Demystifying Treatment for Body Dysmorphic Disorder

By MARGARITA TARTAKOVSKY, M.S.

Some dismiss body dysmorphic disorder (BDD) as vanity; others believe it's a rare and extreme condition. Though many misconceptions continue to circulate, BDD is a real, fairly common body image disorder. It affects men and women equally and has shades of severity. Fortunately, BDD can be successfully treated with medication and psychotherapy. In fact, both cognitive-behavioral therapy (CBT) and selective serotonin reuptake inhibitors (SSRIs or SRIs) are considered the first line of treatment for BDD, according to Jennifer L. Greenberg, Psy.D, Clinical and Research Fellow in Psychology (Psychiatry) at the Massachusetts General Hospital/Harvard Medical School.

Here's a closer look at how this underdiagnosed, often misconstrued condition is treated in adults and adolescents.

CBT Techniques

CBT is a "present-focused, short-term, goal-directed therapy," Greenberg said. The goal of this treatment is to reduce an individual's negative thoughts about their appearance and their compulsive behaviors—the rituals they use to quell their anxiety. These rituals can include checking themselves in the mirror, seeking reassurance from others, camouflaging the area of concern with cosmetics, clothing or tanning and picking their skin.

When looking for a therapist, make sure he or she "has CBT training and experience treating a number of people with this condition," Corboy said. "If your therapist doesn't know what BDD is, does not specialize in CBT, and has not treated others with BDD, find another therapist."

As part of CBT, the therapist will use a variety of techniques, including:

Cognitive Restructuring. Patients with BDD hold deeply negative thoughts about their appearance. They might have an all or nothing perspective (e.g., "I'm either beautiful, or I'm hideous") and discount any positive aspects. The goal of cognitive restructuring is to "teach clients to challenge the validity and importance of their distorted thoughts about their bodies," said Tom Corboy, M.F.T., director of the OCD Center of Los Angeles.

Patients learn to "restructure the negative thought patterns to be more realistic," said Sari Fine Shepphird, Ph.D, a Los Angeles clinical psychologist who specializes in BDD and eating disorders.

Part of having a realistic perspective is evaluating the evidence for negative beliefs. So, a therapist asks "what evidence do you have for this thought?" Challenging distortions "shows a patient that this thinking isn't just irrational and inaccurate, but it's also not helpful," Shepphird said.

> Sandra regularly tells herself that she is hideous and no one will ever date her because she has a large—in reality a minute—mole on her face. Her therapist helps her challenge the "distortion that her small mole is a huge, hideous flaw, and the irrational belief that nobody would ever date her (or anyone) with such a mole," Corboy said.

Mind Reading. In addition to holding negative thoughts about themselves, people with BDD assume that others view them negatively. With this technique, patients learn that these assumptions aren't rational. Therapists also challenge these assumptions by giving patients a realistic set of reasons, Shepphird said.

> Jane catches someone looking at her and automatically thinks, "Oh, they must be looking at my huge scar, and thinking I'm ugly." Jane's therapist talks to her about possible reasons the person looked her way. "The person could've been looking over your shoulder, admiring your clothing or thinking your hair is attractive," Shepphird said.

Mindfulness/Meta-Cognitive Therapy. "From a meta-cognitive perspective, the important thing is to learn to accept the presence of distorted thoughts and uncomfortable feelings without over-responding to them with avoidant and compulsive behaviors, which actually reinforce and worsen the thoughts and feelings," Corboy said. In other words, patients don't let their thoughts drive their behavior.

> Mike can't stop thinking about how large his nose is. These thoughts are so pervasive that Mike frequently avoids class. By practicing mindfulness with his therapist, Mike learns to accept his beliefs and release them, working on attending his class.

Exposure and Response Prevention. BDD and obsessive-compulsive disorder (OCD) have distinct similarities. Patients who have BDD or OCD typically engage in ritualistic behaviors to avoid anxiety. This is where exposure comes in. To stop avoidance, patients create a hierarchy of situations that cause them anxiety, and give each situation a rating of 0—causes no anxiety or avoidance—to 100—causes intense anxiety and avoidance—working up to the situation that causes the most concern. While in the situation, patients also gather evidence about their beliefs.

In response prevention, the goal is to reduce—and eventually stop—the compulsive behaviors that patients use to decrease their anxiety. "Paradoxically, rituals and avoidant behaviors reinforce and maintain BDD symptoms," said Greenberg. These time-consuming rituals interfere with daily life and increase anxiety and avoidance.

To reduce rituals, a therapist might assign what's called a competing action, a behavior that the patient uses instead of the ritual. Ultimately, by facing anxiety-provoking situations and reducing rituals, "the patient is opened up to new and healthier behaviors that will

actually help," Shepphird said.

> Together with his therapist, Jim creates a hierarchy of situations. On his list, Jim includes: taking out the trash during the day (rating of 10); walking his dog (20); going to the grocery store (30); paying the cashier (40); sitting next to someone on the bus (50); having lunch at a restaurant with a friend (60); shopping at the mall (70); attending a social gathering (80); going on a date (90); and joining a sports league (100). While in each situation, Jim collects his evidence. At lunch, he monitors people's reactions to him. He might ask: Are they gawking? Do they seem disgusted? Are they laughing? He finds that no one is reacting negatively to him and his anxiety starts to decrease after facing these situations.
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> Samantha is deeply bothered by her acne. She checks her face in the mirror 12 times a day, constantly picks at her acne, compares her skin to celebrity photos and spends hours trying to camouflage her blemishes. To start reducing these behaviors, Samantha and her therapist create a ritual hierarchy, recording the least difficult habit to the most difficult to give up. Her hierarchy looks like this: photo comparing (20); skin picking (30); mirror checking (50); and camouflaging acne with makeup (80). Every time Samantha wants to check her acne in the mirror, she closes her eyes and counts to 10.

In her book, *Understanding Body Dysmorphic Disorder: An Essential Guide*, Katharine M. Phillips, M.D., a leading expert on BDD and director of The Body Dysmorphic Disorder and Body Image Program at Butler Hospital in Providence, R.I., lists additional strategies for reducing rituals:

1. **Decrease the number of times you do the behavior per day**. Instead of checking the mirror 12 times a day, try reducing it to eight times.
2. **Spend less time on the behavior**. If you typically look in the mirror for 20 minutes, reduce the time to 10 minutes.
3. **Delay the behavior**. If you have the desire to check yourself in the mirror, consider postponing it. The more you delay a behavior, the less likely you are to rely on it in the future.
4. **Make it tougher to do the behavior**. Some patients cut their hair throughout the day to get it just perfect. To avoid this, stop carrying scissors with you, have a loved one keep them or get rid of them altogether.

Mirror Retraining. Patients can spend the majority of their day scrutinizing themselves in the mirror. This might be partly because patients selectively focus on the details—such as a small mole or scar—instead of taking in the whole picture. In mirror retraining, "patients learn to pay attention to their appearance in a new, non-judgmental way, learning to give neutral and positive feedback," Shepphird said.

> When Jonathan looks in the mirror, he says, "All I can see is my hideous mole and my big nose." Instead of focusing on his flaws, the therapist asks Jonathan to describe himself in neutral terms, such as "I have brown hair, I'm wearing a blue suit" and in positive terms, "I like the buttons on my suit myself, I think my hair looks good today."

Eventually, patients learn that their rituals only further their anxiety and that this anxiety is fleeting. A woman who always wears hats to hide her small mole will find that after she takes off her hat, "the anxiety she has usually fades quite quickly, because other people don't gawk, stare or point," Corboy said. He notes that people are typically too busy worrying about their own thoughts and feelings to notice others. And even if some people do evaluate us negatively, this isn't "nearly as catastrophic as one might initially fear. Ultimately, "does it really matter if some stranger at a grocery store thinks we are unattractive?"

Medication

Research has found that SSRIs are tremendously helpful for patients with BDD. These antidepressants—which include Prozac, Paxil, Celexa, Lexapro, Zoloft, Anafranil and Luvox—are also commonly prescribed for depression, OCD and social anxiety disorder, all of which share similarities with BDD.

Other antidepressants—with the exception of clomipramine (Anafranil), a tricyclic antidepressant—and neuroleptics haven't shown the same effectiveness as SSRIs, though these medications can be prescribed as supplements to SSRIs, Greenberg said. SSRIs are particularly effective because they focus on reducing obsessional thinking (e.g., "I can't stop thinking about my terrible acne!"), compulsive behaviors (e.g., mirror checking, camouflaging) and depression.

Patients often are concerned that taking medication will change their personality and turn them into zombies. However, as Dr. Phillips notes in her book, "patients who improve with an SSRI say that they feel like themselves again—the way they used to—or the way they'd like to feel."

When taking medication, there are several recommended approaches. SSRIs "should be tried at their optimal dose for at least 12 weeks before switching or augmenting medication," Greenberg said. On its Web site, Butler Hospital also suggests taking SSRIs for one to two years or longer and taking the highest recommended dose, unless a lower dose has been effective.

Treatment for Kids

BDD typically develops around 13 years old, though younger kids can also have the disorder. It seems to occur equally in boys and girls.

CBT also is helpful for kids and teens; however, "it is important for treatment providers to consider age-appropriate language and strategies," said Greenberg. "Most teens with BDD have not yet developed the emotional and cognitive skills to fully and openly address their body image concerns," according to Corboy. Adolescents might have a tough time "articulating what they are thinking and feeling, and may not even recognize that their fears are exaggerated and unrealistic," he said.

Younger patients also might feel uncomfortable disclosing information to a person they've just met—many rarely even talk to their parents. They also may deny body concerns because they feel ashamed or embarrassed and hope their concerns will simply go away, Corboy said.

When looking for a therapist for your child, make sure the professional has experience treating children with BDD, Corby said. Along with finding a reputable and experienced therapist, parents should get involved in both the assessment and treatment process, said Greenberg. For instance, during the clinical interview, parents can provide information about the child's symptoms. In treatment, parents can become "great allies," said Greenberg. "Parents can remind children to use their CBT skills and provide praise and rewards for their child's hard work."

Together, parents and children can develop a reward system for improvements such as spending less time checking the mirror and attending class regularly, according to Greenberg, who said this helps keep the child "active and interested in the treatment."

"As BDD and appearance becomes less important and time-consuming, it is important that the patient is working to improve other skills—sports, music, art—friendships and experiences—such as dating, going to parties—which are important in helping to improve the child's overall quality of life," Greenberg said.

Case reports suggest that SSRIs, which already are used to treat pediatric OCD, are effective for treating childhood BDD, she said. Currently, three hospitals are conducting the first multi-site controlled trial of SSRIs in children.

Important Factors for Treatment

"Most individuals probably need at least 18-22 sessions of CBT for BDD in order for their symptoms to improve," Greenberg said. With one session per week, treatment typically lasts four to six months, though patients who want to see dramatic improvements in their symptoms might want to stay in treatment longer, said Shepphird.

Length of treatment can depend on the severity of symptoms, whether the patient is delusional—wholeheartedly believes the flaw is real and can't be convinced otherwise—or has another untreated disorder, Corboy said. For instance, if a delusional patient refuses to take medication, this prolongs treatment. As Greenberg points out, patients who have delusional BDD respond as well to SSRIs as those with nondelusional BDD.

Other factors in recovery from BDD include:

- **Active participation**. CBT is a collaborative treatment. "CBT requires that the client directly face and challenge their distorted thoughts and maladaptive behaviors," Corboy said. Patients might be eager in the beginning, but dealing with anxiety-provoking situations can be difficult and dampen willingness. "While virtually every client initially says they are willing to do anything to get past this problem, many find that they are unwilling to do the work if it means they will experience a concomitant spike in their anxiety," Corboy said.
- **Social support and healthy lifestyle**. "If a client has a loving spouse, a supportive family, close friends, and meaningful work, the odds of successful treatment are far greater than if the client has a condescending or critical spouse, parents who think the problem isn't legitimate, few or no close friends, and no meaningful work or school life," Corboy said.
- **Medication**. Before starting medication, talk to your doctor about what to expect. Wise questions to ask include: What are the side effects? Which symptoms will improve with medication? When will the medication take effect?

  Once you start taking medication, you might want to keep a log of its side effects and benefits and bring it to doctor appointments. Remember that you're working as a team. Your doctor can't help you if he or she isn't aware of everything going on.
- **Ineffective treatments**. It's common for individuals with BDD to seek dermatological and dental treatments and plastic surgery in hopes of fixing their flaws. "Patients with the delusional variant often falsely believe that cosmetic procedures are their only salvation," Greenberg said. For instance, Shepphird was seeing a patient who already had two procedures but wanted multiple surgeries to look like a figure in a painting. He couldn't stand his current appearance and felt that the additional surgeries would improve his look.

  Instead of soothing symptoms, cosmetic treatments and procedures typically worsen them. "More often individuals feel worse (e.g., 'disfigured') and may subsequently blame themselves for having had a procedure they feel made them 'look worse than before,'" Greenberg said. Individuals also can become preoccupied with another part of their body.

Co-occurring Disorders

"Depression is very common among individuals with BDD and the suicide rate among BDD patients, including adolescents with BDD, is substantially higher than that among other psychiatric populations—including eating disorders, major depression and bipolar disorder—and the general U.S. population," Greenberg said.

She notes that once BDD symptoms improve, patients tend to feel less depressed. Yet, if depression "becomes the primary concern" or suicide becomes an imminent risk, then it's important for treatment to focus on this. Individuals who're considering suicide — or know of someone who is — should seek professional help immediately.

Thanks to effective treatments, there is hope, and individuals get better and are able to lead productive, fulfilling lives.

Further Reading

Body Dysmorphic Disorder: When the Reflection Is Revolting

Phillips, K.A. (2009). *Understanding Body Dysmorphic Disorder: An Essential Guide*. New York: Oxford University Press.

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