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# An introduction to body dysmorphic disorder for mental health counselors

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# An introduction to body dysmorphic disorder for mental health counselors

## **Abstract**

Although researchers have been studying Body Dysmorphic Disorder (BDD) for almost two decades, the majority of research findings with regard to the disorder have only recently been reviewed and published. Additional research is needed to better understand and treat BDD. But those that currently suffer from BDD cannot wait for these studies to be published; they are in need of adequate treatment and competent professionals to assist them with their disorder. Information from published literature has been synthesized within this paper to provide mental health counselors with an awareness of BDD including the definition of BDD, the relation of gender to BDD, assessment tools, treatment, and additional resources available in order to better serve clients seeking mental health services.

AN INTRODUCTION TO BODY DYSMORPHIC DISORDER  
FOR MENTAL HEALTH COUNSELORS

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Master of Arts

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by

Teresa M. Barrett

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## Abstract

Although researchers have been studying Body Dysmorphic Disorder (BDD) for almost two decades, the majority of research findings with regard to the disorder have only recently been reviewed and published. Additional research is needed to better understand and treat BDD, but those that currently suffer from BDD cannot wait for these studies to be published; they are in need of adequate treatment and competent professionals to assist them with their disorder. Information from published literature has been synthesized within this paper to provide mental health counselors with an awareness of BDD including the definition of BDD, the relation of gender to BDD, assessment tools, treatment, and additional resources available in order to better serve clients seeking mental health services.

An Introduction to Body Dysmorphic Disorder for Mental Health Counselors

Body dysmorphic disorder (BDD), once known as dysmorphophobia, is defined by The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000) as a "preoccupation with an imagined or exaggerated defect in physical appearance" (pg. 485). Although the research pool of information on the course of BDD is still very limited, in 2006, Phillips, Pagano, Menard, and Stout published a study that examined the course of BDD in 183 subjects over 1 year. They found that the full remission probability for BDD was only 9% and they concluded that BDD, similar to social phobia, is a chronic disorder (Phillips, Pagano, et al., 2006). In addition, several studies conducted on the prevalence of BDD have yielded results from 2.2% in a sample of ethnically diverse adolescents have been diagnosed with BDD (Mayville, Katz, Gipson, & Cabral, 1999) to 7% in a community sample of women (Otto, Wilhelm, Cohen, & Harlow, 2001). Two other studies on prevalence in college student samples also yielded similar rates, with 4% in American students (Bohne, Keuthen, et al., 2002) to 5.3% in German students (Bohne, Wilhelm, et al., 2002).

Although numerous authors have suggested that additional research should be conducted in order to better understand various aspects of BDD, the current available literature available does provide a general understanding of the disorder. The purpose of this paper is to provide mental health counselors with a general awareness of BDD in order to help them better understand the disorder and better serve their clients.

## Definition of Body Dysmorphic Disorder and Related Topics

### *DSM-IV-TR Diagnostic Criteria*

As referenced above, the *DSM-IV-TR* (2000) established criteria necessary for the diagnosis of BDD. The *DSM-IV-TR* criteria include:

- 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, or 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)

In addition, the above criteria are found under the section of the *DSM-IV-TR* specific to the disorder, but BDD is included under the Somatoform Disorders section of the manual because of clinical utility and not necessarily because it shares the etiology of other somatoform disorders (DSM-IV-TR, 2000).

### *Preoccupations and Obsessions*

As mentioned in the above criteria, BDD is characterized by a number of preoccupations and obsessions that cause distress or impairment within an individual's life (DSM-IV-TR, 2000). Any part(s) of the body may be the focus of attention in clients with BDD, although the face and head are the most common focal point, and the client's criticism(s) may be specific or vague (DSM-IV-TR, 2000; Veale, 2004b). Examples include, but are not limited to, facial flaws, acne, facial asymmetry, and excessive or thinning hair (DSM-IV-TR, 2000; Veale, 2004b).

Also, according to the *DSM-IV-TR* (2000), patients with BDD are often embarrassed about their concerns, describe extreme suffering because of their disorder, and may become obsessed with thoughts of their “defect.” As mentioned within the diagnostic criteria, the consequences of BDD may also cause individuals to experience significant dysfunction within their occupation, academic career, or social lives and the social impairment associated with BDD may be seen on many levels from becoming socially isolated to becoming housebound (*DSM-IV-TR*, 2000).

Finally, in a study conducted by Eisen, Phillips, Coles, and Rasmussen (2004), the authors found that, when compared to individuals with OCD, the subjects they studied with BDD tended to hold a higher belief that their defect was, in fact, true and that other individuals noticed it and agreed that those diagnosed with BDD were ugly. This fact has important implications for treatment professionals, as discussed later within the treatment section of this paper.

### *Behaviors*

In addition to preoccupations and obsessions, clients with BDD engage in certain behaviors aimed at reducing the anxiety and distress that they experience (*DSM-IV-TR*, 2000). These behaviors may be quite time consuming and may include frequent mirror checking or mirror avoidance, excessive grooming, excessive exercise, dieting, frequent clothing changes, attempts to camouflage the defect, avoidance of usual activities, and social isolation (*DSM-IV-TR*, 2000). The *DSM-IV-TR* (2000) also notes that preoccupations associated with BDD may lead to repeated hospitalizations and attempts to fix or get rid of the defect through medial procedures or, in extreme cases, self-surgery and attempts at suicide.



### *Medical Procedures*

As mentioned above, individuals with BDD may seek out medical treatments in an attempt to fix the defect that is the focus of their attention (DSM-IV-TR, 2000). Gorbis and Kholodenko (2005) asserted that individuals with BDD may become addicted to plastic surgery even though these procedures did not relieve their symptoms of BDD and there is also a chance that the disorder may worsen or move to another part of their body. The authors also stated that the main manifestation of BDD is through plastic surgery and that individuals who are able financially to seek out these services may be more likely to be referred for appropriate treatment of BDD (Gorbis & Kholodenko, 2005). This information seems to stress the importance of contact and referral between mental health professionals and plastic surgeons.

In addition, Crerand, Phillips, Menard, and Fay (2005) found that many individuals with BDD seek out nonpsychiatric medical treatments in order to fix their disorder, as referenced above, but that only 3.6% of individuals interviewed within their study reported a lessening of their symptoms due to the nonpsychiatric treatment. The study also found that individuals most often sought dermatological and surgical treatments, with rhinoplasty being most often performed (Crerand, et al., 2005).

### *Suicide Ideation and Attempts*

The severity of BDD has been stressed throughout the research being synthesized for this paper because suicidal ideation is a primary characteristic of this disorder. Phillips, Coles, et al. (2005) found that 78% of the 200 subjects they interviewed had “a history of suicidal ideation, and more than half reported suicidal ideation attributed primarily to BDD” (p. 720). Another important finding of this study was that many of the individuals

that had suicidal thoughts or had attempted suicide had not talked to their mental health professional about the thoughts or their BDD symptoms (Phillips, Coles, et al., 2005). Also, those individuals in treatment “were significantly more likely to have experienced suicidal ideation due to BDD and had a greater number of suicidal attempts” (Phillips, Coles, et al., 2005, p. 720). These findings are important to be aware of when treating clients with BDD and implications of these findings for the treatment of individuals with BDD is discussed later within the treatment section.

### *Differential Diagnosis and Related Disorders*

It is also important to note that BDD should not be confused with an individual with normal concerns about their appearance or with someone who is involved in a healthy exercise routine (DSM-IV-TR, 2000). There are a number of disorders that share some similar characteristics with BDD that may instead be considered the focus of attention in a therapeutic setting (DSM-IV-TR, 2000). These include anorexia nervosa, gender identity disorder, major depressive episode (unless depression is a secondary diagnosis to BDD), avoidant personality disorder, social phobia, obsessive-compulsive disorder, trichotillomania, or koro (DSM-IV-TR, 2000).

One of the most closely related disorders to BDD within the *DSM-IV-TR*, which was also mentioned above, is anorexia nervosa (Grant & Phillips, 2004). Similarities of the two disorders include disturbance of body image within their diagnostic criteria, intrusive thoughts, dissatisfaction, an overall emphasis on appearance in the evaluation of self-worth, and appearance-related ritualistic or repetitive behaviors (Grant & Phillips, 2004). Although research related to the relationship between BDD and anorexia remains limited, Grant and Phillips have concluded that BDD and anorexia nervosa share enough

differences, including response to treatment, to continue to be classified as separate disorders.

### Gender and Body Dysmorphic Disorder

Both men and women are diagnosed with and treated for BDD, although it is unclear which gender holds a higher prevalence rate for the disorder (Phillips, 2005a, chap. 9). Muscle dysmorphia, a form of BDD, tends to occur almost exclusively in men and involves compulsive workouts and obsessive attention to diet and dietary supplements (Phillips & Castle, 2001). In addition, Phillips and Castle noted that social pressures seem to be encouraging boys and men to become larger and more muscular and embarrassment and shame hinder males' openness with regard to their symptoms. Phillips, Menard, and Fay (2006) found that men with BDD were more likely to suffer more severe side effects than women with BDD including unemployment, disability, and lower levels of functioning. The authors also found that men with BDD were more likely to seek out plastic surgery than men in the general population indicating that a high percentage of men seeking out plastic surgery may have BDD (Phillips, Menard, & Fay, 2006).

### Assessment of Body Dysmorphic Disorder

Numerous studies have utilized various forms and scales that assess BDD. It is not the author's intent to provide a review of the reliability and validity of these assessments, but to simply make the reader aware of what is available and being utilized within the field of research of BDD. Within their study of gender similarities and differences in relation to BDD, Phillips, Menard, and Fay (2006) used The BDD Form, The Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-

YBOCS), The Body Dysmorphic Disorder Examination (BDDE), The Psychiatric Status Rating Scale for Body Dysmorphic Disorder (BDD-PSR), The Brown Assessment of Beliefs Scale (BABS), and the Global Assessment of Functioning Scale (GAF) to assess 200 subjects diagnosed with BDD. Additional studies referenced in this paper also utilized a number of these tests, but the Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder, which assesses an individual's current severity of symptoms, was most commonly used (Eisen, Phillips, Coles, & Rasmussen, 2004; Phillips, 2005b; Phillips, Coles, et al., 2005; Phillips, Menard, & Fay, 2006; Phillips, Menard, Fay, & Pagano, 2005; Phillips, Pagano, et al., 2006). Cororve and Gleaves (2001) also found that the most commonly utilized assessment tools within the field are the YBOCS-BDD and the BDDE.

In addition, in his review of BDD, Veale (2004b) listed eight questions that are appropriate to use in making a diagnosis of BDD (see Appendix for complete list). These questions can at least provide the reader with a tool to use within a treatment setting to briefly assess a diagnosis of BDD and as a point for referral, if necessary.

#### Treatment for Body Dysmorphic Disorder

Knowledge of the current information on the treatment of BDD is essential for mental health counselors to recognize in order to be able to refer clients with BDD to competent treatment professionals and, for those treating clients with BDD to be able to collaborate with other mental health professionals, (such as psychiatrists). Williams, Hadjistavropoulos, and Sharpe (2006) noted that most studies conducted with regard to treatment of BDD have focused on behavioral therapy (BT), cognitive-behavior therapy (CBT), and serotonin reuptake inhibitors (SRIs). They conducted a meta-analysis and

found that both psychological and pharmacological treatments are effective when used to treat BDD, but that cognitive behavioral treatment was most successful within the studies they examined (Williams et al., 2006).

In addition, Neziroglu and Khemlani-Patel (2003) recommended a multi-modal treatment approach for BDD based upon a review of research and the complexity of the disorder. They also recommended utilizing collaboration with other professionals, intensive treatment, and including family members in treatment (Neziroglu & Khemlani-Patel).

Veale (2004a) developed a cognitive behavioral model of BDD that may be helpful when utilized in the treatment of BDD in order to help the client understand their own disorder and guide the treatment plan. Also, Veale (2004a) suggested the use of imagery, identifying the meaning of their defect, challenging the assumptions related to their defect, helping the client define their self with less importance upon appearance, and the use of reverse role-play.

According to the findings of Eisen et al. (2004) within their study of the insight of individuals with BDD, it is important for treatment professionals to address insight within the treatment of the disorder in addition to monitoring the client's functioning and suicidality. The findings of Phillips, Coles, et al. (2005) also suggest that it is important to assess and monitor individuals with BDD for suicidality and those individuals who have suicide ideation for symptoms of BDD as many of these individuals do not reveal their symptoms and ideology to clinicians.

Also, Phillips, Menard, Fay, & Pagano (2005) found that:

Body dysmorphic disorder subjects' scores were very poor across all functioning and mental health domains, including psychological distress, emotional well-being, work, school, role activities, leisure activities, household functioning, all components of social functioning (friends, extended family, parental, family unit, and primary relationships), and life satisfaction. A strikingly high proportion of subjects were not currently working (36%) or in school (32%) because of psychopathology. Most subjects (79%) considered BDD their most problematic disorder. (p. 258)

This inclusive finding indicates the importance of the counselor's attention to clients' functioning and quality of life within the treatment setting.

Finally, it is also important to note that individuals with depression, especially early-onset atypical depression, could have a high chance of also experiencing symptoms of BDD (Nierenberg, et al., 2002). Utilizing this information, the authors recommended screening all individuals with depression for symptoms of BDD (Nierenberg, et al., 2002).

#### Additional Resources

There are a number of valid resources beyond this paper available to help professionals gain a greater understanding of BDD. Three books are especially helpful and focus on treatment related aspects of the disorder. These include *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder* (Revised and Expanded Edition) (Phillips, 2005a), *The Adonis Complex: How to Identify, Treat, and Prevent Body Obsession in Men and Boys* (Pope, Phillips, & Olivardia, 2000), and *The BDD*

*Workbook: Overcome Body Dysmorphic Disorder and End Body Image Obsessions*

(Claiborn & Pedrick, 2002). Each book is readily available either at major book retailers or on-line. In addition, *The Broken Mirror* is written by one of the leading experts of BDD and is also appropriate for those suffering from BDD and their family members (Phillips, 2005a).

Also, as with any topic, on-line resources, such as websites and blogs, are readily available to gain additional information and support for professionals, individuals, and families struggling with BDD. The author is unable to verify the reliability and efficacy of these sites, therefore none will be referenced in this paper, although readers are encouraged to search out such web-based resources in order to be aware of what their clients may be accessing and utilizing.

Finally, *Body Dysmorphic Disorder: A Medical Dictionary, Bibliography, and Annotated Research Guide to Internet Resources* (Parker & Parker, 2004) is an excellent source for those wanting more clinical information about BDD and links to internet-based medical libraries. The glossary of terms is especially helpful for individuals who are beginning their introduction to BDD and are unfamiliar with the disorder's symptoms and traits.

### Conclusion

New research and information on BDD is consistently being published, but researchers point out that current literature on the subject has only begun to gain attention. The following authors point out that additional studies are needed to research suicidality in BDD (Phillips, Coles, et al., 2005), prevalence among men and women and specific similarities and differences between genders (Phillips, Menard, & Fay, 2006),

functioning and quality of life and the effectiveness of treatment upon these variables (Phillips, Menard, Fay, & Pagano, 2005), augmentation of SRIs (Phillips, 2005b), concurrent usage of medication and psychological treatments for BDD (Williams et al., 2006), development and treatment of BDD with cognitive behavioral models (Cororve & Gleaves, 2001), similarities and differences of individuals with BDD and anorexia (Grant & Phillips, 2004), and comparing insight in OCD and BDD and the treatment implications of these findings (Eisen, et al., 2004). Most authors of studies cited in this paper also noted the need for duplication and validation of their findings through additional clinical trials (Bohne, Keuthen, et al., 2002; Bohne, Wilhelm, et al., 2002; Phillips, Coles, et al., 2005; Phillips, Menard, & Fay, 2006; Phillips, Pagano, et al., 2006; Williams, et al., 2006).

Finally, counselors are encouraged to stay current with research and findings important to the study of BDD and to regularly seek out additional literature and resources regarding BDD in order to uphold their duties as counselors to be competent and serve their clients' needs in the most professional manner. Professional competence is an important aspect of a mental health counselor's profession and the author's hope is that this paper has provided an extra level of competence of BDD toward the reader's professional practice.



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Appendix

1. Do you currently think a lot about your appearance? What features are you unhappy with? Do you feel your features(s) are ugly or unattractive?
2. How noticeable do you think your feature(s) is to other people?
3. On an average day, how many hours do you spend thinking about your feature(s)? Please add up all the time that your feature is on your mind and make the best estimate.
4. Does your feature(s) currently cause you a lot of distress?
5. How many times a day do you usually check your features(s)? (Include looking in a mirror or other reflective surface, such as a shop window, or feeling it with your fingers.)
6. How often do you feel anxious about your feature(s) in social situations? Does it lead you to avoid social situations?
7. Has your feature(s) had an effect on dating or on an existing relationship?
8. Has your feature(s) interfered with your ability to work or study, or your role as a homemaker?