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Advances in a cognitive behavioural model of body dysmorphic disorder

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Abstract

Body dysmorphic disorder (BDD) is the most distressing and handicapping of all the body image disorders. A cognitive behavioural model of BDD is discussed which incorporates evidence from recent studies and advances in the author's 1996 conceptual model. The model aims to understand the maintenance of symptoms in BDD, to assist in the process of engagement of therapy and to guide the strategies to use. At the core of BDD is an excessive self-focussed attention on a distorted body image, the negative appraisal of such images leading to rumination, changes in mood and the use of safety behaviours. Evidence for possible risk factors in the development of BDD is also discussed.

Keywords: Body dysmorphic disorder; Cognitive behaviour therapy; Risk factors; Body image

Introduction

Body dysmorphic disorder (BDD) is characterised by a preoccupation with an imagined defect in one's appearance or, in the case of a slight physical anomaly, the person's concern is markedly excessive. The person must also be significantly distressed or handicapped in his or her occupational and social functioning (American Psychiatric Association, 1994). There is frequent comorbidity in BDD especially for depression, social phobia and obsessive–compulsive disorder (OCD) (Neziroglu, McKay, Todaro, & Yaryura Tobias, 1996; Phillips & Diaz, 1997; Veale et al., 1996a). There is also heterogeneity in the presentation of BDD from individuals with borderline personality disorder with self-harming behaviours to others with muscle dysmorphia (Pope, Gruber, Choi, Olivardia, & Phillips, 1997), who are less handicapped. They share a common feature of a preoccupation with an imagined defect or minor physical anomaly. The most common preoccupations concern the skin, hair, nose, eyes, eyelids, mouth, lips, jaw, and chin, however any part of the body may be involved and the preoccupation is frequently focussed on several body parts simultaneously (Phillips, McElroy, Keck, Pope, & Hudson, 1993). Complaints typically involve perceived or slight flaws on the face, asymmetrical or

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disproportionate body features, thinning hair, acne, wrinkles, scars, vascular markings, and pallor, or ruddiness of complexion. Sometimes the complaint is extremely vague or amounts to no more than a general perception of ugliness. BDD is characterised by time consuming behaviours such as mirror gazing, comparing particular features to those of others, excessive camouflage, skin-picking, and reassurance seeking. There is usually avoidance of social situations and of intimacy. Alternatively such situations are endured with the use of alcohol, illegal substances or safety behaviours similar to social phobia.

The prevalence rate of BDD in the community is reported as 0.7% in two studies (Faravelli et al., 1997; Otto, Wilhelm, Cohen, & Harlow, 2001) with a higher prevalence of milder cases in adolescents and young adults (Bohne et al., 2002). The prevalence of BDD is about 5% in a cosmetic surgery setting (Sarwer, Wadden, Pertschuk, & Whitaker, 1998) and 12% in a dermatology clinic (Phillips, Dufresne, Wilkel, & Vittorio, 2000). Surveys of BDD patients attending a psychiatric clinic tend to show an equal sex incidence and sufferers are usually single or separated (Neziroglu & Yaryura-Tobias, 1993; Phillips & Diaz, 1997; Phillips et al., 1993; Veale et al., 1996a). Veale et al. (1996a) found a greater preponderance of women but this may be because of a referral bias. It is also possible that, in the community, while more women are affected overall, a greater proportion experience milder symptoms.

Although the age of onset of BDD is during adolescence, patients are usually diagnosed 10–15 years later (Phillips, 1991; Phillips & Diaz, 1997; Veale et al., 1996a). Patients may be secretive because they may think they will be viewed as vain or narcissistic. They are therefore more likely to present to mental health practitioners with symptoms of depression or social anxiety unless they are specifically questioned about symptoms of BDD. BDD patients are the most distressed and handicapped of all the body image disorders with a high rate of depression and suicide or "do it yourself" (DIY) cosmetic surgery. Phillips (2000) used a quality of life measure and found a degree of distress that is worse than that of depression, diabetes or bipolar disorder.

BDD is probably best conceptualised as having both quantitative and qualitative differences from normal body dissatisfaction and body image. For example, the degree of importance attached to one's appearance in defining one's self might be at the extreme end of a normal dimension. However, the distorted imagery experienced by some BDD patients has a more qualitative difference to normal body image.

A cognitive behavioural model of BDD

There are similar features in psychopathology of BDD with OCD and social phobia, with frequent comorbidity. It is not therefore surprising that a cognitive behavioural model of BDD described below has some overlap with that of social phobia (Clark & Wells, 1995), OCD (Salkovskis, 1999) and health anxiety (Warwick & Salkovskis, 1990) which influence I would like to acknowledge. A model for BDD needs to focus on features, which are unique to BDD. One such feature is the relationship with reflective surfaces such as mirrors or old photos, which acts a trigger for the symptoms. The model has some overlap with a cognitive behavioural model of body image developed by Cash and Pruzinsky (2002) which is most commonly applied to dissatisfaction for body weight and shape in a non-psychiatric population.

Cognitive behavioural models are relevant for answering questions about the maintenance of symptoms. For example, why does an individual with BDD "see" a grossly distorted body image in a mirror when others view the person as genuinely attractive and contradict their views? Furthermore, the model needs to be understood by a patient; to provide an alternative explanation for their experience; to assist in the process of engagement and to guide the strategies to use in therapy. For each section of the model, I will discuss the theory, the evidence for the model so far and the clinical implications in therapy. I will discuss putative risk factors for the development of BDD in the second half of the article.

The self as an aesthetic object

The self as an aesthetic object refers to the experience of extreme self-consciousness and self-focussed attention on a distorted image. It is proposed that the cycle begins when an external representation of the person's appearance (e.g. looking in a mirror)