A PRIMER ON BODY DYSMORPHIC DISORDER (BDD)

The Center for OCD & Anxiety, LLC

AGENDA

- Define BDD and it's core features and diagnostic criteria
- Differentiate BDD from related disorders, particularly OCD and ED
- Identify evidence based treatment approaches for BDD, including ERP, CBT and emerging interventions
- Understand when ERP may be contraindicated or need modifications
- Explore the role of sociocultural factors in BDD (e.g. body ideals, social media)
- Learn how to approach BDD clients with nuance, empathy, and clinical effectiveness
- Know when and where to refer out for specialized services

UNDERSTANDING BDD

DEFINITION & DSM V TR CRITERIA

- Preoccupation with one or more perceived flaws in physical appearance (not observable, or appear slight to others)
  - Examples: a client believes their nose is grotesque in shape but this is not noticed by others; a client that is focused on age spots when few are actually visible to others
- Repetitive behaviors or mental acts
  - Examples: mirror checking, reassurance seeking, comparing, camouflaging, medical interventions, grooming, skin picking, photo editing, mental review of flaws, rumination
- Clinically significant distress or impairment resulting from this preoccupation or the repetitive behaviors often marked by social avoidance, occupational impairment and/or isolation
- NOT better explained by concerns about weight, body fat (e.g. not explained by an eating disorder)

BDD v “NORMAL”

- BDD Clinical Differentiation from Normal
  - The “invisible” or “slight” flaw criterion is what differentiates BDDD from normal appearance dissatisfaction or from concerns associated with a genuine disfigurement.
    - In typical body image concerns, a person may dislike a feature of their appearance but recognizes that others don’t see it as extreme.
    - In BDD, that perception is distorted, fixed and often resistant to reassurance or evidence, suggesting perceptual and cognitive distortion rather than the perception being a mark of vanity or insecurity.
  - In assessment, clinicians SHOULD explore not only what the client perceives as flawed, but also how they are interpreting others reactions.
    - Clients with BDD often do not believe the reassurance that they are provided by others; rather, they believe that others are noticing, judging or disgusted by their flaw (even when there is no confirmation of this factually).
    - This additional discrepancy between internal perception and external observation is a hallmark of the BDD diagnosis.

BDD v OCD v ED

- BDD and OCD Overlap
  - Similar mechanisms: intrusive thoughts, compulsive rituals, anxiety driven behaviors
  - Differences: BDD obsessions are purely focused on appearance; insight is poor.
  - Treatment Overlaps: ERP, CBT are used for both, but targets are different (e.g. target appearance fears in ERP instead of OCD issues likes contamination).
- BDD and ED Overlap
  - BDD is focused narrowly on a specific body part (e.g. nose, hair, skin, etc.)
  - ED is focused on the whole body (e.g. weight, shape, body fat percentage, eating behaviors that relate to weight loss/gain)
  - Both CAN coexist

THE EXPERIENCE OF BDD

PERCEPTUAL STUDIES ON BDD

- Research has shown that they experience differences with visual processing compared to peers, specifically around facial recognition and detail orientation.
  - Feusner et al (2007; 2010; 2011) found that individuals with BDD show abnormal patterns during fMRI of visual-cortex activation consistent with a bias toward detailed (local) processing and relative under engagement of configural/holistic processing (low spatial frequency) across domains. Higher emotional reactivity was also evident (hyperactivity in the fronto striatal regions of the brain was observed). These studies justify inclusion of perceptual training for BDD (e.g. visual field exposures, work to see the body as unified or integrated whole and not in parts).
  - Monzani et al (2013) found that individuals with BDD have abnormal global AND local processing, so their bias is not just specific to appearance but may be a broader perceptual difficulty, again supporting perceptual retraining.
  - Greenberg, et al (2014) found that individuals with BDD show attention bias towards areas they judge unattractive and towards attractive features in others (used eye tracking to monitor this).
  - More recent reviews indicate a model that focuses on perceptual style and top down appraisal interactions is most supportive for those with BDD as it targets both perception (how they look) AND cognition/emotion (how they think and feel).

PERCEPTUAL V PSYCHOLOGICAL DISTORTION

- Individuals with BDD literally perceive themselves differently.
- It's not "all in their head" as their perception is neurologically influenced AND psychologically reinforced by thoughts/behaviors.
- Clinicians SHOULD validate that the individual's distress and perception are REAL EXPERIENCES, even if they are not objectively accurate.

THE ROLE OF INSIGHT

- Insight ranges from good to delusional (primary assessment tool = Brown Assessment of Beliefs Scale/BABS)
  - Eisen et al (2004) found that individuals with BDD have significantly poorer global insight than OCD patients.
  - This was replicated in a Phillips et al (2012) study, and which also showed that poorer insight led to increased symptom severity for those with BDD.
  - Harrison et al (2017) again found low to absent insight in BDD patients was comparable to those with psychotic disorders in the belief domain.
  - Schulte et al (2021) observed that there can also be variance in level of insight from one day to the next for those with BDD (as is true in the general population)
- Clinicians should assess and engage their clients to determine insight and allow this knowledge and rapport to influence treatment approaches.

THE ROLE OF SHAME

- Shame, social comparison and identity are core themes
  - Shame levels in BDD are higher than in the general population and correlate moderately with SI and marginally with greater BDD severity; shame reduction significantly reduces correlated SI even when accounting for reduced BDD severity (Weingarden, et al, 2018).
  - Both “body shame” and “general shame” are associated with BDD, so assessment should include both (Weingarden, et al 2017).
  - Shame is a significant predictor of depression outcomes in those with BDD (Weingarden, et al 2016). Interventions focused on reducing shame can help remit depression/functional collapse.
  - Linde et al (2022) had a small study showing that CFT and ACT reduced shame and improved BDD outcomes.
  - When BDD and ED overlap, shame and self-criticism should be targeted directly to improve outcomes (Matos, 2023).

SOCIETAL NORMS & CULTURAL CONTEXT

THE IMPACT OF SOCIETAL BEAUTY STANDARDS

- Media and social platforms amplify body “ideals” (thinness, symmetry, perfection)
  - Highlight reels (TikTok, Instagram) provide constant exposure to filtered, edited selfies and specific content (“fitspo” or “what I eat in a day”) that removes imperfection and exaggerates symmetry,or thinness, or meal restriction as “achievable” or normal–this can increase comparison and shame.
  - AI editors (like those on Snapchat or TikTok) can slim the face, enlarge the eyes, smooth skin, whiten teeth, increase facial symmetry, etc. and some of those posting these images tag them as “natural beauty” and “no make up.” These filters and editors along with content normalize the idea that flaws are not acceptable and increase shame, ritualized beahviors for those with BDD.
  - Exposure to gendered trends, to cosmetic procedures, to “transformation” videos can all occur.
  - Algorithms reinforce exposure which can lock BDD clients into a digital checking and/or researching loop.
- All of the above (and more!) can act as triggers for BDD onset OR relapse.

NAVIGATING NORMS IN THERAPY

- Validate the social pressure
  - What this sounds like: “It makes sense that you feel pressure in a culture that idealizes thinness.”
- Differentiate between systemic ideals and internalized beliefs
  - What this sounds like: Use ACT to determine what client thinks and values compared to social norms; explore how their own media algorithms may be influencing this thought process
- Explore media literacy and cultural criticism
  - What this sounds like: exploring how beauty norms are constructed from one culture to another, how stepping outside of one algorithm can create new and unique perspectives
- Move beyond self compassion
  - What this sounds like: embodiment work (engaging and reconnecting with the body through sensory, functional or movement based approaches); ACT work (learning to live meaningfully despite distress); narrative therapy (separating self from the social narrative–the problem is the story and not the body!)

TREATMENT APPROACHES

CBT FOR BDD

- Primary evidence based modality
- Treatment Structure:
  - Psychoeducation
  - Cognitive Restructuring (challenging appearance assumptions)
  - Behavioral Experiments
  - Exposure and Response Prevention (ERP) with BDD modifications
- SSRIs are the most effective class of medications
  - Studies show that those with BDD have a response rate to medication (along with CBT) the 50-70% range.
  - SImilar to OCD, BDD clients often need higher doses and longer trials than those with depression and may take longer to respond to medication (e.g. need a full 12 week trial). Guidelines are to have 12 months of stability after positive response before titrating off medication.

ERP–WHEN IT HELPS AND WHEN IT HURTS!

- ERP works when it is focused on reducing avoidance and safety behaviors (like mirror checking, reassurance seeking, makeup application, etc.).
- ERP can be harmful when the client is severely dysregulated or suicidal.
- ERP can be harmful when the client has poor insight and exposure feels like forced invalidation of their concerns.
- ERP can be harmful when the clinician is emphasizing a goal of “seeing the flaw differently” rather than using an inhibitory approach of tolerating the distress produced by the flaw.
- Therefore, ERP should be introduced gradually with LOTS of therapist support and should emphasize distress tolerance over habituation/”seeing things differently.”

COMPASSION FOCUSED THERAPY (GILBERT, 2009)

- Compassion Focused Therapy (CFT): Very useful when shame is central to BDD beliefs
  - Targets shame by teaching clients to relate to their shame differently–with warmth, validation and acceptance instead of avoidance or self attack.
  - BDD clients often use self-criticism to fuel other BDD behaviors (“If I am harsh enough, I will fix myself”) and CFT teaches that compassion is not indulgence but courage. CFT can help shift the internal voice from critical to caring.
  - Corrects this misuse of threat driven safety behaviors (like mirror checking) and teaches use of soothing behaviors instead (grounding, breathing, compassionate imagery).
  - Can support clients in addressing early experiences of shame and invalidation that may reduce internal preoccupation with BDD’s perceived flaws.
  - Similar to ACT, engaging in CFT can enhance participation in CBT and ERP.

OTHER INTERVENTIONS

- General CBT:
  - Cognitive restructuring helps BDD clients question the accuracy and utility of their beliefs and generate alternative interpretations that are more balanced
- ACT:
  - Develop understanding of values and focus on acting in alignment with them despite painful thoughts or feelings
  - Cognitive defusion(enhances knowledge that thoughts are not facts)
  - Acceptance of uncertainty (targets experiential avoidance and control symptoms of BDD)
- Mindfulness Based Approaches:
  - Can be helpful for building awareness of body related thoughts without fusing with them
  - Teach ways to counteract the detail oriented bias of those with BDD
- EMDR for BDD
  - **May** be useful **if** BDD has trauma or shame related origins

REFERRALS

- BDD specialized CBT/ERP providers
  - Use IOCDF “Find a Provider” Tool and filter for BDD
- Higher levels of care (IOP and RTF)
  - McLean
  - Rogers
  - UCLA BDD Program
  - Use BDD Foundation page to assist in searching for reputable providers

VISUAL FIELD EXPOSURES

VISUAL FIELD EXPOSURE (NOT MIRROR BASED)

- Developed from perceptual training and mirror retraining research
- Focuses on modifying the way clients visually scan themselves and the world
  - Expands the visual field from “zoomed in” on BDD flaw to broader context (e.g. all of their face, all of their body, the environment) which supports the shift from detail processing to holistic processing.
  - Exposures are not related directly to mirror work, but may include viewing themselves or others from multiple distances and perspectives, using photographs or video, doing public view exposures, shifting their gaze patterns, or using alternative lighting.
  - Ties these exposures to anxiety producing situations (like entering a room, passing a reflection) so that client learns to tolerate the distress and that they can scan differently.
- Goal is to reduce distorted visual processing and increase tolerance of self-viewing experiences

MIRROR RETRAINING

- Teaches clients to observe their whole face/body neutrally rather than zooming in so that the client can break the cycle of compulsive mirror checking OR avoidance of mirrors AND self-criticism/shame that these behaviors induce.
- Practice describing themselves nonjudgmentally (“My face has two eyes, a nose, a mouth....”) so that they are shifting both HOW they attend to the mirror and WHAT meaning they are assigning to it.
- Mirror retraining is both an ERP exercise, an attention retraining exercise AND a cognitive restructuring exercise (client and clinician can shape language used during the ERP). Mindfulness skills and CFT skills may need to be added in for additional support.

MIRROR RETRAINING GOAL EXAMPLES

- Normalize mirror use–teach client to be able to functionally use the mirror (e.g. to complete grooming and hygiene) rather than for reassurance or flaw searching
- Reduce selective attention–train the client to view not just the flawed area but the whole face or body
- Build emotional tolerance–allow anxiety, shame, guilt, disgust to be present and ebb and flow without the use of safety behaviors
- Foster a more balanced perspective–help clients describe themselves in objective, nonjudgmental language
- Shift from self criticism to curiosity–replace evaluative (“I look horrible”) with descriptive (“my eyes are blue and I have freckles”)

DIFFERENCES BETWEEN MIRROR RETRAINING & VISUAL FIELD EXPOSURE

FEATURE	MIRROR RETRAINING	VISUAL FIELD EXPOSURE
SETTING	Typically mirror based, structured	Broader (mirror, photo, real world reflections, other people)
FOCUS	Relationship with your own reflection	Shifting visual attention patterns and perceptual processing
PRIMARY GOAL	Normalize using a mirror and reduce rituals	Broaden visual processing, reduce detail bias
MAIN TECHNIQUE	Neutral descriptions, global scanning, response prevention	Attention shifting, varying distance/angle, real-world scanning

INTEGRATIVE CASE PRACTICE

CASE EXAMPLE: CHAD

Chad is a 20 year old white male who has BDD around facial scarring from acne. He engages in mirror checking (pushes and pulls at skin to distort scarring), social avoidance(limits interacting with anyone new, preferring to spend time with those who knew him “before” acne began due to belief that they at least see a “better” version of Chad), reassurance seeking (asks multiple times per day of others and via Reddit posts and AI if his scars are noticeable) and has sought medical interventions to reduce the appearance of scarring from his dermatologist (trying a range of treatment that has not satisfactorily resolved his concerns).

CASE EXAMPLE: CHAD

- Differentiate between social anxiety, BDD, OCD
- Explore cultural pressures (beauty norms, filters and “Instagram face”)
- ERP modification planning
- ACT/values integration

CASE EXAMPLE: LINDSAY

Lindsay is a 45 year old ER nurse and the mother of a 3 year old. She has BDD around her hair. Lindsay believes that her hormone disorder has thinned her hair and created excessive hair loss as did her “geriatric pregnancy.” She engages in avoidance (limits leaving the home for things other than for work, where she regularly wears a scrub cap) and comparison (will scan media, community to observe hairlines of others and compare to her own), mirror checking (spends hours in front of mirror, often focused on her part). Lindsay also engages in extensive researching around supplements for hair growth, although she struggles to decide what supplements to take.

CASE EXAMPLE: LINDSAY

- Differentiate between social anxiety, BDD, OCD, perfectionism
- Explore cultural pressures (beauty norms in her community, cultural norms for parenting)
- Explore actual medical diagnosis/hormone disorder
- ERP modification planning
- ACT/values integration

RESOURCES AND REFERENCES

BOOKS

- The Broken Mirror (Phillips, 2005)
- Cognitive Behavioral Therapy for Body Dysmorphic Disorder (Wilhelm, Phillips, Steketee, 2013)

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RESEARCH STUDIES-ROLE OF SHAME

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ORGANIZATIONS

- International OCD Foundation (IOCDF)
- BDD Foundation (UK based; excellent clinician resources)

PODCASTS

- Kim Quinlan's "Your Anxiety Toolkit" has episodes specific to BDD
- Interviews with Sabine Wilhelm, Katharine Phillips from a research perspective
- Interviews with Chris Tronsden, Scott Granet about lived experiences

SUPERVISION & CONSULTATION

- Kim Quinlan's "Your Anxiety Toolkit" has episodes specific to BDD
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THANK YOU!

The Center for OCD & Anxiety, LLC