

Chapter 2

Becky's Body Worries

2.1 Case Presentation

Becky is a 29-year-old unmarried woman with asthma and seasonal allergies who is referred to see a psychiatrist, Dr. Clark, by her primary care provider for the evaluation of a possible eating disorder because of expressed preoccupation with what she is eating and a 7 lb weight loss since her last visit six months before. Becky tells Dr. Clark that “this isn’t in my head,” describing “a rash” on her face which she believes may be related to food allergies. Despite negative allergen testing, she endorses being convinced that she is sensitive to wheat and dairy and that she develops flushing on her face when she eats them. She explains that she has been aware of her flushed skin for the past eight years. Feeling “embarrassed” by this aspect of her appearance, she had tried to manage the symptom on her own for several years, trying numerous topical treatments and home remedies, such as drinking apple cider vinegar. About a year ago, becoming increasingly frustrated by her symptom, she saw a dermatologist who—she reports—told her there was “nothing to see” and seemed “patronizing”. Becky saw two more dermatologists after that, whom she describes as equally unresponsive. About two months ago, she began reading about food allergies and is sure that wheat, dairy,

and “nightshade vegetables” are causing her symptoms, so she began progressively limiting her diet. She says the flushing has persisted, but attributes this to her sense that “trace amounts” of these food allergens are present in other foods despite her efforts to buy “pure products”. She has been spending an estimated 3 h a day reading about food allergies and checking ingredient lists of foods. She also spends about 2 h in the morning applying makeup to conceal her flushed skin and more time throughout the day when she “checks” on her flushing in her handheld mirror. She avoids looking at herself in bathroom mirrors during the day, afraid of how her flushing might look in “new” mirrors.

Dr. Clark does not appreciate any abnormal discoloration of Becky's skin from her chair across the office room; when she asks where on her face the flushing is, Becky becomes angry, saying that everyone tells her she looks “normal”, and the fact that they do not seem to “notice” upsets her even more.

Upon further history, Becky describes a history of worries about her body going back to childhood, with concerns about going blind or dying as a young girl, and worries about the width of her thighs as a teenager. She admits that in high school she would measure her thighs three times a day and do various exercises that she thought might make them smaller. She had a period of food restriction in order to lose weight from her thighs at age 16, reporting that she lost approximately 5 lb over two months but then resumed a more normal diet. She had seen a therapist as an 8-year-old for her “worries” about sickness and dying; she subsequently saw the school counselor during her senior year because of concerns by her parents and teachers that she was anxious, but she did not find this helpful. She has never been on psychiatric medications.

2.2 Diagnosis/Assessment

Preferred diagnosis: Body Dysmorphic Disorder

With further exploration of her symptoms, Dr. Clark diagnoses Becky with body dysmorphic disorder (BDD). BDD is not considered an eating disorder but has many overlapping features with the feeding and eating disorders and should be considered in the

evaluation of an individual presenting with concerns about physical appearance (see Differential Diagnosis for further discussion).

The diagnosis of BDD requires preoccupations with perceived flaws or defects in one's physical appearance, repetitive behaviors in response to these thoughts about appearance, impairment in functioning due to the preoccupations and behaviors, and the exclusion of an eating disorder that could better explain the patient's symptoms. The individual's physical flaw may not be evident to others; in cases where an objective physical defect is present, the individual's response to the defect surpasses what would be expected, including the intensity of the concerns or the degree of behaviors associated with the defect. Specifiers for BDD include the muscle dysmorphia variant, which applies to individuals focused on not being muscular enough, and the insight specifier (categorized as "with good or fair insight," "with poor insight," and "with absent insight/delusional beliefs"). Previously located in the somatoform disorders section, BDD is currently classified as one of the *obsessive-compulsive and related disorders* in DSM-5, with modifications based on advances in the understanding of the condition [see Text box: "Spotlight on DSM-5: Body Dysmorphic Disorder"].

BDD has a point prevalence of approximately 1.5–2.5, though these estimates are thought to be lower than the actual prevalence, as this diagnosis is often missed—due to various factors, including lack of widespread awareness of, and screening for, the condition, and the shame that individuals with BDD often experience, making them less likely to disclose their thoughts and behaviors about their appearance. In clinical samples, both psychiatric outpatient and inpatient settings, the prevalence is higher; notably, up to one-quarter of all patients seeking non-psychiatric treatment, such as dermatologic and surgical interventions, may have BDD, based on some estimates [2]. BDD is slightly more common in women than men, though this difference is not marked. Gender and cultural standards may influence the focus of the patient's attention; for example, while the most common physical areas of concern include skin, hair, and nose, women with BDD appear to be more preoccupied with weight, breasts, buttock, and legs, while men may be more concerned about their genitals, musculature, and hair/balding.

BDD has a typical age of onset in mid-adolescence and tends to have a chronic course, often taking on different forms over a lifetime (with shifting physical concerns and behaviors). One of the most

important aspects of this condition is its high suicide rate, with suicidal ideation present in as many as 80 % of individuals with BDD and up to 25 % attempting suicide at some point [3].

Treatment, including therapeutic and pharmacologic, can be effective, but relapse rates are high if treatment is not actively continued. Many never receive treatment because they never come to clinical attention (for reasons mentioned previously), or because shame, avoidance, or lack of insight prevents engagement in care. Pharmacologic management of BDD emphasizes serotonin reuptake inhibitors (SRIs, including the selective serotonin reuptake inhibitors, the serotonin norepinephrine reuptake inhibitors, and the tricyclic antidepressants that have potent serotonin reuptake inhibition), often at high doses, with fair response rates but high relapse rates after discontinuation [4]. Antipsychotic medications may sometimes be used to address severe distress or delusional thoughts, though evidence indicates that the delusional variant of BDD is equally responsive to SRIs alone as is the non-delusional type. Relapse rates after a successful treatment with SRIs are very high and therefore might need to be continued long term if not supplemented with another type of treatment, such as Cognitive Behavioral Therapy (CBT). CBT has been demonstrated to be effective for BDD, involving a combination of psychoeducation, challenging the thoughts about appearance that drive the behaviors and distress, and exposure and response prevention (such as looking in the mirror and perceiving flaws, but resisting engaging in maneuvers to hide them). The improvement gained from a treatment course of CBT may endure for an extended period after completion, though there are limited long-term data. An important component of CBT for BDD is relapse prevention, in which the patient might be trained to continue to participate in CBT exercises on his or her own after the therapy is completed, as this seems to improve outcome.

Surgical and other cosmetic treatments to address a patient's perceived flaw is not effective and should not be recommended; BDD symptoms reemerge after these interventions in nearly 100 % of patients. In general, a priority for patients with BDD is detection of the disorder and minimization of iatrogenic harm that might be caused by engaging in repeated treatments and procedures.

It is thought that BDD is substantially more prevalent than population studies indicate, because individuals are not coming to clinical attention. Many patients may be seeking treatment;

however, because of shame related to their concerns and behaviors, or because of clinicians' lack of awareness of BDD or how to detect it, they are not being diagnosed. Experts encourage more broad screening for BDD. The body dysmorphic disorder Questionnaire(BDDQ) is a simple 4-question screening tool, which can be clinician- or patient-administered, and requires no special training to utilize or interpret. It can be found online [<http://www.rhodeislandhospital.org/psychiatry/body-image-program.html>]; the BDDQ asks about preoccupation with one's appearance and the amount of time and distress that these preoccupations are causing. A positive screen would be an indication for more extensive evaluation, perhaps with an expert.

Spotlight on DSM-5: Body Dysmorphic Disorder

In DSM-III and -IV, BDD was located in the *somatiform disorders* section (the group of diagnoses now referred to as the *somatic symptom disorders*). One major change from DSM-IV to DSM-5 was the development of a new diagnostic category, the *obsessive-compulsive and related disorders*, which includes BDD as well as obsessive-compulsive disorder (OCD) and other disorders, such as Trichotillomania, which appear to share common neurobiological circuitry and have similar clinical phenomenology and response to treatment [1].

The diagnostic criteria for BDD have been modified in DSM-5 to include—in addition to preoccupation with perceived physical flaws or defects—the presence of repetitive thoughts or behaviors in response to the thoughts about physical appearance. In DSM-IV, individuals with beliefs reaching delusional intensity were classified as having *delusional disorder, somatic type*. Emerging evidence, however, indicates that nearly one-half of individuals with BDD may hold their distorted thoughts to a delusional degree and that these individuals do not appear to have significant clinical or demographic differences compared to those with non-delusional beliefs about appearance. The delusional variant may be a more severe form of the illness. DSM-5 added the *absent insight/delusional beliefs* specifier to denote this clinical presentation.

2.3 Differential Diagnosis

Becky presents several different signs and symptoms, including preoccupation with her body both externally (concerns about her skin) and internally (beliefs about the effects certain foods and allergens are causing her); weight loss; anxiety; and ritualistic behaviors. In addition, she has a history of concerns about her body shape leading to food restriction, as well as substantial anxiety symptoms as a youngster. The differential diagnosis is broad, and her evaluation should be thorough.

She was referred for a possible eating disorder. She has experienced recent weight loss. She attributes this to dietary limitations related to her skin; however, individuals with eating disorders will commonly explain their food restriction based on “allergies” or “sensitivities” [see Chap. 14 for further discussion]. To differentiate Becky’s presentation from an emerging case of anorexia nervosa (food restriction in an effort to lose weight), Dr. Clark would want to explore the primary motivation for the food limitations as well as Becky’s specific concerns about her body. In cases where the preoccupation is primarily about weight or body shape, a diagnosis of an eating disorder should be prioritized. In Becky’s case, if the motivation for her food restriction was considered to be for weight loss, but it had not yet led to substantial weight loss, a diagnosis of other specified feeding and eating disorder (not meeting criteria for anorexia nervosa due to weight still within normal limits) would be appropriate. If, on the other hand, she was describing an aversion to certain foods or otherwise refusing to eat them, but not indicating a motivation such as weight loss, then a diagnosis of avoidant–restrictive food intake disorder would be applicable.

Because of ritualistic behavior and intrusive, repetitive thoughts, a diagnosis of OCD should be high in the differential. Indeed, it is thought that there is substantial overlap, neurobiologically and phenomenologically, between OCD and BDD, which led to the categorization change in DSM-5 placing them in the same chapter. In BDD, the focus of the patient’s concerns and rituals should be a perceived physical defect or flaw, as opposed to another worry or distress-laden preoccupation (as in the case of OCD).

Other relevant diagnoses include various anxiety disorders, including social anxiety disorder, in which an individual may feel

scrutinized by others; in Becky's case, her specific preoccupation with her skin, and her substantial ritualistic behavior in response to this, would make a diagnosis of BDD more appropriate and useful (for conceptualization and treatment purposes). It is possible that Becky has comorbid generalized anxiety disorder or social anxiety disorder, and this could be further explored. Somatic symptom disorder (known as somatoform disorders prior to DSM-5) should also be considered. In somatic symptom disorder, an individual has significant distress related to physical symptoms. In Becky's case, though she describes flushing and substantial related distress, she is specifically preoccupied with appearance, and thus, the diagnosis of BDD is more apt. Delusional disorder can also be considered. As mentioned previously in this section, delusional variants of BDD were classified as delusional disorder, somatic type prior to DSM-5. As with other alternate diagnoses, Becky's specific focus on a physical appearance-related matter and her associated ritualistic behavior make BDD the most suitable diagnosis.

Individuals with BDD may commonly have comorbid depressive disorders, perhaps in part in response to the distress caused by their physical preoccupation and their ritualistic behaviors. Suicidality, as mentioned previously, is particularly high in this population and should be assessed carefully and in an ongoing way. There may be comorbid anxiety disorders and OCD.

2.4 Outcome

Dr. Clark, after a careful psychiatric evaluation, made a diagnosis of BDD. Becky was initially remained fixated on her appearance flaw and had difficulty considering the possibility that her skin problem was less evident to others than to her. She was resistant to following up with Dr. Clark, insisting that she has a dermatologic or allergic issue; she continued to seek care from other specialists. She denied clear symptoms of a major depressive episode, but did have low mood and reduced concentration; in addition, she felt socially isolated because of her symptoms and her need to spend hours a day doing her rituals. She denied suicidal thoughts. Dr. Clark was able to engage her on the level of the distress that her worries were causing her, and her interpersonal dissatisfaction; she

agreed to follow up with him to “process” some of these feelings. She agreed to try sertraline for her “anxiety and sadness”. With time and gentle encouragement, she began to participate with some cognitive restructuring of her body-related thoughts. She started to be more open to the possibility that her distress was at least in part related to BDD. She was eventually referred for a structured course of CBT for BDD with improvement in her overall preoccupation with her skin and the time spent engaging in compensatory behaviors. After several months of seeing Dr. Clark, taking sertraline, and engaging in CBT, Becky was feeling less burdened by her thoughts and her behaviors and was overall happier. She was eating a normal diet, her weight was stable, and she was no longer seeking out medical specialists for her skin.

References

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Suggested Readings

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- Van Ameringen M, Patterson B, Simpson W. DSM-5 obsessive-compulsive and related disorders: clinical implications of new criteria. *Depress Anxiety.* 2014;31(6):487–93.



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