

# Body Dysmorphic Disorder

## 'A Guide for People with BDD'

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## **Introduction**

Body image is the mental picture we have of the size, shape and form of our bodies through our mind's eye. It is not so much about our actual appearance but is more about the 'internal' view of how we look – how we feel about the way we think we look and what we think others see when they look at us. Body image is strongly affected by social factors including the culture we live in, the influence of the media, fashion trends and even our family members, friends and colleagues at work and school.

In our society over the past few years, increasing importance and emphasis has been placed on physical beauty and perfection and many of us are spending a lot of time and effort on our appearance. We wear make up, go to the gym, buy clothes that are stylish and flattering, spend a lot of time styling our hair and even resort to having cosmetic surgery - all in the hope of looking more attractive. Growing up in such a world can leave us feeling a little insecure especially if we don't think we measure up to how we believe the 'ideal' woman or man should look. It isn't surprising some people become so preoccupied with attaining perfection that they develop a distorted picture of their own body image.

At one time or another, we all worry about our appearance – that we might have put on a little too much weight or that our skin is blotchy or that we don't like the shape of our nose - things which irritate us but don't affect our lives too much. However, there are some of us who dislike an aspect of how we look to such a degree we become preoccupied with this part of our body. We imagine it is often much worse than it is until it gets to the point where it is hard to feel comfortable mixing and even talking with other people without worrying about how we look. This is very distressing and can impair our ability to enjoy life, to socialise and even to work or study.

Such extreme dissatisfaction with an aspect of appearance is known as Body Dysmorphic Disorder or BDD. The historical term was 'Dysmorphophobia'.

## **What is BDD?**

BDD is defined as a pre-occupation with an imagined or very slight defect in physical appearance which causes significant distress to sufferer. It is not a rare disorder, only an under-recognised one, and affects men and women from all walks of life.

It was first described in 1886 by an Italian physician named Morselli (he called it 'dysmorphophobia', a term that is still used sometimes today) but it received little attention until the 1980s when it officially entered American psychiatric literature.

People who suffer from BDD dislike some aspect of how they look to such an extent they can't stop thinking and worrying about it. To other people, these reactions may seem excessive as the supposed problem may not even be noticeable or is related to a very minor blemish such as a mole, or mild acne scarring, which anyone else may not even notice. However, to BDD sufferers the 'defects' are very real, very obvious and very severe. They believe that because they can "see" a defect, then it must be there and they cannot be convinced otherwise. It is as if when they look in the mirror they cannot see what everyone else sees (or doesn't see).

BDD is a serious psychiatric condition that goes beyond vanity. It is not something that a person will grow out of or will just 'forget' about.

## What are the Symptoms of BDD?

There are two major features of BDD – a pre-occupation with the supposed appearance problem; and the actions people take to either ‘hide’ the defect or avoid situations because they feel ugly and don’t want to be seen by others.

Most of us spend only a few minutes each day thinking about our appearance, but the BDD sufferer may spend hours worrying about how he or she looks. Some say they are obsessed with their appearance and find it very hard to stop thinking about what it is that worries them. Some people with BDD realise they look worse to themselves than to others and that their view of their appearance problem is exaggerated and distorted. However, there are others who are convinced their view of their physical ‘defect’ is accurate. One aspect of BDD which can be especially troubling is the feeling that other people are taking special notice of this “defect” – that people are staring at it, making fun of it or laughing about it behind their backs when in reality, no one may even notice it. Many sufferers feel ashamed and fear being rejected by others.

The other feature of this disorder is what people try to do to reduce their distress. Most people with BDD perform one or more repetitive and often time consuming behaviours also known as ‘rituals’. These are usually aimed at examining, ‘improving’ or hiding the perceived flaw in appearance.

BDD sufferers usually spend a lot of time ‘checking’ themselves in the mirror to see whether their perceived ‘defect’ is noticeable or has changed in some way. Others will frequently compare themselves with other people or images in magazines or billboards. Others spend hours ‘grooming’ themselves by applying make-up, changing clothes or re-arranging their hair to ‘correct’ or cover up the ‘problem’. Others attempt to camouflage or hide their defect by wearing a hat, a wig or sunglasses. In extreme cases, some people wear a mask or hood over their head. Others try by acting or standing in a certain way in public to make the defect seem less noticeable. Others weigh or measure themselves continually or wear big and baggy clothing to hide what they think are ‘huge’ hips or large breasts. Some may wear many layers of clothing to make themselves appear larger or more muscular, and some men (especially those who suffer from ‘muscle dysmorphia’) lift weights or exercise excessively to try to bulk up. They may eat special diets or use drugs such as anabolic steroids to try to build up their muscles. Finally, some people approach cosmetic surgeons or dermatologists seeking surgery or medical treatments.

### **CASE STUDY: “Muscle Dysmorphia”**

*Phil was a tall and thin 19 year old who had been teased relentlessly by his school mates since he was about 14 when he had a growth spurt and grew very much taller than the rest of them. He was always thin but his excessive height seemed to emphasise his slight frame. By the time he was 16 he was clinically depressed. He lived at home with his parents and younger brothers. He did not have many friends and only went out socially one night a week to play basketball. His basketball coach was always hassling him about not taking off his track suit top when it came time to play. He spent many hours in front of the computer and his only social interaction other than with his immediate family was through internet chat rooms. While on the internet he saw an advertisement about body-building and purchased home gym equipment and a quantity of high-protein formula for muscle bulking. Over the next few months, he spent hours in his room, working out on the equipment and consuming the diet supplement and began to bulk up significantly. However, he did not see the muscle growth and continued seeing a weak, thin, puny person staring back at him from the mirror. This perception led him to an on-going cycle of obsessive thoughts about his body which led him to spend a lot of time in front of the mirror checking his muscle size.*

Some people will spend hours picking at their skin and even though this may be seen as an attempt at removing imperfections or making the skin surface smooth, it can result in scars and wounds that may never heal and ironically make the skin look much worse. Some people with BDD repeatedly ask family members or friends for reassurance that they look okay or alternately try to convince others of their ugliness. This behaviour can be especially frustrating for family members because the BDD sufferer isn't usually reassured no matter how much time, support and encouragement they are given.

### **What People Worry About**

The face is the most common body part that people with BDD worry about. The concern can be about some specific part of the face, such as the nose, lips, or ears or it can include facial skin appearance, including wrinkles, skin colour, blemishes, scars, veins, texture or the size of the pores. Hair or hairlines are also commonly the focus of concern. Any body feature, such as the size or shape of the legs, arms, buttocks, breast or genitals, may be considered 'ugly' by the person with BDD. People with eating disorders such as anorexia or bulimia are usually very concerned with body weight or being fat while people with BDD focus on specific parts of the body.

#### **CASE STUDY: "Skin Concerns in BDD"**

*Linda was a 23 year old woman who worried incessantly about her face which she described as spotty & pock-marked. She thought about what she saw as the 'horrendous holes' on her nose and face for many hours a day. She also repeatedly checked her skin and nose in mirrors, picking at her skin in an attempt to 'get out all of the impurities'. Although she often wanted to ask others if she looked OK, she usually resisted because she feared they would think she was 'crazy'. She spent more than an hour each day painstakingly applying make-up to cover what was in fact, minimal acne. Linda described her pre-occupation as 'severely upsetting' and said it had caused her self-esteem to plummet and had made her depressed. She had difficulty working, often stayed in her house, and refused invitations to go out because she thought she looked so ugly. Despite her suffering, Linda kept her pre-occupation secret because she found it so shameful and humiliating.*

### **Consequences of BDD**

Some people with BDD manage to function well despite their distress. Others, however, are severely impaired by their symptoms, often becoming socially isolated by not going to school or work and in extreme cases refusing to leave home for fear of being embarrassed about their appearance.

It can be especially difficult for sufferers to go to places such as beaches, hairdressers, shopping or places where the person may feel anxious about how they look. It is not uncommon for people with BDD to feel depressed about their problem and the negative impact this has on their life. Some become so desperate that they attempt suicide.

Relationship problems are common and many BDD sufferers have few friends; avoiding dating and other social activities or even getting divorced because of their symptoms.

## How is BDD Diagnosed?

Sufferers of BDD may not realise they have a serious but treatable psychological problem. Often their concerns are considered by others to be vanity or attention seeking because the body part they worry about usually looks normal. Sufferers may have a sense that their concerns are unrealistic but worry if they talk about it to anyone, it won't be taken seriously and their problem will be dismissed. Others may worry if they talk about their appearance concerns, it will just draw more attention to them. Families and friends may even trivialise the problem, not realising that this extreme distortion cannot be just forgotten or overcome. BDD is not widely recognised and health professionals may not be familiar with the disorder, leading to misdiagnosis. Unless BDD is specifically asked about, the diagnosis can be missed. This can be problematic because the person may feel misunderstood and not properly informed about treatment options.

An issue commonly raised when talking about BDD is how to differentiate it from normal appearance concerns. What distinguishes such normal appearance concerns from BDD is:

1. extent of the preoccupation with the perceived defect;
2. amount of distress it causes; and
3. extent to which it interferes with the person's life.

These questions are designed to screen certain concerns that are often difficult and embarrassing to talk about with your doctor/family/friends and often difficult to find the right help for:

- Have you ever been concerned about some aspect of your physical appearance?
- Have you ever considered yourself to be misformed or misshapen in some way (eg. nose, hair, skin, sexual organs, overall body build )?
- Have you ever considered your body to be malfunctioning in some way (eg. excessive body odour, flatulence, or sweating)?
- Have you ever consulted or felt that you needed to consult a plastic surgeon, dermatologist or physician about these concerns?
- Have you been told by others or doctors that you are normal in spite of you strongly believing that something is wrong with your appearance or bodily functioning?
- Have you spent a lot of time worrying about a defect in your appearance or bodily functioning?
- Have you spent a lot of time covering up defects in your appearance or bodily functioning?

Dysmorphic Concerns Questionnaire, Oosthuizen et al, 1998;  
(Reproduced with Permission)

## Who is Affected by BDD?

BDD often begins in early adolescence and may remain undiagnosed for many years. It is estimated to affect between 1 – 2% of the population and roughly equal numbers of males and females. Research data suggests that BDD usually persists for years, sometimes worsening over time, unless appropriately treated.

## What Causes BDD?

Currently the cause of BDD is unknown. Many theories exist but much more research is required before there will be an answer to this question. There are most likely multiple biological, psychological and socio-cultural factors which contribute to its cause. There is suggestion an imbalance in the chemical serotonin in the brain may make some people more likely to express the symptoms of BDD. It is also possible psychological factors such as excessive teasing during childhood, or family or peer emphasis on appearance or some trauma such as sexual abuse might be risk factors for the expression of symptoms. Media messages may worsen the condition in vulnerable people with BDD.

## Conditions Associated with BDD

Many people with BDD also suffer from depression at some point in their life and there is also a high rate of depression in families of people who develop BDD. Both BDD and depression are characterised by low self-esteem, feelings of rejection, heightened sensitivity and of being unworthy. Occasionally, even without depression, BDD sufferers may have thoughts of suicide. BDD sufferers can present with other disorders as well. Obsessive Compulsive Disorder (OCD), eating disorders, anxiety disorders, and Trichotillomania (hair pulling) are all problems that can be associated with BDD. Other BDD sufferers abuse drugs or alcohol.

### **CASE STUDY: “Trichotillomania”**

*Anna was a 27 year old woman who had been pulling out her hair since she was 13. She recalled it began when she found a single white hair and pulled it out. She then developed a ‘fascination with the hair root’ and felt a sense of ‘release’ when the hair was pulled. Sporadic, brief episodes of pulling a few hairs a day gradually progressed over years to the point where she would sometimes spend hours pulling her hair each day. She found that it got worse just before she got her period, or when she was upset or under increased stress at school and at work or when she was worrying about an up-coming event. The hair pulling was a complex and ritualised process where she would search for the right hair, attempting to pull it out by the root. She would spend some time fiddling with the root and then repeat the process. She used tweezers and other implements to pull the root out. Her hair pulling grew worse and she began wearing a bandana to cover the areas of hair loss and then a scarf to cover extensive areas; eventually she wore a wig. Her hair pulling forced her to give up her promising career as an athlete because of an intense fear that her hair pulling would be exposed. It also caused difficulties with social relationships & dating because she was fearful her ‘shameful habit’ would be exposed.*

There are several things BDD and OCD have in common such as obsessive preoccupations which are intrusive and difficult to control as well as repetitive compulsive behaviours which attempt to reduce anxiety. The difference is people with OCD can be obsessive about any issue and involve rituals such as excessive washing or checking, whilst BDD obsessions and rituals focus only on appearance or body image. According to researchers, most people with OCD have insight into the exaggerated response that is part of their disorder at least some of the time while BDD sufferers often have little if any insight into their exaggerated response and are firmly convinced their ‘defect’ is real and noticeable. This can present some challenges for treatment because if the person feels their concern is justified, they have little reason to seek help from a mental health professional, and instead go to cosmetic specialists for a ‘cure’.

### **How is BDD Treated?**

Many people with body image problems such as BDD may spend a lot of time and money trying to correct their perceived defect on things such as make-up and grooming aids and will seek often expensive treatments from dermatologists, plastic surgeons and other health care providers.

If the surgeon does not see the defect as significant enough to be changeable, the BDD sufferer may move on to find another surgeon who may in time operate on them. Often they will be dissatisfied with the results of the surgery or become obsessed with another body part. The person may even think the surgery was botched and made the defect worse giving rise to new appearance preoccupations. They may then seek further surgery, or legal action, or even try to get revenge against the surgeon for ‘ruining’ their appearance. Some sufferers, out of desperation, even attempt to do surgery on themselves. It seems that most BDD sufferers are unable to find relief using these treatments and many end up disliking their appearance even more.

Although research on BDD is in its early stages, there are treatment methods which have been identified as helpful:

### **CASE STUDY: “BDD & Cosmetic Surgery”**

*Jane was a 21 year old student who lived at home with her mother and sister. Since starting high school at 13, she had been concerned about the size and shape of her nose which she felt was too “bulby” on the tip. She was sure when she went to school or even down the street to the shops, everyone was staring at her and talking about how big and ugly her nose was. At school she had few friends and would sit alone, not joining group activities. She desperately begged her mother to have cosmetic surgery, and after years of badgering, her mother finally relented, allowing her to have surgery and paying for the operation. The procedure was minimal and Jane was very happy for a while but not long after the procedure, she became dissatisfied with the outcome claiming not enough was taken off the tip of her nose. She was sure further surgery would solve her problems and made another appointment with the surgeon to see what else could be done. This led to a series of operations by a number of different surgeons. Jane was increasingly unhappy with the results, blaming the surgeons for “making things worse”.*

### **Medications**

Serotonin-reuptake inhibitors (SRIs) are a group of medications which appear to be useful and effective for many people with BDD. The SRIs are a type of antidepressant used successfully in the treatment of both depression and obsessive compulsive disorder. These include Prozac, Zoloft, Cipramil and Aropax.

People who respond to SRI therapy generally find they spend less time obsessing about their ‘defect’ and if they start thinking about it, it’s easier to push the thoughts aside and think about other things. People who respond usually feel as though they have regained the control of their mind and it becomes easier to resist BDD related behaviours such as mirror checking and seeking assurance from others. Many people find functioning improves as well and it becomes easier to be around other people and to work effectively at school and work. Self-consciousness and feelings of anxiety, depression and suicide often diminish and self-esteem and body image often improve. The SRIs appear to work by increasing the overall activity of serotonin in the brain and thereby correcting a chemical imbalance. Patience is needed when starting the medication as it may take up to 12 weeks for the medication to work and sometimes different drugs need to be tried to find one that suits the individual.

### **Psychotherapy**

Cognitive Behavioural Therapy (CBT) appears to be another effective treatment for BDD. This type of therapy is often recommended in addition to medication. The behavioural component consists of ‘Exposure & Response Prevention’. ‘Exposure’ consists of having the person expose their ‘defect’ in situations which they would usually avoid whilst ‘response prevention’ involves helping the person stop carrying out the compulsive behaviours related to that defect. The aim over time is to decrease anxiety involved with that particular avoided situation. The cognitive component refers to addressing the range of intrusive thoughts that accompany the behaviours, or rituals such as mirror checking, in BDD. This work focuses on exploring beliefs and values that support and strengthen a person’s perceptions about their body.

Cognitive Restructuring is aimed at developing an understanding of how these strongly held values impact the person’s sense of ‘self’, and to progressively build up alternative ways of thinking about the intrusive thought, rather than going through the usual range of behaviours such as mirror checking and reassurance seeking. Restructuring consists of a range of techniques involving making changes to a person’s values whilst not directly questioning the repetitive and intrusive thought the person has about their body.

**CASE STUDY: “CBT for BDD”**

*Sophie would only go out in public if her make-up perfectly covered her ‘blotchy’ skin. Her makeup routine took over an hour each morning. She also checked excessively in mirrors and other reflecting surfaces and continually asked her family for reassurance about how her skin looked. As a first step, she halved the amount of make-up she usually applied and decreased her mirror checking from one hour to 30 minutes a day using a timer. Each day she went out of the house to do tasks she thought were manageable such as going to the Post Office or getting a few groceries until she became more confident. She increased the length of time she stayed out and then began taking on more challenging situations such as going to the bank, going to a restaurant or to a party. She reduced her camouflaging and checking of her appearance until she could face provoking situations without going through her compulsive behaviours. Her family were shown that continually giving reassurance made no difference to how Sophie saw herself.*

**Living With Someone with BDD**

People with BDD are often secretive about their condition and the symptoms may not be immediately recognisable even to close family and friends. The experience of many family members is that BDD sufferers are vain, selfish and preoccupied with their appearance and continually asking for reassurance about how they look. It is not widely understood it is often almost impossible for people with BDD to just take their mind off their obsessions. The more attempts made to convince them they are worrying for nothing, the more it can make them feel misunderstood and anxious. Although it may be difficult, it may be better to avoid commenting directly on the supposed defect and simply listening or offering support, perhaps suggesting it might be worthwhile talking to a counsellor, psychologist or family doctor. Even though they may insist that fixing the defect by cosmetic surgery may solve their problems, visiting plastic surgeons and dermatologists should not be encouraged without first seeking counselling.

It must be remembered that BDD is not something that someone will ‘grow out of’ or ‘get over’, so it is crucial that the disorder is taken seriously. The “just stop worrying about yourself and look around you” approach does not work with this disorder, as it is asking sufferers to respond rationally to thoughts that are irrational.

Often people with BDD are too ashamed to come forward and discuss their problem, believing they are the only ones who have such painful and persistent thoughts. In the process of trying to reassure them that their appearance is OK, frustration can lead to tension, arguments and feelings of helplessness within the family. Rather than engaging in fruitless reassurance, it is better to explain to the sufferer that you understand their distress and that by not discussing appearance issues with them you are actually helping them. Encouraging sufferers to talk about their problem may actually provide some relief by acknowledging that their symptoms are taken seriously. Getting them to talk to health professionals can provide them with a diagnosis and alert them to treatment that is readily available.

**CASE STUDY: “FAMILY SUPPORT”**

*Barbara was a 21 year old student who lived with her mother. She was pre-occupied with what she considered to be her excessively frizzy hair. She spent many hours each day washing and styling her hair, often getting up early in the morning only to return to the bathroom just before going to work and start all over again. She would continually seek reassurance from her mother, sometimes asking her many times a day whether her hair looked straight and not too curly. Her long-suffering mother would at first patiently console her daughter and try to reassure her that her hair was fine, but in the end, she would become so frustrated and overwhelmed with Barbara’s relentless demands and questioning that any discussion of the topic would end in arguments between the two. In the end, her mother suggested that Barbara consult a Psychologist to discuss her obsession and pre-occupation with her appearance. Her mother was able to assist Barbara as a “co-therapist” (support person) in her psychological treatment.*



There are many ways to determine whether your family member or friend has BDD. Dr Katharine Phillips, a leading international researcher on Body Dysmorphic Disorder, in her booklet, 'Learning to Live with Body Dysmorphic Disorder', offers some clues:

frequently checking the appearance of their face or another part of their body in mirrors or other reflective surfaces; or alternately avoiding mirrors altogether.

continually comparing themselves unfavourably with other people

camouflaging their perceived 'defect' with clothing, hats, makeup, hands or even body posture

seeking surgery or treatment by a dermatologist or other medical treatment when doctors or other people have said that the 'flaws' are minimal or nonexistent or that such treatment is not necessary

seeking reassurance about their perceived 'flaw' or attempting to convince others of it's ugliness

excessive grooming (hair combing, shaving, removing or cutting hair or applying makeup)

touching the perceived 'defect'

picking their skin or pulling out their hair

measuring the disliked body part

excessive reading about the 'defective' body part

avoiding social situations where the perceived defect may be exposed

feeling anxious and self-conscious around other people because of the perceived defect.

## Helping with Treatment & Recovery

Adapted from “Learning to Live with BDD” by Phillips, Van Noppen and Shapiro

Family members can vary in how they respond to BDD. In many cases, families and friends of BDD sufferers often do not know what to do to help. The role of family or friends in the recovery process is often a complicated one and some guidelines on how to approach the situation may prove helpful.

- Learn to recognise the symptoms of BDD.
- Recognise the need for professional help.
- Create an empathic and supportive home environment. With an open door policy to problem solving and a non-judgemental attitude, explain that your participation in their rituals will only perpetuate their symptoms. Emphasise that you care about them and that you will try to understand and support them through their treatment and recovery.
- Provide clear and simple communication about appearance. Some BDD sufferers continually engage others in lengthy discussion about their perceived defects and this can be frustrating for everyone, often ending up in argument. Try to point out that continual questioning and seeking of reassurance is a symptom of BDD and that talking about it won't change the way they feel about their appearance. Sometimes it is necessary to provide them with a 'reality check' to let them know that the reason they see themselves as unattractive is because BDD distorts their view of themselves, and not because others see them this way.
- Don't make excuses for them but rather encourage participation in family events. Remind them that the focus of the event is not going to be them and that they may even feel much better about themselves because they participated and nobody had to make excuses for them on their behalf.
- Try keeping the stress levels down as many BDD sufferers say that an increase in stress increases the severity of their symptoms and changes of any kind can be anxiety provoking.
- Appreciate small gains made. It is very important to recognise and support every step toward resisting BDD behaviours including rituals and intrusive thoughts. Resisting rituals such as the urge to check skin blemishes in the mirror for an hour may not seem like a big deal for most people, but for someone with BDD, it can prove to be enormous. Even if someone cuts down on their 'checking' time from 1 hour to 30 minutes, this may be for them a major accomplishment. Recognising and acknowledging this effort to reach such a goal is very important. Encouraging the BDD sufferer to keep going and not give up, while offering support for any progress no matter how small, is a powerful tool in recovery.
- If your friend or family member with BDD is on medication, make sure you offer plenty of support. Taking medication for a psychiatric disorder does not represent a weakness of character. In fact, it will often allow the person to work more effectively with their counsellor or psychologist. However, it must be remembered that medications do have side effects and if problems arise make sure you take them seriously, encourage them to discuss these issues with their mental health professional but don't allow them to just stop their medication without first consulting their Doctor.

## Further Reading

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