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Case Conceptualization and Treatment of Comorbid Body Dysmorphic Disorder and Bulimia Nervosa

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Body dysmorphic disorder (BDD) and eating disorders often co-occur and share some clinical features. In addition, the co-occurrence of BDD and an eating disorder may be associated with greater impairment in functioning. Furthermore, clinical impressions suggest that this comorbidity may be more treatment resistant than either disorder alone. The current article discusses the treatment of a 48-year-old female diagnosed with BDD and comorbid bulimia. We attempted to address these co-occurring disorders in a strategic, formulation-based manner using a variety of cognitive-behavioral strategies such as cognitive restructuring, rational disputation, exposure with response prevention, and mirror retraining. Despite the complexity of this case, results suggest that comorbid BDD and bulimia nervosa can be effectively managed with cognitive behavioral therapy.

Body dysmorphic disorder (BDD) is defined as a distressing or impairing preoccupation with an imagined defect in appearance; if a slight anomaly is present, the concern is markedly excessive (American Psychiatric Association, 2000). The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, and it must not be better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa). Studies have found that BDD is relatively common, occurring in 0.7% to 2.4% of community samples (Bienvenu et al., 2000; Faravelli et al., 1997; Koran, Abujaoude, Large, & Serpe, 2008; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brahler, 2006), 2% to 13% of student samples (Biby, 1998; Bohne et al., 2002; Mayville, Katz, Gipson, & Cabral, 1999), and 13% of psychiatric inpatients (Grant, Kim, & Crow, 2001). BDD is associated with very poor psychosocial functioning and quality of life (Phillips, 2000; Phillips, Menard, Fay, & Pagano, 2005), and a high rate of suicide ideation and attempts (Phillips, Coles, et al., 2005; Phillips & Menard, 2006; Veale et al., 1996). BDD is often comorbid with other disorders (e.g., Gunstad & Phillips, 2003), but its relationship to them is unclear. For example, it has been suggested that BDD and eating disorders may be related conditions (Grant & Phillips, 2004).

Some authors suggest that body image dissatisfaction may be the essential pathology underlying both BDD and eating disorders (Cororve & Gleaves, 2001; Rosen & Rameriz, 1998). BDD is the only diagnosis in the *DSM-IV-TR*, other than an eating disorder, that is characterized by a disturbance in body image. BDD and eating disorders also share some phenomenological features, such as body image dissatisfaction (Rosen & Ramirez, 1998), obsessional thinking (Godart, Flament, Perdereau, & Jeammet, 2002; Halmi, 2005), poor interpersonal functioning (Fairburn, 1997), and chronic low self-esteem (Polivy & Herman, 2002). In addition, many patients with eating disorders are preoccupied with non-weight aspects of appearance, such as the size of their stomach or thighs, or even body areas such as the skin or nose (Grant, Kim & Eckert, 2002; Gupta & Gupta, 2001; Gupta & Johnson, 2000), similar to patients with BDD, although the latter concerns would be diagnosed as BDD if diagnostic criteria are met. Conversely, some BDD patients are preoccupied with body weight and shape (Kittler, Menard, & Phillips, 2007; Phillips & Diaz, 1997). BDD individuals with weight concerns have been found to be as impaired or more impaired, across measures of symptom severity, comorbidity, and quality of life as those who have more classic BDD concerns (e.g., nose, skin, and hair; Kittler et al., 2007). The prevalence of eating disorders in individuals with BDD has varied across studies and appears elevated compared to the prevalence in the general population. In a study of 293 subjects with BDD, 10% had anorexia nervosa (AN) and/or bulimia nervosa (BN) at some point in their life (3% with AN, 8% with BN), and 4% had

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current comorbid AN/BN (1% with AN, 3% with BN; Gunstad & Phillips, 2003; this study did not assess the prevalence of an eating disorder NOS). Another small study of 16 individuals with BDD found that 19% of subjects reported a lifetime prevalence of an eating disorder (Zimmerman & Mattia, 1998). Both studies, however, consisted of individuals who were seeking or receiving psychiatric treatment, and 40% of the subjects in the former study were participating in a pharmacotherapy trial (Gunstad & Phillips, 2003), which may have introduced a selection bias. In a recent naturalistic study of 200 individuals with lifetime BDD who were not seeking or receiving treatment as part of the study, 33% reported having a lifetime eating disorder (9% with AN, 6.5% with BN, and 17.5% with an eating disorder NOS; Ruffolo, Phillips, Menard, Fay, & Weisberg, 2006). Those with (n=65) and without (n=135) a comorbid eating disorder were compared across a number of clinical variables, including severity of body image disturbance, functioning, and suicidality. BDD subjects with and without an eating disorder did not significantly differ on most variables. However, those with comorbid BDD and an eating disorder were more likely to be female, less likely to be African American, and had more comorbidity. Controlling for gender, comorbidity, and age, those with comorbid BDD and ED had greater body image disturbance and dissatisfaction, were more likely to have been hospitalized, and had received more psychotherapy and medication (Ruffolo et al., 2006). In a study of 41 inpatients diagnosed with AN (Grant et al., 2002), 39% were found to have a lifetime diagnosis of BDD with concerns unrelated to weight. Those with comorbid AN and BDD had lower overall levels of functioning and higher levels of delusionality than those without BDD. The comorbid AN and BDD group also had double the number of psychiatric hospitalizations, and three times as many subjects with comorbid AN and BDD had attempted suicide (63% versus 20%).

Despite the co-occurance of these disorders and clinical similarities, only one study (Rosen & Ramirez, 1998) has compared the clinical features of BDD and eating disorder patients directly. In this study, 45 female outpatients with AN or BN were compared with 51 female outpatients with BDD and 50 nonclinical controls. Both clinical groups had equally severe body image overall and poor self-esteem. However, BDD patients reported slightly more avoidance and negative self-evaluation due to appearance concerns, whereas the eating disorder patients reported more widespread psychopathology. Limitations of this study are that the BDD group included only females and the groups were compared on only a small set of variables and important questions regarding many central features about the commonalities and differences between these disorders have remained unanswered.

Research on treatment efficacy suggests that cognitive behavioral therapy (CBT) may be effective for both BDD (Veale, Gournay, et al., 1996; Wilhelm, Otto, Lohr, & Deckersbach, 1999) and bulimia (for review see Fairburn, 2006). Although few controlled treatment outcome studies for BDD have been completed, preliminary studies on the efficacy of CBT are very promising (Neziroglu & Khemlani-Patel, 2002). In a randomized controlled trial of group CBT for BDD, 54 women were assigned to a CBT treatment group or to a wait list (Rosen, Reiter, & Orosan, 1995). Subjects who received CBT had significantly greater improvement in BDD symptoms, self-esteem, and depression than those on a waiting list. Veale, Gournay, and colleagues (1996) randomized 19 patients to 12 weekly sessions of CBT (n=9) or a 12-week wait list (n=10). Two measures of BDD symptoms showed significant improvement with CBT compared to the wait-list control. In an open trial of group CBT (n=13; Wilhelm et al., 1999) group CBT was associated with significant improvement in symptoms (improving from severe to moderate). Other smaller case series offer support for CBT's efficacy (Neziroglu & Khemlani-Patel, 2002). Numerous reviews and meta-analyses have examined the efficacy of CBT for BN (for review see Fairburn, 2006). CBT has been the most extensively studied psychosocial treatment for BN and its utility the most consistently substantiated (American Psychiatric Association, 2000). The leading form of treatment for BN is a specific form of CBT (Fairburn, Marcus, & Wilson, 1993). CBT for BN appears very effective at reducing core features of the disorder, including purging, dietary restraint, and improving maladaptive attitudes toward weight and shape (Fairburn et al., 1995; Thackwray, Smith, Bodfish, & Meyers, 1993). These results suggest that CBT appears to be an effective intervention for both disorders of body image. IPT has also been shown to be efficacious for BN (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Cooper, & Steere, 1995; Fairburn, 1997; Fairburn et al., 1991) but has not been studied in BDD.

In sum, BDD and eating disorders often co-occur and share some clinical features. Comorbidity of BDD and ED may be associated with greater impairment. Given the significant rates of co-occurrence of these disorders, treatments are needed that address comorbidity in BDD. In this article, we present a case study of a patient who presented for treatment with BDD and comorbid BN. Treatment followed the CBT conceptualization and treatment strategies recommended by Fairburn et al. (1993) for BN and Rosen (1995a) for BDD. The purpose of this article is to describe an application of CBT in the treatment of a 48-year-old female with significant body dysmorphic and bulimic symptoms. In this clinically complex case, we attempted to address co-occurring disorders in a strategic, formulation-based manner.