

## Part A

# Knowledge and Theory of Body Dysmorphic Disorder

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# Chapter 1

## The diagnosis of body dysmorphic disorder

### Summary

The diagnosis of body dysmorphic disorder (BDD) is relatively easy to make but is often overlooked because few professionals ask a simple screening question. The key criterion is a *preoccupation* with an imagined defect or minor physical anomaly. The preoccupation must be sufficient to cause significant distress or handicap. An additional diagnosis of delusional disorder is made on the strength of the conviction of the client's beliefs and reflects the severity of the disorder. There is high degree of comorbidity in BDD, especially of depression, social phobia, or obsessive compulsive disorder (OCD). The differential diagnosis of BDD is discussed in other common disorders. The most common Axis II diagnoses are avoidant, paranoid, and obsessive-compulsive personality disorder.

### Sections

- 1.1 Presentation
- 1.2 Diagnosing BDD
- 1.3 Preoccupation
- 1.4 Distress and handicap in BDD
- 1.5 Suicide attempts and suicide in BDD
- 1.6 Age restrictions
- 1.7 Delusional disorder
- 1.8 Making a diagnosis in ICD-10
- 1.9 Differential diagnosis of BDD and comorbidity
- 1.10 Affective disorders
- 1.11 Social phobia

## 4 *Knowledge and Theory of Body Dysmorphic Disorder*

- 1.12 Alcohol and substance misuse
- 1.13 Obsessive compulsive disorder
- 1.14 Eating disorders
- 1.15 Psychogenic excoriation
- 1.16 Trichotillomania
- 1.17 Olfactory reference syndrome
- 1.18 Schizophrenia and persecutory Delusional disorder
- 1.19 Body integrity identity disorder
- 1.20 Body modification or self-mutilation
- 1.21 Koro
- 1.22 Personality disorder

### **1.1 Presentation**

The diagnosis of BDD in DSM IV is relatively easy to make but is often overlooked. Patients present in a variety of settings: medical, dermatological, or cosmetic surgery. They are typically preoccupied by perceived or slight flaws on the face, asymmetrical or disproportionate body features, thinning hair, acne, wrinkles, scars, vascular markings, pallor, or ruddiness of complexion. Sometimes the complaint is extremely vague or amounts to no more than a general perception of ugliness or other aesthetic attributes, such as being too masculine or feminine. The most common preoccupations in BDD are around the face, especially the nose, skin, hair, eyes, eyelids, mouth, lips, jaw, and chin (Neziroglu & Yaryura-Tobias 1993a; Phillips et al., 1993; Veale et al., 1996; Neziroglu et al., 1999). However, any part of the body may be involved and the preoccupation frequently focuses on several body parts (Andreasen et al., 1977). Over time, the location of the main defect may change. In one of the largest surveys of people with BDD, Phillips & Diaz (1997) report there are far more similarities than differences between men and women in the location of their BDD concerns. Both genders are most commonly concerned with their skin, followed by hair and nose. Although women are more likely to have hair concerns (e.g., asymmetry, wrong color, lacking body, excessive body hair), men are significantly more concerned with hair thinning or baldness. The gender differences occur with body size and shape. Women are more likely to be preoccupied by their breasts, hips, weight, and legs, usually believing that they are too large or fat. In contrast, men are more likely to be preoccupied with body build and believe that their body is too small, skinny, or not muscular enough. This has been described as muscle dysmorphia (Pope et al., 2005). Despite such concerns, many such men are unusually muscular and large. They spend many hours weightlifting, and pay minute attention to nutrition. Others may abuse steroids. Another significant gender difference is that

men are more likely to report hair thinning and preoccupation with their genitals (usually a concern that their penis is too small). However, women may report their labia being too large and seek a cosmetic operation to reduce the size (Liao & Creighton, 2007).

Phillips & Diaz (1997) note that some of these gender differences appear to reflect those reported in the general population, suggesting that cultural norms and values may influence the content of BDD symptoms. Women are more likely to pick their skin, camouflage with make-up, and have comorbid bulimia nervosa. Men with BDD are as likely as women to *seek* non-psychiatric medical treatments, although women are significantly more likely to *receive* medical treatments, especially dental treatment. Men with BDD, however, are as likely as women to have received cosmetic surgery.

The diagnosis of BDD is, however, often overlooked if the interviewer does not ask about specific symptoms of BDD as clients are often too ashamed to reveal the true nature of their problem. This seems to occur especially in psychiatric inpatients (Grant et al., 2002). Grant et al. screened 122 consecutive inpatients and 16 (13.1%) were diagnosed as having BDD by a structured interview; none of the participants had been diagnosed as having BDD by their treating physician. All 16 subjects reported that they would not raise the issue with their physician unless specifically asked, due to feelings of shame. This study underlines the importance of clinicians asking about symptoms of BDD in routine interviews and screening, especially in an inpatient population.

## **1.2 Diagnosing BDD**

BDD is classified as a somatoform disorder in DSM IV (American Psychiatric Association, 1994) (Table 1.1). Identifying and diagnosing BDD is relatively easy if the assessor asks the right questions or uses a structured diagnostic interview; there is then a high degree of inter-rater reliability.

**Table 1.1:** Diagnostic criteria for Body Dysmorphic Disorder (DSM IV)

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1. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
  2. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  3. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa).
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## 6 Knowledge and Theory of Body Dysmorphic Disorder

A simple open question that can be used in a screening interview is:

“Some people worry a lot about their appearance. Do you worry a lot about the way you look and wish you could think about it less?”

Without direct questioning, individuals may present with symptoms of depression, social phobia, or OCD. Clients are especially secretive about symptoms such as mirror-gazing, probably because they think they will be viewed as vain or narcissistic. Clinicians do not ask the right questions, probably because they regard BDD as rare or believe that concerns about their appearance are part of another disorder, such as depression.

There are also validated screening measures for BDD. The Body Dysmorphic Disorder Questionnaire (Phillips, 1996a) is a brief, simple, self-report screening measure. It has a high sensitivity and specificity for the diagnosis in both outpatient and inpatient settings (Grant et al., 2001) and in dermatology settings (Dufresne et al., 2001). Cash et al. (2004) have developed the screening questionnaire into a formal scale, although a cut-off point was not set for screening. Cash (personal communication) found in a preliminary study that a seven-item mean Body Image Disturbance Questionnaire (BIDQ) score greater than or equal to a summed score of 21 would detect 98% of individuals with BDD vs. a positive screen for only 10% of the clinical (psychiatric) controls, 26% of the treatment-seeking obese patients, and 67% of eating disordered patients. Among normal controls (college students), there would be a positive screen for only 6% with a score of 21 or more. Self-report questionnaires and diagnostic interviews are provided in Appendix 1. A brief, clinician-administered diagnostic measure, the BDD Module, has been shown to have good inter-rater reliability (Phillips, 1996a).

Each of three main criteria for diagnosis of BDD is discussed below.

### 1.3 Preoccupation

The cornerstone of the diagnosis of BDD is *preoccupation* with an imagined or minor defect in appearance. To fulfill the first criterion, Phillips (1996a) suggests that the preoccupation with perceived defects should be at the forefront of the mind for a minimum of an hour a day. We would concur, although this threshold may be too low for some individuals seeking cosmetic surgery who desire a cosmetic enhancement (i.e., they have no “defect”) and other criteria, such as significant distress, may be difficult to apply in this setting. Most clients with BDD in a psychiatric clinic describe being excessively self-conscious of their appearance; however, there are some clients who are not preoccupied as they can avoid others viewing their feature by camouflaging it

with clothing. They would, though, become severely distressed if they were not camouflaged. Such clients can generally avoid intimacy or revealing their body in changing rooms or when swimming. Another pitfall in fulfilling the criteria for preoccupation is misuse of substances such as cannabis or alcohol, which may prevent the client thinking about his appearance. Others may be less preoccupied because their avoidance is high and they are housebound, spending many hours in bed, watching television, or surfing the Internet. Rather than be preoccupied, many of these clients may be depressed about their appearance and score low on standardized scales for BDD.

We discuss the nature of the preoccupation in Chapter 4, but it appears to consist of excessive, self-focused attention on body image, ruminating and comparing features with those of others. Changing the agenda and trying to define the problem to be solved as one of excessive worrying or thinking about one's appearance are emphasized in the process of engagement. The preoccupation often covers multiple locations and may fluctuate over time and shift to another area of the body.

The term *imagined defect* in the diagnostic criteria can be problematic. It is not one we use with our clients for several reasons. First, the defect(s) is very real to the individual and telling a client that he has an "imagined defect" does not assist in engagement or building a therapeutic alliance. Second, aesthetic judgments *partly* depend on personal aesthetic standards and there is evidence that clients with BDD may be slightly more aesthetically sensitive than average and have lost a self-serving positive bias in judgements about their appearance. We discuss later the phenomenology of an "imagined defect," but it is best explained psychologically as excessively self-focused attention on a "felt impression" of appearance, which is fused with past experiences and is now viewed as current reality.

The criterion can also be met if a "*minor physical anomaly is present and the person's concern is regarded as markedly excessive.*" In practice, the criterion means that the feature(s) under consideration is/are either not significantly noticeable to others or that many other people have the same or similar feature(s). However, some people with BDD are not concerned by whether the feature is noticeable by others but usually have a deep self-disgust about certain feature(s). We discuss later a psychological understanding of the discrepancy between the aesthetic evaluation by the individual with BDD and that of clinicians and relatives.

The term *minor physical anomaly* covers the normal variation in features (e.g., freckles, small breast size, or baldness) which may be noticeable, but which are not that abnormal compared to one's peers. There is clearly a gray area between those who have a minor and those with, for example, a moderate physical anomaly and yet may fulfill other diagnostic criteria, such as being excessively preoccupied, significantly distressed, and/or handicapped. The

most common example is women with A or AA cup size breasts; someone who has lost a lot of weight and has excessive skin folds; or someone who has an extremely small stature. Such individuals may be very self-conscious, be quite avoidant in intimacy, and have been teased about their appearance. Although an argument can be made that these are minor anomalies or normal variations in bodily appearance, we do not generally view such clients as having an imagined or minor defect – one of the criteria for BDD. To complicate matters further, a client may have one or two features that are regarded as moderate physical anomalies that are noticeable, and others that are “imagined” or minor anomalies.

Alternatively, a feature (e.g., a skin blemish) may be noticeable if your attention is drawn to it by your client or if you look closely enough *and* raise your aesthetic standards. In such situations an individual may even acknowledge that his blemish is not noticeable to a stranger passing in the street (especially if it is camouflaged), but might feel very self-conscious in an intimate relationship or if a stranger came too close. To overcome some of the difficulties with an imagined defect or a minor physical anomaly, it might be better if the criteria for BDD in the new DSM V are modified to: “a preoccupation with one or more features in one’s appearance that is either not significantly noticeable or abnormal to others.”

Most clients with BDD acknowledge that they are not *disfigured*, but believe themselves to be ugly or very unattractive. Some clients may be preoccupied not with “a defect,” but with one or more features being not perfect, not “right,” or not equal. They might accept that they look “normal” to others but are preoccupied by self-disgust. A variation on this is a hatred of one’s own race and a desire to pass as a different race.

Occasionally, a person may be preoccupied by features that have *changed* for the worse (e.g., an actual change after cosmetic surgery). Thus he may acknowledge that his “defect” is not that noticeable or abnormal but that it has changed for the worse. Thus he may be comparing himself repeatedly with old photos and be fearful of meeting people who knew him before he changed. Occasionally, a person will be preoccupied with a feature which he cannot easily explain (e.g., after a drug experience) or psychotic experience. There are, therefore, many variations on the content of the presenting symptoms, which we discuss in Chapter 4. However, all BDD individuals share a preoccupation with one or more aspects of their appearance which is not shared by others and is excessive and very distressing or handicapping. Rarely, an individual is excessively preoccupied with the imagined defects of another individual, such as a partner or close relative. This has been termed “BDD by proxy” (Josephson & Hollander, 1997; Laugharne et al., 1998; Atiullah & Phillips, 2001).



## **1.4 Distress and Handicap in BDD**

The second criterion for the diagnosis of BDD is that the preoccupation must cause significant distress or handicap. Trying to operationalize these criteria can be problematic, although this is an issue for most disorders in DSM IV.

This criterion usually helps to distinguish between “dissatisfaction” about appearance (especially during adolescence) and a diagnosis of BDD. Body dissatisfaction is very common (Fitts et al., 1989; Castelnuevo-Tedesco, 1992). Studies have reported rates as high as 50%, especially during adolescence. BDD is, however, at the extreme end of dissatisfaction leading to significant *distress or handicap*. This is not usually an issue in a clinical population. The evidence from a study on a common quality of life measure (Short Form Health Survey, SF-36) has found a degree of distress that is worse than that of depression, diabetes mellitus, or recent myocardial infarction in 62 consecutive BDD outpatients (Phillips, 2000). Of note, quality of life measures were not explained by comorbid symptoms of depression. Hrabosky et al. (2009) also found that people with BDD had a worse quality of life on the Body Image Quality of Life measure than those with eating disorders.

At the milder end of the spectrum of BDD, some clients function with great effort and distress, but are usually disadvantaged in their occupational or academic functioning. Their motivation and concentration may be impaired because of excessive self-consciousness. Time-consuming behaviors such as mirror-gazing and excessive grooming impair their performance or make them late for work. However, BDD patients are more likely to be unemployed (Phillips et al., 1997) or drop out of school (Albertini & Phillips, 1999) because of their BDD.

People with BDD may have few friends or may not take any risks in social situations. They tend to avoid situations where they believe they will be evaluated negatively, such as swimming, beaches, public changing rooms, or gymnasias. In social situations they are more likely to use alcohol or illegal substances or safety-seeking behaviors similar to those with social phobia. They are more likely to avoid dating and are often single, separated, or divorced as a result of arguments and jealousy in a relationship: Veale et al. (1996) found that 74% of a sample of 50 BDD patients were single, separate, or divorced. At the severe end of spectrum, patients may be suicidal or hospitalized, have stopped working or attending full-time education, be housebound and avoid all interaction, and be totally socially isolated because of their BDD.

The final diagnostic criteria in DSM IV state that the preoccupation must not be better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa). We discuss this in more detail under each of the comorbid diagnoses below.

## **1.5 Suicide Attempts and Suicide in BDD**

Indications of high rates of suicide attempts were found in early surveys (Phillips, 1991; Phillips et al., 1997) and Veale et al. (1996), who found that 25–30% of BDD patients in psychiatric clinic have had a history of attempted suicide. In the largest sample described since then, Phillips et al. (2005) found that 78% of a sample of 200 individuals with BDD had lifetime suicidal ideation and 27.5% had made suicide attempts. BDD was reported as being the primary reason for suicidal ideation in 70.5% of those with a history of ideation and nearly half of the subjects with a past attempt. Both suicide ideation and suicide attempts were associated with functional impairment due to BDD, bipolar disorder, and personality disorder. Furthermore, suicidal subjects often did not reveal their symptoms of BDD to their clinicians.

Phillips and Menard (2006) in the same sample were able to conduct a prospective study of 185 subjects for up to four years (mean  $2.1 \pm 0.8$  years). Suicidal ideation was reported by a mean of 56.7% of subjects per year and a mean of 2.8% attempted suicide per year. This is approximately 10–25 times greater than in the US population. Two subjects completed suicide (0.3% per year), which is 4–13 times higher than in the US population. The findings are preliminary but suggest that suicide in BDD is markedly high. Finally, in a study of dermatology patients who had committed suicide, Cotterill (1981) noted that most either had BDD or acne; of course, the former may have been a manifestation of the latter.

## **1.6 Age Restrictions**

There are no age restrictions on the diagnosis of BDD. Generally, BDD is uncommon in childhood; the onset tends to develop in adolescence. The clinical features of adolescent BDD are similar to that of adults (Albertini & Phillips, 1999). Although the age of onset of BDD in adults is during late adolescence (Phillips, 1991), patients are usually diagnosed on average 15 years later (Veale et al., 1996; Phillips & Diaz, 1997).

## **1.7 Delusional Disorder**

Beliefs about one's appearance (e.g., that “my skin is wrinkled and puffy”) may be held with poor insight, when it is regarded as an overvalued idea in DSM IV; or no insight, when it is termed delusional. DSM IV allows BDD to be classified on the strength of beliefs and whether there is an *additional* diagnosis of a delusional disorder. The belief must be regarded as not bizarre

and of at least one month's duration. One should also exclude schizophrenia or the direct physiological effects of a substance. The older literature is confusing as delusional disorder was previously termed "monosymptomatic hypochondriacal psychosis" (Munro & Stewart, 1991) and included delusions of body odor ("olfactory reference syndrome"), infestation, or dysmorphic delusions.

A structured diagnostic interview such as the Overvalued Ideas Scale (OVIS) (Neziroglu et al., 1999) or the Brown Assessment of Beliefs (BABS) (Eisen et al., 1998) (see Appendix 1) may be used to assess the strength of conviction and whether there is an additional diagnosis of delusional disorder. The additional diagnosis of a delusional disorder generally reflects the severity of the distress and handicap experienced.

The validity and usefulness of an additional diagnosis of delusional disorder is questionable for several reasons. Phillips et al. (1994) first found no difference in the characteristics between delusional and non-delusional BDD patients. Furthermore, delusional patients respond just as well as non-delusional patients to a selective serotonin reuptake inhibitor (SSRI) (Phillips et al., 1998; 2002). Phillips, Menard, Pagano, et al. (2006) compared delusional and non-delusional variants in 191 subjects with BDD. Individuals with BDD and delusional disorder were similar to those with non-delusional BDD in terms of most variables, including most demographic features, BDD characteristics, most measures of functional impairment and quality of life, comorbidity, and family history. However, delusional subjects had significantly lower educational attainment, were more likely to have attempted suicide, had poorer social functioning on several measures, were more likely to have drug abuse or dependence, were less likely to be receiving mental health treatment, and had more severe BDD symptoms. However, when controlling for BDD symptom severity, the two groups differed only in terms of educational attainment. The conclusion from all the studies above was that the delusional and non-delusional variants of BDD have many more similarities than differences, although on several measures delusional subjects evidenced greater morbidity, which appeared to be accounted for by their more severe BDD symptoms.

We have no data from randomized controlled trials (RCTs) on whether BDD clients with or without a delusional disorder respond equally well to CBT. BDD clients are not just disturbed by what their appearance *is*, but by what it is *not* or what it *should be*. It appears, therefore, that the strength of their belief is merely an indicator of the severity of the disorder and there seems little justification for adding another diagnosis of a delusional disorder. If this logic were applied to other disorders like OCD or hypochondriacal disorder, then each diagnosis might require a comorbid delusional disorder. It is also questionable whether body image can be represented solely as a belief (Ben-Tovim et al., 1998). Body image is a complex interaction of beliefs,

imagery, tactile sensation, and affect. The concept of a delusion is not an issue in other body image disorders such as anorexia nervosa. Such clients may well hold beliefs about how fat they feel with delusional conviction. Such considerations do not seem to have any advantage in routine clinical care other than alerting the clinician to increased difficulties in engagement. We describe a number of case vignettes at the end of this chapter to illustrate the discussion about diagnosis about the heterogeneity of symptoms within BDD.

Although the additional diagnosis of delusionality does not seem to be important in treatment, assessing for overvalued ideas regarding the importance of attractiveness on attaining certain goals, the strength of conviction about their own flaws is important, and has been found to be a predictor of treatment outcome with CBT (Neziroglu et al., 1996). For this reason we suggest using scales assessing overvalued ideation.

## 1.8 Making a Diagnosis in ICD-10

In ICD-10, the term BDD, or the older term “dysmorphophobia,” is not separately classified but is subsumed under hypochondriacal disorder (World Health Organization, 1992). Although there is some overlap between the symptoms of hypochondriacal disorder and BDD, we believe there is greater merit in following DSM IV and separating the two disorders. Many clinicians outside the USA therefore “vote with their feet” and do not use the diagnosis of hypochondriacal disorder for BDD. The diagnostic criteria for hypochondriacal disorder in ICD-10 are shown in Table 1.2. Like DSM IV, the essential feature is a persistent preoccupation with the possibility of having one or more serious and progressive “physical” disorders, associated with persistent distress or handicap. There is sometimes true comorbidity where a client has both BDD as well as a fear or conviction about having a serious disease in another bodily part.

An important distinction in ICD-10 compared to DSM IV is that if the beliefs about being defective are considered delusional, then a client would receive an *alternative* diagnosis of “Other persistent delusional disorder” (F22.8) instead of hypochondriacal disorder. This is in contrast to DSM IV, which allows an *additional* diagnosis of delusional disorder to BDD. The ICD-10 diagnosis is a residual category for persistent delusional disorders that do not meet the criteria for delusional disorder (F22.0). They are disorders in which the delusion(s) are accompanied by persistent hallucinatory voices or by schizophrenic symptoms that do not justify a diagnosis of schizophrenia (F20.–) and include “Delusional dysmorphophobia.” Delusional disorders that have lasted for less than three months should, however, be coded, at least temporarily, under F23 (Acute transient psychotic disorders).

**Table 1.2:** Diagnostic criteria for hypochondriacal disorder (F45.2) (ICD-10)

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- A. Either of the following must be present:
    - 1. persistent belief, of at least six months' duration, of the presence of a maximum of two serious physical diseases (of which at least one must be specifically named by the patient);
    - 2. persistent preoccupation with a presumed deformity or disfigurement (body dysmorphic disorder).
  - B. Preoccupation with the belief and the symptoms causes persistent distress or interference with personal functioning in daily living, and leads the patient to seek medical treatment or investigations (or equivalent help from local healers).
  - C. There is a persistent refusal to accept medical reassurance that there is no physical cause for the symptoms or physical abnormality. (Short-term acceptance of such reassurance, i.e. for a few weeks during or immediately after investigations, does not exclude this diagnosis.)
  - D. Most commonly used exclusion clause. The symptoms do not occur only during any of the schizophrenic and related disorders (F20–F29, particularly F22) or any of the mood [affective] disorders (F30–F39).
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## **1.9 Differential Diagnosis of BDD and Comorbidity**

Before discussing the differential diagnosis of BDD in DSM IV or ICD-10, we should note that although our classification of mental disorders has had clear benefits, there are also significant limitations. The benefits are that diagnoses are useful shorthand for communication with researchers and clinicians or for legal purposes. Clients and carers are also often relieved to receive a diagnosis (this is not always the case for clients with BDD). Diagnostic systems have undoubtedly assisted research for studying relatively homogeneous groups of clients in clinical trials, but have also generated a whole industry of studies on comorbidity and other associations. However, diagnostic systems also have significant limitations for a psychological approach to mental disorder. A structured clinical interview can make a diagnosis more reliable but not necessarily more valid. A diagnostic cake can be divided in many ways and has limited value in determining treatment or prognosis. There are many studies of comorbidity. This has resulted in a major criticism of the current diagnostic systems because of the high level of comorbidity and the lack of specificity for treatment. Making a diagnosis in DSM IV or ICD-10 is therefore just one way of organizing information and we shall be emphasizing the importance of a functional analysis and the relationship between disorders as well as highlighting the similarities in the behavioral and cognitive processes in BDD that cut across other diagnoses.

One of the diagnostic criteria for BDD is that the preoccupation must be with either an imagined defect or a slight physical anomaly. Clients with “moderate to severe” physical anomalies (e.g., facial burns, a port wine stain, or very small breast size) who have difficulty coping might receive another diagnosis, such as an adjustment disorder, or, if it is sufficiently severe, another disorder such as depressive episode. An adjustment disorder consists of clinically significant emotional distress or handicap that has developed within three months of an identifiable psychosocial stress such as a deformity. The diagnosis is “trumped” if the client meets the criteria for another specific Axis I diagnosis that better describes their symptoms, such as a depressive episode or even a “Not otherwise specified” category. For an adjustment disorder, the symptoms should also resolve within six months of the termination of the stressor although a chronic stressor (e.g., a disfigurement) that lasts more than six months and has enduring consequences is also recognized. The diagnosis is important as it bridges “normality” and pathology – for example, an adjustment disorder was diagnosed in 60% of burn patients (Perez Jimenez et al., 1994).

The boundaries of BDD and a minor or moderate physical anomaly are not always clear. The definition of a “minor physical anomaly” is somewhat subjective and there is a gray area between this and more noticeable or moderate “anomalies” which present to cosmetic surgeons and dermatologists. We are trying to improve this with an observer and subjective rated scale which measures how noticeable a defect is and how abnormal it is compared to others (see Body Image Questionnaire in Appendix 1) and therefore determining the discrepancy between the two. The severity of a physical defect is not always relevant to a psychiatric diagnosis as there are individuals with “moderate to severe” anomalies or a disfigurement who might have similar preoccupation, distress, and handicap to BDD although the large majority do not. A similar situation exists in health anxiety/hypochondriasis where a client with a “real” organic condition such as diabetes might have marked anxiety and preoccupation with, for example, his blood sugar, with constant checking and repeated reassurance-seeking. However, clients with moderate to severe physical disfigurement are more likely to experience intense curiosity, teasing, or staring by others. They may avoid public or social situations but check less. Further research is required to differentiate symptoms of BDD from individuals with moderate to severe physical anomalies who are not coping. In theory, some aspects of this treatment manual can be used for such a population, but additional modules may be required to prepare individuals for intense curiosity or teasing by strangers (e.g., assertiveness training and role-playing of being teased).

The diagnostic criteria in DSM IV state that the preoccupation must not be better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa). It is not always easy to separate a

disorder that better accounts for symptoms of BDD; we discuss this under each of the diagnoses below. Comorbidity is the rule rather than the exception in BDD, although this may partly reflect the populations from which surveys are drawn. The data are from centers with a special interest in BDD which are likely to attract more severe cases. A large community survey is more likely to recruit those with less severity and comorbidity. There have been four surveys of treatment centers (Table 1.3). The most common current comorbid diagnoses are, in descending order, major depressive episode, social phobia, obsessive compulsive disorder, and alcohol or substance abuse. It is not known whether BDD has relatively higher levels of comorbidity compared to, say, other anxiety or somatoform disorders because such studies have not been done. In similar survey of clients presenting to an anxiety disorders clinic, Brown & Barlow (1992) found that the point prevalence rate of comorbidity was relatively high, with 50% of the participants with an anxiety disorder having an additional anxiety disorder or depression at the time of the assessment. This has been replicated across a whole range of other disorders presenting at treatment centers such as eating disorders (Schwalberg et al., 1992), bipolar disorder (Tamam & Ozpoyraz, 2002), or generalized anxiety disorder (Judd et al., 1998).

## **1.10 Affective Disorders**

We have already noted that a diagnosis of BDD is often missed because clinicians do not ask about the symptoms or do not use a structured diagnostic interview. Clients are ashamed of being labeled as vain or narcissistic; it is more acceptable to present with symptoms of depression. Some European clinicians may also assume a diagnostic hierarchy whereby symptoms of BDD are regarded as a symptom of a depressive episode. Occasionally, a diagnosis of a major depressive episode might better account for the symptoms of BDD if the preoccupation is limited to mood-congruent ruminations involving appearance during a major depressive episode only. This becomes apparent in clients with a recurrent depression in which BDD is episodic and occurs at the same time as deterioration in mood. The distinction can be difficult because a depressive episode is frequently comorbid but typically develops *after the onset of symptoms of BDD* (Gunstad & Phillips, 2003).

Axis I current comorbidity rates in clients identified with BDD are shown in Table 1.3 and the lifetime rates in Table 1.4. Gunstad & Phillips (2003) have conducted the largest survey of comorbidity in a survey of 293 BDD patients and found a current rate of 59% with major depression and a lifetime rate of 76%. Veale et al. (1996) found a lower rate of major depressive disorder of 8% and dysthymia of 18%, although it is not entirely clear why.

**Table 1.3:**    Axis 1 Current Comorbidity Rates

Study	N	Assessment instrument	Major depression	Bipolar disorder	Dysthymia	OCD	Social phobia	Eating disorder	Substance use disorder
Veale et al. (1996)	50	SCID-P (DSM III-R)	8%	–	18%	6%	16%	–	2%
Zimmerman & Mattia (1998)	16	SCID-P, DSM IV	69%	6%	19%	38%	69%	19%	6%
Gunstad & Phillips (2003)	293	SCID-P, DSM IV	58%	5%	×	25%	32%	4%	8%



Table 1.4: Axis 1 Lifetime Comorbidity Rates

Study	N	Assessment instrument	Major depression	Bipolar disorder	Dysthymia	OCD	Social phobia	Eating disorder	Substance use disorder
Hollander et al. (1993)	50	Clinical Interview (DSM III-R)	68%	8%	–	78%	12%	20%	22%
Perugi et al. (1997)	58	Semi-structured interview (DSM III-R)	41%	31%	–	41%	12%	22%	–
Phillips & Diaz (1997)	188	SCID-P (DSM III-R)	82%	7%	7%	30%	38%	10%	36%
Nirenberg et al. (2002)	28	SCID-P (DSM IV)	–	–	18%	14%	54%	21%	32%
Gunstad & Phillips (2003)	293	SCID-P (DSM IV)	76%	5%	6%	32%	37%	4%	28%

An additional diagnosis of depression appears to reflect the severity of BDD and perhaps a reason for seeking help. Although the rates of depression vary, it has always been the most common additional Axis I disorder. Treatment of depression usually has to be done in parallel with that of BDD. Many of the symptoms, such as avoidance of social activity and being withdrawn, overlap although there may be different motivations. When depression is severe, people avoid social activity or tackling problems because they have lost motivation and feel hopeless and become less worried about fears of negative evaluation.

With BDD and comorbid depression, it is particularly important to assess suicide risk. Suicide ideation and attempts appear to be especially high in BDD. A sense of hopelessness and suicidal ideation is more likely to occur when people with BDD believe that they are trapped and have exhausted all abilities to camouflage or alter their appearance. They may have just had cosmetic surgery and realize that all their hopes have been dashed after an unsatisfactory operation.

Beck recognized the link between concerns about appearance with depression in his original depression inventory (Beck et al., 1961). Item 14 asks a client to pick one of the following statements that best describes the way he has been feeling:

- a) "I don't feel I look any worse than I used to" (score 0),
- b) "I am worried that I am looking old and unattractive" (score 1),
- c) "I feel there are permanent changes in my appearance that make me look unattractive" (score 2),
- d) "I believe that I look ugly" (score 3).

This item has unfortunately been dropped from the Revised Version of the BDI-II (Beck et al., 1996) on psychometric grounds. The original version of the BDI was, however, a useful screening item for BDD clients presenting with depression. Oosthuizen et al. (1998) also developed a dysmorphic questionnaire and found that concerns about appearance were strongly correlated with cognitive items on the BDI.

## **1.11 Social Phobia**

Someone with social phobia believes that they will *behave* in a way that is unacceptable and that this will lead to rejection, loss of worth or status, or failure to achieve important goals. This is confined to situations in which others will evaluate them negatively. The behavior includes being anxious, such as being seen to be sweating, shaking, or blushing. However, someone with BDD

is more likely to believe they *look* unacceptable, whether in social or non-social situations. Confusion arises because people with BDD are often anxious and fear being evaluated negatively in social situations. A comorbid diagnosis of social phobia in BDD can only be made when there is a broader fear of one or more social and performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and the individual fears that he will *act* in a way, or show anxiety symptoms, that will be humiliating or embarrassing. Thus a person with social phobia might fear he will go red or appear shaky in social situations, whilst an individual with BDD might fear that his skin is permanently red, which is ugly and distressing. Most surveys of BDD clients have found an additional current diagnosis of social phobia of 16–69% (Table 1.3) and a lifetime rate of 12–54% (Table 1.4). Although the prevalence varies, it is the second most common diagnosis in all studies after a major depressive episode. Coles et al. (2005) examined the differences between individuals with BDD with and without social phobia. They found that those with BDD with social phobia were less likely to be employed, more likely to report lifetime suicide ideation, and had poorer global social adjustment on one of two measures. They were somewhat less likely to experience remission of their BDD symptoms over one year follow-up, although this difference was not statistically significant. Although this study was conducted with a structured diagnostic interview, be aware that rates may be excessively high because the diagnosis may have been given due to avoidance of social situations because of appearance and a thorough evaluation of the reasons of the avoidance may not have been assessed.

Individuals presenting with social phobia may also be anxious about aspects of their appearance, but it may not be regarded as a preoccupation that is excessively distressing or handicapping. In two surveys of patients attending a clinic for anxiety disorders, the rates of BDD were highest among those diagnosed with social phobia at 12% in Wilhelm et al. (1997) and 13% in Brawman-Mintzer et al. (1995). In all case series and in the study reported by Gunstad Phillips (2003), the onset of social phobia *preceded* the onset of BDD by at least 10 years. This is in contrast to other comorbid disorders such as depression or OCD in which BDD usually develops first. This may have some developmental relevance.

## **1.12 Alcohol and Substance Misuse**

BDD clients frequently misuse alcohol and illegal substances as a way of coping with distress and preoccupation. Comorbid current rates vary from 2% to 17%, but may be much higher in an inpatient setting (Grant et al., 2001). Grant et al. (2005) examined rates and clinical correlates of comorbid

substance use in 176 consecutive subjects with BDD of whom 29.5% had lifetime substance abuse and 35.8% had a lifetime substance use disorder (SUD), most commonly, alcohol dependence (29.0%); and 17% ( $N = 30$ ) had current substance abuse or dependence (9.1% reported current substance abuse, 9.7% reported current dependence). There were far more similarities than differences between subjects with a comorbid SUD and those without a SUD, although those with a lifetime SUD had a significantly higher rate of suicide attempts ( $p = 0.004$ ).

Inevitably, alcohol and substances such as cannabis or stimulants increase paranoia and depressed mood and decrease motivation. Like other disorders, clients need help to stop drinking or using substances before BDD treatment is commenced (or at least done in parallel) as substances may interfere with therapy and cognitive and emotional processing.

### **1.13 Obsessive Compulsive Disorder**

An additional diagnosis of obsessive compulsive disorder (OCD) is only given when the “obsessions” or “compulsions” are not restricted to concerns about appearance. Sometimes the symptoms overlap and there is gray area between the two. For example, a client may believe that his skin is defective through contamination and this is associated with washing compulsions or skin picking. A similar situation exists in clients preoccupied with perfection and symmetry, which may extend to their appearance. Typically, such clients do *not* believe their feature to be defective or ugly, but the preoccupation might be a need for the hair to be exactly symmetrical or their make-up to be perfect or “just right.” Some of the older literature on OCD probably included clients with BDD and there are no diagnostic rules that determine whether such clients should be regarded as having OCD or BDD.

In surveys of clients with BDD, comorbid current rates of OCD are between 6% and 38% (Table 1.3) (Veale et al., 1996; Zimmerman & Mattia, 1998; Gunstad & Phillips, 2003) and lifetime rates from 14% to 78% (Table 1.4). In a study of 165 patients seeking treatment for an anxiety disorder, 3 of 40 (7.5%) OCD patients had a current diagnosis of BDD (Wilhelm et al., 1997). Other studies of OCD found that 12% of patients had a lifetime diagnosis of BDD (Simeon et al., 1995). Although age of onset is similar for BDD and OCD, the onset of BDD usually precedes OCD (Gunstad et al., 2003). One pattern of comorbidity of BDD and OCD is that the person experiences recurrent intrusive thoughts or images about a defect(s) which the person knows is absurd and the intrusions are regarded as egodystonic.

There are a number of group differences between individuals with OCD and BDD. Phillips et al. (1998) compared individuals with BDD ( $N = 53$ ) with

OCD (N = 53), or both disorders (N = 33). They found that 14.5% (9 of 62) of subjects initially diagnosed with OCD had comorbid BDD. The two disorders did not differ significantly in terms of sex ratio; most other demographic, course, and impairment variables; illness severity; or lifetime frequency of most associated disorders in probands or first-degree relatives. However, individuals with BDD were less likely to be married and more likely to have had suicidal ideation or make a suicide attempt because of their disorder. They also had an earlier onset of major depression and higher lifetime rates of major depression, social phobia, and psychotic disorder diagnoses, as well as higher rates of substance use disorders in first-degree relatives. Phillips et al. (2007) reported on a larger study which compared subjects with OCD (N = 210), BDD (N = 45), and co-morbid BDD/OCD (N = 40). OCD and BDD did not significantly differ in terms of demographic features, age of OCD or BDD onset, illness duration, and many other variables. As in the previous study, subjects with BDD had significantly poorer insight than those with OCD and were more likely to be delusional. Subjects with BDD were also significantly more likely than those with OCD to have lifetime suicidal ideation, as well as lifetime major depressive disorder and a lifetime substance use disorder.

## **1.14 Eating Disorders**

A common diagnostic dilemma for BDD is that of an eating disorder. BDD and eating disorders often share an altered body image and many other symptoms such as a low self-esteem or perfectionism. DSM IV states that a diagnosis of BDD should not be used if the patient's symptoms are best accounted for hierarchically by a diagnosis of an eating disorder. If, therefore, the preoccupation is predominantly focused on being "too fat" or overweight, it does not meet criteria for BDD.

There is a gray area between individuals with disordered eating who do not fulfill the criteria for anorexia or bulimia nervosa. Rosen et al. (1995a) describe a sample of BDD clients in whom an eating disorder was excluded using the Eating Disorders Examination (Cooper & Fairburn, 1987). Rosen et al.'s sample was all female and 38% were preoccupied with their weight and shape alone, and they were generally less handicapped and less socially avoidant than BDD clients described in most other centers. Such clients might still have periods of disordered eating or excessive exercise as a means of altering their body shape and weight. It is not known whether some of Rosen et al.'s sample would have fulfilled the later criterion for an Eating Disorder Not Otherwise Specified (EDNOS), which was not used in this study. The diagnosis of EDNOS is important as it has the largest prevalence of all eating disorders in the community (Fairburn & Harrison, 2003). To fulfill a diagnosis of EDNOS, the

person fails to meet all the criteria for anorexia nervosa (e.g., if female, has regular menses) or of bulimia nervosa (e.g., binge eating and vomiting at a frequency of less than twice a week). The main criticism of the diagnosis of EDNOS is that different research groups may use slightly different criteria and it is difficult to establish the boundaries.

True comorbidity of BDD and eating disorder occurs when a client is preoccupied by imagined defects in his appearance unrelated to weight and shape. The comorbid current rates of an eating disorder in BDD vary from 0% to 19% (Table 1.3) and lifetime rates from 4% to 22.5% (Table 1.4). In the largest survey, Ruffolo et al. (2006) described 200 individuals with BDD and found that 32.5% had had a comorbid lifetime eating disorder (9% anorexia nervosa, 6.5% bulimia nervosa, 17.5% EDNOS). Those with a comorbid lifetime eating disorder were more likely to be female, less likely to be African American, had more comorbidity, and had significantly greater body image disturbance than those without a history of an eating disorder. There were no significant differences in BDD symptom severity, degree of delusionality, or suicidal ideation or attempts.

More interesting are the data reported by Grant et al. (2002), which indicate that 16 of 41 patients (39%) with anorexia nervosa were diagnosed with comorbid BDD unrelated to weight concerns. Therefore, preoccupation with a body part because it is “too fat” or because the body part is somehow affected by the patient’s weight did not meet the criteria for BDD. The most common preoccupations in the study were (in descending order) with the nose, skin, hair, chin, lips, and eyes, which is virtually identical to BDD clients without anorexia. The patients with anorexia nervosa and BDD had significantly lower overall functioning and higher levels of delusionality than the anorexic patients without BDD, suggesting that the former had a more severe form of illness. Further research is required to replicate these findings in a larger sample of patients with anorexia and to investigate the prevalence of BDD in those diagnosed with bulimia nervosa and EDNOS. It is not known whether a diagnosis of BDD in an eating disorder is a poor prognostic factor and whether the symptoms alter when the eating disorder improves. In our experience, the diagnosis of BDD is rarely made by clinicians in eating disorder units and more attention needs to be focused on BDD aspects within that population. It is our experience that many eating disordered patients do have other body parts of concern and fulfill the criteria of BDD.

## **1.15 Psychogenic Excoriation**

Psychogenic excoriation (“skin picking”) and the differential diagnosis of various associated disorders are discussed in Chapter 5.

### **1.16 Trichotillomania**

Like skin picking, hair pulling or body depilation can occur in BDD when an individual pulls hair from his skin as a response to a preoccupation with a “defect” to improve his appearance. This would be regarded as part of BDD and should be distinguished from trichotillomania, which is reinforced by tension reduction and a sense of gratification that usually occur with the hair pulling. Individuals may then become ashamed of the consequences of hair pulling and bald patches, which they strenuously try to cover. This is not usually BDD as they are not preoccupied with an imagined defect or minor psychical anomaly. It represents the shame that stems from an adjustment disorder or another Axis I disorder.

### **1.17 Olfactory Reference Syndrome**

Olfactory reference syndrome (ORS) is sometimes regarded as part of BDD or obsessive compulsive spectrum disorder. ORS is not a recognized diagnosis in DSM IV or ICD-10 but is used to describe an individual who is preoccupied by their body odor or halitosis and feels persistent shame. They may be experiencing olfactory hallucinations or mental images. They may use a range of safety behaviors (e.g., excessive use of perfume) to mask the presumed odor. They frequently shower, brush their teeth, change their clothes, and ultimately avoid public and social situations where they think their body odor will be noticed. The degree of insight in ORS varies and has many similarities to BDD. Some patients are like someone with OCD with intrusive doubts and seeking frequent reassurance about their body odor. Others have a delusional disorder and often marked avoidance behavior. For further discussion of ORS and case reports, the reader is referred to Pryse-Phillips (1971), Lochner et al. (2001), and Suzuki et al. (2004). We have had a small number of BDD patients who are also preoccupied with their body odor, which blended easily with their preoccupation with aspects of their appearance. For example, if you believe you look hideous, it is not surprising if you also believe that you smell disgusting.

### **1.18 Schizophrenia and Persecutory Delusional Disorder**

The differential diagnosis of BDD from schizophrenia is not usually an issue because of the presence of hallucinations, thought disorder, or more bizarre delusions in schizophrenia. Comorbidity is uncommon. Several authors (Traub et al. 1967; Chapman et al. 1978; Priebe & Rohricht, 2001) have described

general distortions of body image in schizophrenia. Patients with schizophrenia may make dramatic changes to their appearance (e.g., bizarre use of make-up, sunglasses, or inappropriate clothes). These may be part of a command hallucination or delusion, or an attempt to retain their sense of identity. They may be inaccurate in their body size estimations feeling that parts of the body are unusually small or that their body size has changed. They can also experience symptoms of disembodiment, such as feeling they are no longer part of their body, feeling disintegrated or the body is torn apart.

Some clients with BDD may have extreme forms of delusions of reference and persecutory delusional disorder focused on others humiliating and laughing at them or being treated malevolently. This can be usually be treated in parallel with the approaches described in this book and finding an alternative explanation for the experience. This should, however, be differentiated from paranoid schizophrenia in which delusions and hallucinations are present.

## **1.19 Body Integrity Identity Disorder**

BDD is sometimes confused with Body Integrity Identity Disorder (BIID) (previously known as “Amputee Identity Disorder,” AID). This is not a recognized diagnosis in DSM IV or ICD-10, but is used to describe individuals who desire one or more digits or limbs to be amputated (Furth et al., 2000; Smith & Fisher, 2003; First, 2005). The term apotemnophilia has also been used, but this is strictly speaking a sexual fetish, whose adherents are known as “devotees.” They have a special interest or a sexual desire for people who are disabled (Money et al., 1977).

Individuals with BIID feel that one or more limbs are not part of their “self” (a form of reverse “phantom limb”) and that amputation will lead to them becoming more able-bodied. It is a preoccupation which derives not from a feeling of defectiveness or inadequacy but the expectation that they would be so much more comfortable if one or more limbs or digits were amputated. Prior to amputation, individuals with BIID may live as if they had a disability, when they are known as “pretenders.” They may live with a wheelchair, crutches, or leg braces. In the face of opposition from surgeons, some individuals hasten amputation (e.g., chainsaw wound or shooting) or carry out self-amputation (e.g., on a rail track). Although such individuals are preoccupied with becoming disabled, they do not believe (as in BDD) their limbs to be defective or ugly, nor do they wish cosmetically to alter their limb. First (2005) interviewed 52 subjects (47 male, four female, one intersex) with BIID, of whom 17% (N = 9) had had an arm or leg amputated, with two-thirds using methods that put the subject at risk of death and one-third enlisting the support of a surgeon to amputate a healthy limb. The most common reason



reported for wanting an amputation was the subject's feeling that it would correct a mismatch between the person's anatomy and sense of his true self (identity). None of the subjects was delusional. For all but one subject age at onset was during childhood or adolescence. No benefit occurred from psychotherapy or medication. The six subjects who had an amputation reported that following amputation they felt better and were no longer preoccupied by a desire for an amputation. Mr Robert Smith, an orthopedic surgeon in Scotland, conducted surgical amputation on two patients before the ethical committee stopped him doing further operations at his hospital. Fisher & Smith (2000) report in a letter that the patients experienced a better quality of life once the effort involved in seeking a solution was removed. This is unlike clients with BDD for whom cosmetic surgery is unpredictable (see Chapter 6).

BIID is therefore more akin to a gender identity disorder in which individuals feel that their genitalia do not belong to them and that they are trapped in a body of the wrong gender. There may be other variations of BIID concerning a desire for a disabled identity – for example, individuals who deliberately infect themselves with HIV (Morgan & Jones, 1993) or who have a compelling and persistent desire to be deaf (Veale, 2006). Such individuals feel that they are “a hearing person in a deaf person's body.” There may also be a form of BIID in men who desire castration but not to change sex (Roberts et al., 2007). In summary, people with BIID appear to have in common an onset of desire in childhood or, at the latest, by early adolescence; and a sense that their fundamental identity will be “set right” by having the part of body removed or modified. A core feature is as much the desire for a particular identity (e.g., being an amputee, being a eunuch, being part of the deaf community) as the modification itself (First, personal communication). Patients with BIID or a desire to be disabled should not therefore be confused with those with BDD. There is a dedicated website for BIID ([www.biid.org](http://www.biid.org)) and one by users (<http://biid-info.org>).

## **1.20 Body Modification or Self-mutilation**

There is another group of individuals who are sometimes confused with BDD who modify or mutilate their body as a form of art. Alternatively, they may transform their body into an animal. Self-mutilation commonly occurs in young women, on the forearm with razors or other sharp implements. A number of studies have linked childhood adversity or abuse and especially borderline personality disorder with subsequent self-mutilation (for a more thorough discussion of self mutilation, see McVey-Noble et al., 2006). In the 1990s, self-mutilation developed into body piercing or tattooing partly from

punk fashion and gay sadomasochism, which has now become mainstream. Decorative implants of various sorts are also popular, including some inserted under the skin. They include lobe stretching, ear scalpel and tongue piercing, branding, scarification, and tongue splitting (wiki.bmezone.com). It now extends to circumcision (male or female); penis, scrotal, or labial stretching; glans splitting, and relocation of the urethra, either by the individual or a lay practitioner. Female genital mutilation is illegal in most Western countries unless it is conducted by a surgeon for physical or mental health reasons and sometimes a client may seek body modification on mental health grounds. For most people, body modification appears to be a lifestyle choice with an extensive subculture of sadomasochism. A few people who have modified their body might have BDD as a way of camouflaging their “defect” or distracting attention from it, but this has not been systematically studied.

The porn icon Lolo Ferrari, who died at the age of 37, was thought by some to have had BDD. She was a minor celebrity for having “the largest breasts in the world.” She had 25 cosmetic operations in five years, especially on her bust, which gradually increased to a size 71”. She looked like a freak, had difficulty breathing, and was unable to sleep on her front or back. She was a colorful but sad figure who made her name as a presenter on television shows. She is known to have had an unhappy childhood. She is thought to have committed suicide or may have been murdered by her husband and pimp, who was a transvestite and afraid of altering his own body. Her symptoms are, however, not typical of BDD and in many ways her behavior is an extreme version of body modification and self-mutilation, which was reinforced by male attention.

Another extreme version of body mutilation is “Orlan” who usually represents her modifying her body as “art.” For one operation, Orlan had silicone implants put into her cheeks and forehead to give her “horns” or to make her more ugly and question the nature of beauty. The operations are videoed as “art” and parts of her body are then sold to the public. Examples of extreme body modification into an animal are “Tigerman” and “Lizardman” who can be viewed on the web by a search engine. No cosmetic surgeon will assist such individuals to transform their body and so such surgery is done without anesthetic by lay individuals. As far as we are aware, Orlan, Tigerman, Lizardman, or any other animals have not been psychiatrically evaluated. Such individuals might be regarded as highly eccentric or possibly personality disordered with beliefs akin to over-valued ideas. However, there is no evidence that they have BDD.

## **1.21 Koro**

The Malayo-Indonesian term “Koro” and the Mandarin Chinese term “suo-yang” (Cantonese “suk-yang”) is a syndrome that mainly occurs in Asia and

to a lesser extent in Africa. It is also known as “genital retraction syndrome.” It refers to the fear or belief that one’s penis is shrinking or retracting into the body (Cheng, 1996; Chowdhury, 1998). Koro can also occur in populations without a Chinese influence as well as in women, when it refers to fears that their breasts and labia are shrinking. It is usually a transient state of acute anxiety and avoidance. The individual anticipates impotence, sterility, or even death. Moreover, the immediate family becomes convinced of the same outcome and may hold on to the sufferer’s genitalia manually or with special instruments. Epidemics of Koro have been observed in Singapore, Thailand, and India precipitated by threats to security or even survival of the afflicted population. Some authors have suggested that Koro is a cultural variant of BDD, but the main differences is that in Koro others in the immediate family share the beliefs and usually it consists of a transient state of marked anxiety.

## **1.22 Personality Disorder**

Three studies have used the same structured diagnostic interview of personality disorder in surveys of BDD clients (Table 1.5). Personality disorders were present in 57–100% of patients in the studies by Veale et al. (1996); Neziroglu et al. (1996), and Phillips and McElroy (2000). Cluster C (anxious or fearful) was the most common in all the studies. In descending order, avoidant, paranoid, obsessive compulsive, dependent, and borderline personality disorders were the most common. Neziroglu et al. (1996) found a higher rate (100%) than either Veale et al. (1996) or Phillips & McElroy (2000) and this may have been because the numbers were small ( $N = 17$ ) and because of a higher rate of comorbid OCD (94%). There is often unreliability in the diagnosis of a personality disorder in the context of a chronic Axis I disorder. There are also often disagreements over whether a personality trait is enduring and persistent before the onset of a chronic disorder or whether it is developed after the disorder as a response.

The presence of a personality disorder generally reflects the severity of symptoms and, probably, a poorer prognosis. For example, Phillips & McElroy (2000) reported that those with a personality disorder had a significantly higher score on the Yale Brown Obsessive Compulsive Scale for BDD. They also found that they were unassertive on the Rathus Assertiveness Scale and the mean scores for all subjects were in the high range for neuroticism and in the low range for extraversion on the NEO-Five Factor Inventory. Scores were also in the low range for conscientiousness, the average range for openness to experience, and low–average range for agreeableness. In general, the presence of a personality disorder will make it more difficult to engage and treat patients with BDD. However, the number of personality disorders decreases

**Table 1.5:**    Axis 2 – Current Comorbidity Rates

Study	N	Assessment instrument	At least one personality disorder	Avoidant	Paranoid	Obsessive compulsive	Borderline	Dependent
Veale et al. (1996)	50	SCID-II (DSM III-R)	72%	38%	38%	28%	6%	12%
Neziroglu et al. (1996)	17	SCID-II (DSM III-R)	100%	82%	53%	82%	76%	71%
Phillips & McElroy (2000)	74	SCID-II (DSM III-R)	57%	43%	14%	14%	8%	15%
Nirenberg et al. (2002)	28	SCID-II (DSM IV)	86%	50%	25%	39%	21%	29%

in responders after treatment with either CBT (Neziroglu et al., 1996) or pharmacotherapy with fluvoxamine (Phillips & McElroy 2000). This is probably due to the similarity of symptoms in some personality disorders and Axis I diagnoses. For example, once a client improves in symptoms of BDD and avoids less it is not surprising that the avoidant personality diagnosis disappears.

Lastly, Semiz et al. (2008) have investigated comorbidity of BDD in people with borderline personality disorder. BDD appeared to be extremely common in clients in whom BPD is their main problem. They found that 38 (54.3%) of 70 clients with BPD in a Turkish setting had BDD. Childhood traumatic experiences were significant predictors of diagnosis of BDD (77% correct) even when socio-demographic factors and severity of depressive symptoms were controlled for. However, many practitioners would probably regard a preoccupation with one's body image as just one part of disturbed self-identity in borderline personality disorder and not regard it as a separate problem. Furthermore, the symptoms of BDD in borderline personality are rarely fixed but are more variable and fluctuating in intensity than found in typical BDD. Treatment trials of BDD will therefore usually try to exclude people with BPD when BPD is regarded as the main problem.

