.
- BDD has higher overvalued ideation.
- BDD present with more complexity in emotional reactions: Higher depression, self-hatred, guilt, shame, anger, disgust.
- Total self identification
- More suicidal ideation/attempt

Differential Diagnoses: Social Anxiety vs. BDD

Similarities

- Avoidance of social situations.
- Concern for others' opinion of them.
- Expressed anxiety being in public or crowded spaces.
- Fear of rejection.

Differences

- BDD: Fear of being judged primarily on appearance.
- Social anxiety: Fear of being judged on behavior or embarrassing themselves.

Differential Diagnoses: Depression vs. BDD

Similarities

- Avoidance of social situations.
- Shame and disgust surrounding body.
- Expression of depressive affect, hopelessness, fatigue, and other mood specific symptoms.

Differences

- Avoidance of social situations is due to poor body image in BDD.
- In depression avoidance of social situations is due to lack of energy, lack of interest, loss of hope etc.
- BDD OVI fluctuates less.
- In BDD: Mood is dependent/fluctuates based on appearance evaluation. Isolation secondary to avoidance of BDD provoking situation.

Differential Diagnoses: Skin Picking vs. BDD

Similarities

- Picking behavior
- Visually cued
- Causes mild to significant skin and tissue damage.
- Compulsive – repeated, urges
- Multi-functional – environmental, mood, cognitions

Differences

- In BDD, picking is due primarily to appearance improvement, removing of blemishes, acne, bumps, redness
- In BDD, the internal drive may develop secondary to the primary function over time, but is not what typically initiates the behavior.

Clues to a Body Image Condition

- **Clinical history**
  - Cosmetic surgery history
  - Avoidance of dating and relationships
  - Suicidality
  - Lack of treatment progress with a mood, OCD, or anxiety disorder
- **Behavior in Session**
  - Camouflaging, posture, eye contact, excessive make-up
  - Discomfort with lighting or close physical contact
- **Common co-occurring disorders**
  - Social anxiety, OCD
  - Treatment resistant depression
- **Poor Self-Esteem**
- **Ask directly about body image "How would you rate your body image satisfaction"**

Quick BDD Screening

Body Dysmorphic Disorder Questionnaire

(Katharine Phillips, M.D.)

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

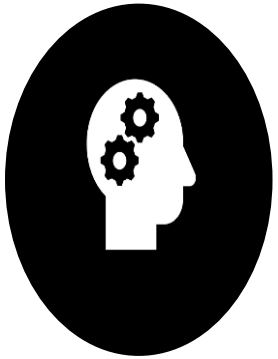
Primary Assessment Measures

SYMPTOMS

BODY DYSMORPHIC DISORDER QUESTIONNAIRE (BDDQ)

SEVERITY

YALE BROWN OBSESSIVE COMPULSIVE SCALE MODIFIED FOR BDD (BDD-YBOCS)



BELIEF STRENGTH

OVERVALUED IDEATION SCALE (OVIS) or BROWN ASSESSMENT OF BELIEFS (BABS)

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

Assessment Tools

- **DIAGNOSTIC & SEVERITY**
  - Body Dysmorphic Disorder Examination: Self Report (BDDE-SR; Rosen, J., & Reiner, J., 1994)
  - Body Dysmorphic Scale based on Y-BOCS (BDD YBOCS; Phillips et al. 1997)
  - Body Dysmorphic Disorder Symptom Scale (BDD-SS, Wilhelm et al., 2016)

- **OVERVALUED IDEATION**
  - Overvalued Idea Scale (OVI; Neziroglu et al. 1996)
  - Brown Assessment of Beliefs Scale (BABS; Eisen et al. 1998)

- **BELIEFS/ATTITDES ABOUT APPEARANCE**
  - Body Image States Scale (BISS; Cash et al. 2002)
  - Defect-Related Beliefs Test (DRB; Butters & Cash, 1987)

    Appearance Attitudes Scale (Veale)

    Body Dissatisfaction Checklist (Veale)
  - Body Dissatisfaction Checklist, a modified version of Part 1 of the Body Dysmorphic Disorder Examination Self-Report (Rosen & Reiter, 1994)

Challenges To Treatment

Overvalued Ideation

Reliance on cosmetic surgery

Homebound

Self-referred vs. other

Comorbidities

Family involvement (accommodation vs. antagonism)

Primary Appropriate Treatments for BDD

- Engagement & Motivation
- Psycho-education
- Cognitive Therapy
- Exposure and Response Prevention
- Psychopharmacological Treatment
- Protocols for suicidality
- Mirror Re-training
- Group Therapy
- Family Involvement

Treatment Beyond CBT: Adjunctive Approaches

- 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?
  - DBT, ACT, Compassion Focused Therapy, Meta-cognitive techniques (Attentional Training Technique, Task Concentration Training)

Tips For Treatment Engagement

Flexibility surrounding where and when patient is seen	Avoid debate/argument over appearance of patient	Focus on impairment & impact at hand
• Late afternoon/evening: darker outside. • Assessments may be conducted outside of practice (in patients home, in parking lot).	• May challenge therapeutic alliance	• Ways in which body appearance beliefs & preoccupation are interfering with values & goals.

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

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 “everyone has flaws similar” or” it’s only noticeable if someone pays close attention.”
- Do not engage in reassurance giving that the patient is attractive or normal looking.
- Be cautious in accepting worst case scenario especially in the early stages of therapy (“If the flaw existed, then could you live your life?”).
- In Summary, target ***Core Beliefs*** & **Appearance Over-Importance & Value**

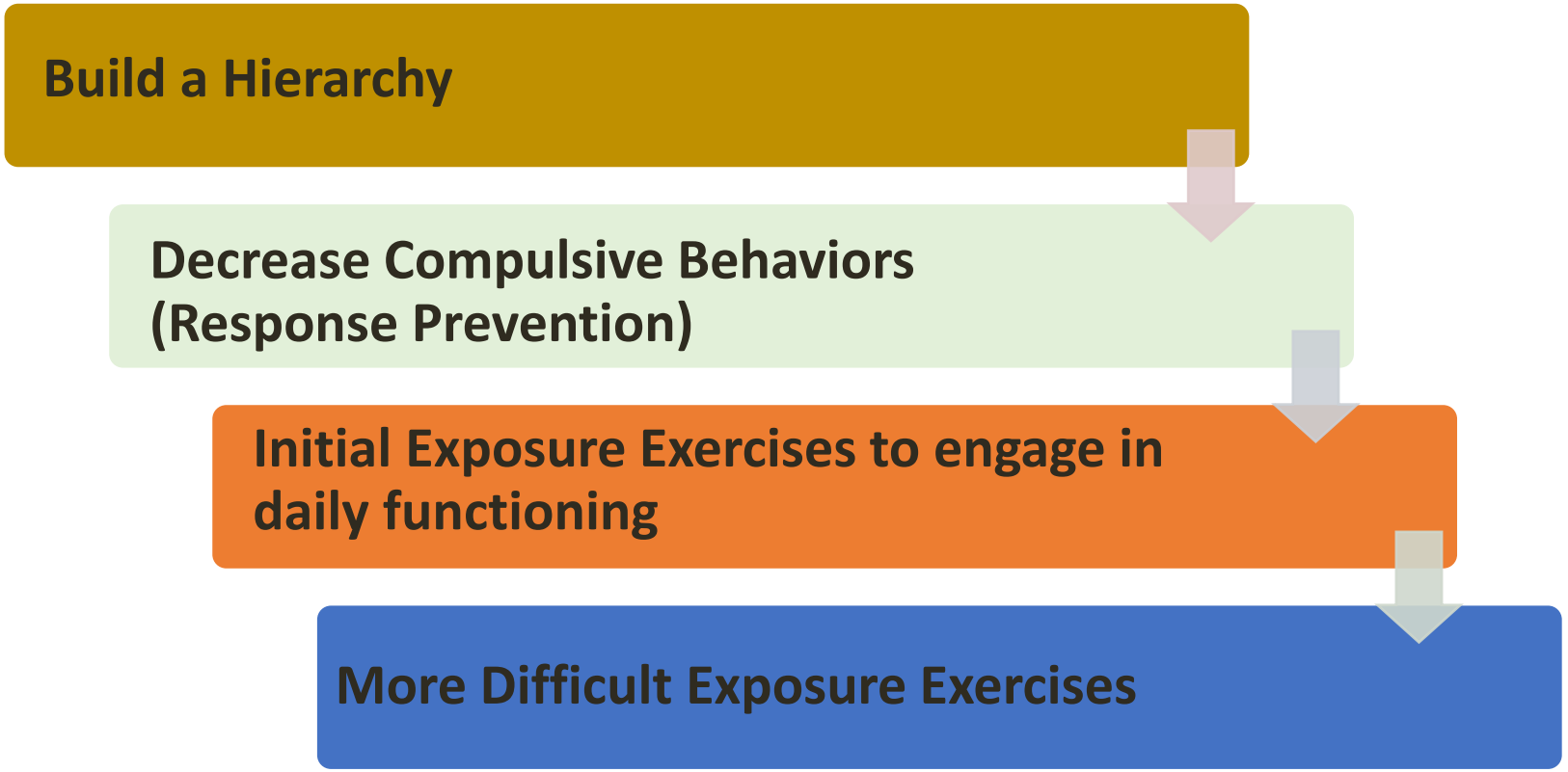
Common BDD Beliefs

- I need to be perfect
- If I ***feel*** that my body part is flawed, that means it ***looks*** flawed.
- If my body part of concern is not perfect, then it must be ugly.
- If I looked better, my whole life would be better.
- Happiness comes from looking good
- Looking good protects you from being treated badly.
- Physical perfection is possible and is a worthwhile goal.

Exposure and Response Prevention Adjusted for BDD

- 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 occurs.
- Design exposures that increase patient's quality of life, address values and increase functionality.
- Extra Planning and De-Briefing:
  - Discuss goal before an ERP, make ERP specific, and then discuss observations & conclusions after an exposure *(What did you learn from that experience?)*

Course Of Behavioral Treatment



NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

Mirror Re-training

Perceptual training addresses perceptual disturbances and related mirror checking.

Patients learn to focus on their whole body rather than the small features; global vs. detail processing.

Replaces negative language/judgments with objective/neutral language.

Is different from mirror exposure (not staring, criticizing, or exaggerating perceived flaw).

Describe entire body starting at hair and down to feet. Use color, size, shape to describe body in neutral language.

Wilhelm, Philips & Steketee. (2013).

CASE EXAMPLE
LATE BDD ONSET

Household accident in which her nose was bruised very badly when a cabinet hit her face. Sought therapy 6 months after the accident.

SYMPTOMS: depression, sleep disturbance, mirror checking, touching nose to check, seeking cosmetic surgery consultations

AVOIDANCE: Stopped socializing, decreased hours at work.

20 = Cooking in kitchen

30 = Bending down to pick up items

50 = Leaving home without checking reflection
50 = Leaving home without touching nose

60 = Wearing hair in a ponytail

60 = Pinning up one side of hair

70 = Dinner with friend sitting across the table

80 = Sitting side by side at restaurant with colleague

90 = Aerobic exercise

Special Issues: Treatment Resistance & Cosmetic Surgery Seeking Behaviors

- Pacing & flexibility
- Assessing motivation
- Repetition Assess and re-assess motivation
- Slower pace
- Values Based Treatment
- Keep cosmetic surgery conversations out in the open in order to address.
- Maintain firm message that surgery is not supported by research.
- Bargain for time in therapy; delay surgery; therapy to address the anxiety and depression that body image causes first.
- Catch ambivalence in patient and explore it.
- Accompany patient to consultations with cosmetic surgeons.

CBT Success Rates

Long-term naturalistic case series	Follow up over 1-4 years after receiving CBT treatment for BDD 28.2% in full remission 56.4% in partial remission Significant number still experienced chronic symptoms
CBT compared to Anxiety Management	Significant improvements on BDD-YBOCS seen in CBT group when compared to anxiety management group

Cognitive Behavioral Therapy: Reviews & Meta-Analysis Studies

- Review of the BDD treatment research supports efficacy.
- CBT may be more effective than medications; although both helpful.
- CBT superior to wait list or credible placebo treatment.
- Individual and group CBT better than wait list controls.

Harrison, R., de la Cruz, L., Enander, J., Radua, J. & Mataix-Cols, D. (2016); Prazeres, A.M., Nascimento, A.L., & Fontenelle, L.F. (2013). Williams, J., Hadjistavropoulos, T., & Sharpe, D. (2006).

Clinical Resources

- www.iocdf.org/bdd
- https://www.nationaleatingdisorders.org
- Claiborn, J., & Pedrick, C. (2002). The BDD Workbook. *New Harbinger Press.*
- Granet, S. (2020). Body Dysmorphic Disorder, Mine and Yours: A Personal and Clinical Perspective. *Toplight Books.*
- Khemlani-Patel, S. & Neziroglu, F. (2022). Body Dysmorphic Disorder. *Hogrefe Press*.
- Philips, K. (2005). The Broken Mirror. *Oxford University Press.*
- Phillips, K. (Ed;2017). Body Dysmorphic Disorder: Advances in Research and Clinical Practice. *Oxford University Press*.
- Veale, D. & Neziroglu, F. (2010). Body Dysmorphic Disorder: A Treatment Manual. *John Wiley*.
- Wilhelm, S., Philips, K., & Steketee, G. (2013). Cognitive Behavioral Therapy for Body Dysmorphic Disorder. *Guilford Press*.

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

Q&A With Dr. Sony Khemlani-Patel, PhD

- We will now discuss select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

References

- Bogels, S.M. (2006). Task concentration training versus applied relaxation, in combination with cognitive therapy, for social phobia patients with fear of blushing, trembling, and sweating. *Behavior Research and Therapy*, 44, 1199-1210.
- Buhlmann, U., Glaesmer, H., Mewes, R., Fama, J.M., Wilhelm, S., Brahler, E., & Rief, W. (2010) Updates on the prevalence of body dysmorphic disorder: A population based survey. *Psychiatry Research*, 178, 171-175.
- Feusner, J.D. et al., (2010). Abnormalities of visual processing and frontostriatal systems in body dysmorphic disorder. *Archives of General Psychiatry*67, 197-205.
- Greenberg, J.L. & Wilhelm, S. (2011). Cognitive-behavioral therapy for body dysmorphic disorder: A review and future directions. *International Journal of Cognitive Therapy, 4*(4), 349-362.
- Harrison, R., de la Cruz, L., Enander, J., Radua, J. & Mataix-Cols, D. (2016). Cognitive behavioral therapy for body dysmorphic disorder: A systematic review and meta-analysis of randomized controlled trials. *Clinical Psychology Review*, 48, 43-51.
- Koran, L.M., Abujaoude, E., Large, M.D., & Serpe, R.T. (2008). The prevalence of body dysmorphic disorder in the United States adult population. *CNS Spectrums*, 13, 316-322.
- Neziroglu, F., McKay, D., Yaryura-Tobias, J.A., Stevens, K.P., & Todaro, J. (1999). The overvalued ideas scale: Development, reliability, and validity in obsessive compulsive disorder. *Behavior Research and Therapy*, 37, 881-902.
- Prazeres, A.M., Nascimento, A.L., & Fontenelle, L.F. (2013). Cognitive behavioral therapy for body dysmorphic disorder: A review of its efficacy. *Neuropsychiatric Disease and Treatment*, 9, 307-316.
- Weingarden, H., Curley, E., Renshaw, K., & Wilhelm, S. (2017). Patient-identified events implicated in the development of body dysmorphic disorder. *Body Image*, 21, 19-25.

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS