Psychological management of body dysmorphic disorder

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Abstract

There is increasing evidence that supports the view that body dysmorphic disorder (BDD) is a relatively common disorder. The researchers believe that BDD is extremely difficult to treat. Cognitive behaviour therapy (CBT) and serotonin reuptake inhibitors (SRIs) have received increased attention recently in treating this condition. This case report's main aim is to provide clinical experience regarding the usefulness of CBT in two cases of BDD. Yale Brown Obsessive Compulsive Scale modified for BDD (BDD-YBOCS) was administered with both the cases, pre-intervention and post intervention and both the cases scored up to the cut off point, in pre-intervention and post intervention both cases have greater than 30% decrease in BDD-YBOCS scores. Both the cases reported significant improvement subjectively as well as objectively. Future studies will need to further develop more relevant CBT protocols that more fully integrate the patient's perspective and chal¬lenge social cognitions about this disorder.

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Introduction

People are becoming increasingly concerned about their physical appearance and body image improvement; this is considered to be the main reason why most patients are undergoing plastic surgery.[1] In addition to core concerns about appearance, some patients show severe disruptions in self-esteem, time-consuming repetitive behaviours (e.g. mirror checking, measuring or comparing the perceived defect, camouflaging, excessive grooming, skin picking, reassurance seeking), and avoidance (e.g. of social situations, mirrors, posing for photographs bright lights).[2,3] These are said sufferers of a distressing and relatively common disorder called body dysmorphic disorder (BDD), also known as dysmorphophobia.[4] BDD derives its name from the ancient Greek and means "ugliness", particularly of the face.[5] It was firstly described by Morselli in 1886 as a "subjective sensation of deformity or physical defect that causes the patient's belief of being noted by the others, although the physical aspect appears normal".[6] Although normal appearance concerns are common in the general population[7] since individuals with BDD appear normal looking to others, they are preoccupied with distressing and time-consuming thoughts that some aspect of their physical appearance looks flawed or defective.[8] Individuals with BDD have very poor psychosocial functioning, notably poor quality of life, and high rates of suicidal ideation and suicide attempts.[9] The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV)[10], defines BDD as a preoccupation with an imagined defect in appearance; if a slight physical anomaly is present, the concern is markedly excessive. The preoccupation must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. The appearance concerns cannot be better accounted for by another mental disorder such as anorexia nervosa. The appearance preoccupations most often focus on perceived defects of the skin (e.g. acne or scarring), hair (e.g. hair loss), and nose.[11] To differentiate BDD from normal appearance concerns, which are common in the general population,[7] the preoccupation must cause clinically significant distress or impairment by functioning (e.g. social or occupational interference).[10] Approximately 50% of patients who come to psychiatric attention hold on to their belief so tenaciously and unshakeably that it are considered delusional.[12] Seventy per cent of individuals with BDD report a history of suicidal ideation attributed primarily to BDD, and 22%-24% had attempted suicide.[9,13] BDD has been considered a chronic[9], and difficult to treat disorder,[14] but both of the treated patients in this report improved. Between the baseline and final assessments, BDD symptom severity significantly decreased, and level of functioning significantly improved. The effect to treatment in the following two cases was more than the response to treatment which is defined as a 30% or greater decrease in Yale Brown Obsessive Compulsive Scale modified for BDD (BDD-YBOCS) score by other researchers. [15] So present report will provide an insight towards the fact that BDD can be successfully treated with CBT; as both the subsequent cases were contacted after six months of therapy termination and both subjects reported absence of symptoms. Case histories as well as treatment description of both the cases are as follows:

Case 1

A 25 years old man was referred by a plastic surgeon to us as the patient visited him again and again requesting nasal and facial surgery. During his initial medical and psychiatric consultation, he described himself as having always suffered from low self-confidence, and he had difficulty in making friends. He was rather shy and had preferred to stay in his room, where he kept himself busy with books. He reported that he began to feel concerned about the appearance of his nose when he was 16 years old after he had bleeding in his nose after being hit by a swing at school, and had to apply bandage for few days. After that he started comparing his nose with others.

His problem exacerbated six months before coming to us when he had a breakup with his girlfriend. His body concern intensified and was accompanied by behaviours such as prolonged observation of his nose in the mirror for about three hours a day. The opinions of those closest to him, who assured him that he has no abnormality, could not comfort the patient. Progressively he also started having concern regarding cheeks. He avoided conversing from a close distance. Premorbidly he took his job so seriously that he could not stop doing it. But he lost his interest in going to job and meeting friends, for the past six months. He believed that his colleagues and clients are more interested in his looks than work.

The deterioration in his social functioning, together with concern about his appearance was observed by the patient himself and by his family members. According to the patient, he was not able to sleep properly and he would lie awake and brooding about his appearance related thoughts. For past three months he is not able to concentrate properly on his work. His problem had gradually become so bad that he imagined his boss would tell him he is no good at his work and might just as well quit his job. He started arriving at office an hour before everyone else and leaves early and used to do most of conversations over phone. Several times he felt like ending his life. At the initial interview, he appeared reserved. He was able to describe his problem, his mood appeared depressed, and he seemed to have low self-esteem. Although he admitted that he had thought of death occasionally, but no plans for suicide could be detected. At the end of the first visit, he tearfully asked for treatment of his problem as soon as possible. Physical and neurological examinations, including an electroencephalogram, and laboratory investigations were all normal.

Case 2

A 19 years old male was brought to the Hospital Outpatient Department by his father because of sleeping difficulty and excessive crying and mirror gazing, excessive body concern (hair, uneven chin) that was affecting his studies. He admitted spending three to four hours/day thinking about his appearance or checking in mirror as well as performed other compulsive behaviours, which included comparing his appearance with that of other people, wearing and frequently adjusting a cap to cover his hair, and searching the internet for hair loss treatments. At the time of intake, he was participating minimally in daily activities. Most notable was the fact that the patient had not attended college for two months. Patient reported that he was apparently well two years back. The problem had started just a month after the death of his grandmother in an accident and he had to shave his head and beard. And after few days while returning from a jaagran his friends made fun of him regarding his hair. He did not speak or react on it. He, while talking to less familiar people, would tend to focus on the facial expression of others, picking cues to evaluate him (patient), and become anxious leading to stuttering. He, however, felt very comfortable and at ease when he is interacting with familiar persons. He barely spoke to anyone and kept to himself as much as he could. Historically, he was described as active but prone to mood fluctuation. His college grades also deteriorated gradually and later he discontinued his classes. He talked a lot about his problem, and he was full of plans and ideas about future, if he gets treated. During the examination he was polite and cooperative, always trying to answer the questions accurately. He was found preoccupied with his inferiority feeling and his hopeless situation about the problem. Premorbidly he was easy going and sociable. He was described by his family members as an outgoing and cheerful person who was kind and conscientious. He was said to be a perfectionist and a hard worker and was also known as an authority. The findings on physical examination were unremarkable. Routine tests performed (routine blood, biochemistry and thyroid hormones) were also normal.

On mental status examination, he was sad and well groomed and established good rapport with the interviewer. He was noticeably nervous during the initial interview. He sat still in the chair, staring at the floor, looking up only occasionally at the interviewer but never looking in the eyes. He reported suicidal ideation and he felt joyless and fatigued. He also reported that his appetite had been poor for three months and that he had lost about three kg in weight.

Assessments

After having a thorough examination of symptoms and appearance complaints by taking psychiatric history, developmental history of body image, the BDD-YBOCS by Phillips et al.[16] was also administered with the case to measure obsessions and compulsions in BDD. On this 12-items scale, both cases pretreatment scored 32 and 29 respectively, which is higher than the cut-off (16) cited by other researchers.[17]

After establishing the diagnosis and severity of BDD, both the cases were considered for treatment including psychotherapy and pharmacotherapy. So both of them were explained regarding the nature of problem and need for treatment compliance along with treatment available. Both the cases were also provided with reading material on BDD. They read about cognitive behaviour therapy (CBT) on internet and wanted to take part in CBT, and refused to take pills. After taking their consent, treatment started with both of them, individually.

Treatment

Cognitive behaviour therapy: The patients were referred to clinical psychologist. They were taken up for CBT, a promising approach for BDD.[18] The standard program used with these cases was distributed across two months weekly sessions. Each session would include a statement of

goals for that session, review of preceding week, introduction of new information, and homework for the coming week, and monitoring procedure. The treatment program used in these cases consisted of the following components:[19-21]

Psychoeducation began with a description of the nature of BDD and role of body image as well as a detailed description of the nature of intrusive thoughts. The next part of the educational component was to explain the nature of behavioural activities/self-defeating safety behaviours, both mental (comparing with others) and overt (avoidance, escape behaviour; reassurance seeking; mirror gazing; internet searching for surgery, taking frequent photographs or videos recording of themselves, camouflage, comparing current appearance with old photographs, comparing appearance with others, excessive grooming of the hair), and how they can have an adverse effect or play a role in maintaining BDD. For the same, cognitive behavioural model of BDD postulated by Veale[21] was also explained. Just after providing them psychoeducation, goal of the CBT was set and patients were explained that the goal of CBT is to change their body image not to change appearance, by decreasing discomfort or by extinguishing or minimising maladaptive behaviours. A formulation of the problem for an understanding of how it developed and how it is being maintained was developed with the help of each patient.

Self-monitoring was introduced in first session, just after target symptoms were identified. Two methods of self-monitoring were used: Daily record, in which patients recorded the intrusive thoughts on hourly basis. Diary form, in which the patients analysed the experience in an A-B-C sequence (1) activating events (the situations and trigger of physical self-consciousness or body dissatisfaction) (2) beliefs (thoughts about the situation or self) (3) consequences (outcome of the situation or emotional and behavioural reaction).

During the exposure and response prevention (ERP), the patients were persuaded to expose themselves to the anxiety provoking stimuli (i.e. exposing the defective body part in a social setting etc.) and prevented from doing rituals (i.e. not hiding facial features with hands or combed-down hair etc). Repeated and prolonged exposure without rituals or avoidance helps to disconfirm the mistaken fears and beliefs and promotes habituation to previous fearful thoughts and situations. To assess the assumptions held about the perceived defect, downward arrow techniques and diary were used. These assumptions were then used in cognitive restructuring and behavioural experiments by carrying out mini-surveys to analyse and to restructure patients' belief system.

Discussion

It has become widely accepted that body image dissatisfaction is a significant issue for both women and men. More than 50% of women and slightly less than 50% of men report dissatisfaction with their appearance.[7] BDD has been reported to occur in 0.7% to 1.0% of community samples. [22,23] Many sufferers are too embarrassed or ashamed to seek mental health services and, seeing their problem as a cosmetic one, seek treatment from cosmetic specialists.[24] Hence, BDD usually goes unrecognised and undiagnosed in clinical settings.[11] Poor insight makes the situation more dreadful, as found in previous studies approximately in 35% to 40% of BDD patients have reported to have no insight or delusion.[8,25] Although the fact that research on effective treatment is still limited, Phillips[25] considered serotonin reuptake inhibitors (SRIs) and CBT as the medication and psychosocial treatment of choice, respectively. Researchers suggest that some patients respond well to either an SRI or CBT alone, whereas others benefit from treatment with both types of treatment.[26] In spite of clinical experiences no studies have examined the relative efficacy of medication versus CBT, or their combination, for BDD.[26] A meta-analysis of the limited body of randomised controlled trials for the treatment of BDD provides some evidence for the efficacy of SRIs and CBT.[27]

Our findings are in line with other previous research which indicated that when different approaches such as cognitive restructuring, exposure, response prevention, and behavioural experiments are used BDD often significantly improves.[26,28] With our cases we too used the above said approaches having different objectives. Self-monitoring was introduced to discover what may be modulating the variability and symptoms severity and ultimately help in relapse prevention. Exposure therapy was used to overcome distressing self-consciousness and avoidance of feared body image situations. Response prevention was used to decrease body checking behaviours, repeated and prolonged exposure without rituals or avoidance helps to disconfirm the mistaken fears and beliefs and promotes habituation to previous anxiety-provoking thoughts and situations. The interpretations of A-B-C were then used as the basis for a behavioural experiment. The aims of this behavioural experiment (i.e. carrying out mini-surveys in our case) are to reduce unwanted over-predictions by collecting the evidence for and against faulty assumptions, to promote the patient's experience of life without the maladaptive interpretation of their intrusive thoughts by challenging the belief that others share their view of the perceived defect, take notice and disgusted by it.

The two male patients described above experienced significant distress and met DSM-IV criteria for BDD and none had past psychiatric histories. BBD symptoms were treated effectively with CBT. In particular, treatment enabled patients to stay in the community, to practice normalisation, and to sustain or improve their daily functioning within a continuum of care that extends beyond the treatment setting to the home and work environments. Modern text suggests that up to 70% of patients with BDD benefit from systematic exposure to situations they avoided and prevention of anxiety-reducing behaviours.[29] In both cases initial pretreatment scores of a 29 and 32 on the BDD-YBOCS was reduced at posttreatment by 72.41% and 62.50% to a score of eight and 12; a 30% or greater decrease in total BDD-YBOCS is an empirically derived cut-point that reflects clinically significant improvement. The case report shows that although BDD is a difficult and tenacious psychiatric illness; but CBT is a potential approach that can play a key role by helping these high-risk patients to obtain effective and satisfying outcome. Present findings also advocate the need for identifying and referring BDD sufferers for psychi-

atric evaluation and treatment.

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Further reading

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