Comparing and contrasting body-dysmorphic disorder and eating disorders

The medical aesthetics sector is very often associated with ideas of body image and self-perception. It is important that aesthetic practitioners have a sound knowledge of mental health disorders that may affect their patients or drive individuals to seek aesthetic treatment. In this article, Eda Gorbis and Justine Jamero compare some of these disorders and consider the implications for aesthetic practitoners

Abstract

Body-dysmorphic disorder (BDD) and eating disorders (EDs) are psychiatric disorders concerned with negative body image and similar repetitive behaviours, such as checking and reassurance-seeking, that impair cognitive, social and occupational functioning. Though BDD and EDs share common core characteristics, they are unique disorders that must be differentiated, as they require different treatment plans. BDD, anorexia nervosa, binge-eating disorder and bulimia nervosa will be reviewed in this article to address diagnostic criteria, prevalence rates, onset and common characteristics. Similarities, differences and comorbidities of BDD and EDs will be explored and discussed in terms of treatment implications. Treatment recommendations include medical treatment, psychoeducation, nutritional management, cognitive-behavioural therapy (CBT) and psychopharmacology.

Key words

▸ Body dysmorphic disorder ▸ Eating disorders
▸ Mental health ▸ Body image

Body-image concerns are typical in the average person, as most people are not completely satisfied with their body and overall appearance. Some individuals may think negatively about their weight, and, in response to this, they might start to exercise and go on a diet. However, body image concerns, and behaviours driven by these concerns, can be taken to the negative extreme. To illustrate, some individuals may spend many hours every day thinking about their weight, and, in response to this, they will excessively exercise and skip meals to the point of starvation. These thoughts and behaviours can significantly interfere with cognitive, social and occupational functioning. In these cases, individuals may have underlying psychiatric disorders, such as body dysmorphic disorder (BDD) and/or eating disorders (EDs), including anorexia nervosa binge-eating disorder (BED) and bulimia nervosa. This article will review each disorder and explore the similarities, differences and comorbidity of BDD and ED to increase awareness of differential diagnosis and to discuss treatment implications and recommendations.

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Body-dysmorphic disorder

BDD is a psychiatric disorder in which individuals see themselves as ugly, and they distressingly obsess over a slight perceived physical 'defect' in their appearance for at least 1 hour per day (American Psychiatric Association (APA), 2013). BDD affects about 2.5% of females and 2.2% of males in the US, and, in most cases, the onset of BDD occurs before the age of 18 (APA, 2013). In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), BDD is classified under 'Obsessive-compulsive and related disorders', and a diagnosis requires both obsessions and compulsions that are time-consuming and significantly impair cognitive, social and occupational functioning.

Common appearance concerns, or obsessions, in females with BDD consist of flaws in their skin, stomach, weight, breasts/chest, buttocks, thighs, legs, hips, toes and excessive body/facial hair, but BDD obsessions can focus on any other body part that is not listed as well (Phillips et al, 2006). Males are more likely to have obsessions about their genitals, body build (for example, muscles) and thinning hair (Phillips et al, 2006). Muscle dysmorphia, a form of BDD where individuals obsess that their body is too small and not lean enough, primarily occurs in males (APA, 2013).

Preoccupation with perceived 'defects' in appearance can cause a great deal of anxiety among affected individuals. In order to alleviate the anxiety they feel from their appearance obsessions, they perform compulsions in the form of repetitive behaviours (for example, asking others for reassurance, mirror checking, excessive weight-lifting) and/or mental acts (for example, comparing and contrasting appearance to others) (APA,

2013). A rising concern for BDD patients is that they often seek non-psychiatric help and turn to cosmetic surgery in an attempt to physically correct their perceived defect, and since they are rarely satisfied with the outcome of the procedure, they repeatedly request for more procedures. As such, it is important that aesthetic practitioners have an understanding of mental health disorders and are able to spot the warning signs among potential patients who present to clinic.

Eating disorders

Eating disorders (EDs), such as anorexia nervosa, bulimia nervosa and binge-eating disorder (BED), are psychiatric disorders characterised by eating disturbances that can cause harm in physical health and psychosocial functioning (APA, 2013). Individuals who suffer from these disorders have preoccupations about food and their body image. These disorders are classified under 'Feeding and eating disorders' in the DSM-5.

Anorexia nervosa

Anorexia is characterised by actual starvation to the point where the individual is grossly underweight (APA, 2013). It affects about 0.9% of women and 0.3% of men in the US, and it has a median age of onset at 18 years old (Hudson et al, 2007).

Individuals with anorexia are extremely anxious about gaining weight or becoming obese, even when they are already at a seriously low body weight, and they do not recognize that their body weight is as low as it is (APA, 2013). Since they have a fear of losing self-control (such as with weight gain) and of being ineffective in their lives, they feel a satisfaction by performing behaviours meant to control their weight and food (Bruch, 1978). These behaviours can include limiting the food they eat to the point of semi-starvation and exercising excessively.

Binge-eating disorder (BED)

Binge-eating disorder (BED) is characterised by episodes of uncontrolled eating, or binging. Its lifetime prevalence is about 3.2% of women and 2.0% of men in the US, and the median age of onset is 21 years old (Hudson et al, 2007). Most people with this disorder are obese, have a history of weight fluctuations and have more difficulty losing weight and keeping it off (APA, 2013).

An episode of binge eating consists of eating a larger than average amount of food in a certain period of time, and the episodes can include three or more of these features: (1) eating abnormally rapidly, (2) eating until uncomfortably full, (3) eating when not hungry, (4) eating alone because of the embarrassment felt by the amount eaten and (5) feeling disgusted, guilty or depressed after eating (APA, 2013).

Those with BED impulsively binge eat to distract themselves during times of distress and to relieve their anxiety that stems from their concerns of their body shape and weight. Individuals with BED feel disgusted with themselves, depressed and/or very guilty after overeating impulsively (Dunkley and Grilo, 2007).

Bulimia nervosa

Bulimia is characterised by binges and purges that range from once or twice a week to several times a day (APA, 2013). About 1.5% of women and about 0.5% of men will develop this disorder in their lifetime, and the onset is typically around early adulthood (age 18), particularly the time of puberty (Hudson et al, 2007).

Binge eating is a primary characteristic of bulimia, but, in addition, sufferers purge (for example, self-induced vomiting, laxatives, diuretics and enemas) in order to alleviate the guilt from the initial impulsive binge. Nonetheless, the purges serve only as temporary relief. The impulsivity of bulimics, particularly in their tendency to act too hastily, place them at increased risk for suicidal behaviour (Fischer et al, 2003). Because many individuals with bulimia binge and purge in secret and maintain normal or above normal body weight, they can often successfully hide their problem from others for years (Pettersen et al, 2008).

Differentiating body-dysmorphic disorder and eating disorders

The most apparent similarity between BDD and EDs is that they are both concerned with negative body image; however, it is the subject of focus that differentiates the two disorders. Individuals with BDD have concerns about specific body parts, whereas individuals with eating disorders have more general shape and weight concerns (Mitchison et al, 2013). In both cases, the concerns cause significant emotional distress and impair functioning. It is important to note that individuals with BDD can also have general shape and weight concerns, so this is where the line between the two conditions can become blurred. Individuals with BDD or anorexia in particular have both shown to have abnormal visual processing compared with healthy individuals, which can help to explain the distorted self-image they have (Madsen et al, 2013).

A key difference between BDD and ED is that, in ED, a diagnosis requires abnormal eating behaviours, whereas in BDD, a diagnosis does not require abnormal eating behaviours. Abnormal eating behaviours can include diet restriction, binge eating and purging. These eating behaviours can lead to very dangerous medical outcomes and serious health implications that may not be reversible and can lead to death, such as loss of bone mineral density, loss of energy, emaciation, gastrointestinal symptoms, lanugo, obesity, menstrual irregularity and cardiac problems (APA, 2013). Although BDD does not generally have major health implications, there can be an issue when

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patients seek out too many cosmetic surgeries or procedures, which can also have negative outcomes for the patient's physical health.

Both BDD and ED are associated with higher perfectionistic concerns compared with healthy controls (Hewitt et al, 1995; Buhlmann et al, 2008). Individuals with these disorders aspire to be perfect in all areas in life, so they perform frequent checking behaviours, including mirror gazing, weighing self and measuring body parts (APA, 2013). Additionally, both disorders are characterised by avoidant behaviours, such as of public spaces and relationships with other people, but compared with ED, individuals with BDD reported more avoidance (Rosen and Ramirez, 1998). They seek reassurance about their appearance, and a majority of these patients have associated depression (APA, 2013).

Comorbid body-dysmorphic disorder and eating disorders

Though BDD and ED are distinct from each another, they can co-occur in certain individuals. Females with BDD are more likely to have a comorbid ED (APA, 2013). A study by Ruffolo et al (2006) found that 32.5% of BDD patients had a comorbid lifetime ED, specifically 9.0% with anorexia, 6.5% with buli and 17.5% with ED not otherwise specified. The study also found that, compared with the BDD only group, the comorbid BDD and ED group had higher rates of hospitalisation for psychiatric problems, psychotherapy sessions and medications (Ruffolo et al, 2006). This suggests that when there is a BDD and ED comorbidity, this is often a more difficult and dangerous case to treat compared with when only one of these disorders is present.

Implications for aesthetic practitioners

Aesthetic practitioners must be aware of the differences in these disorders in their practice. They can try to identify the following by general interviewing in the initial consultation. BDD is typically of utmost concern in the field of aesthetics due to the amount of individuals with BDD who seek cosmetic help before psychiatric help. To identify BDD, practitioners can give screening questionnaires, such as the BDD Questionnaire-Dermatology Version (BDDQ-DV) and Dysmorphic Concern Questionnaire (DCQ) (Danesh et al, 2015). These questionnaires include questions designed to determine whether the patient might have issues with self-image, such as 'How often do you spend thinking about how you look?' and 'Do you avoid doing certain things because of your perceived defects?'. Patients who are suspected to have BDD should be referred out to a psychologist or psychiatrist for further diagnosis and treatment. If the general screening determines that an ED may also be present, it is important that this is recorded when referring the patient on for psychological help.

It is important for aesthetic practitioners to first determine the patient's motivations for having the chosen procedure. If the aesthetic practitioner feels that these motivations are driven by a psychological disorder, such as BDD or an ED, they must then refer them on to a psychologist who is an expert in BDD. Maintaining professional relationships with psychology experts will help aesthetic practitioners feel more confident when making referrals and when determining whether the procedure should be undertaken.

Treatment considerations

If BDD and/or EDs are detected in an individual, it is important for them to receive proper treatment. Assessment and diagnosis prior to treatment are essential to determining the severity of the disorders present and designing an effective treatment strategy. In treatment, all disorders must be taken into consideration. Since patients with EDs may have medical issues on top of their psychiatric issues, it would be beneficial for them to be treated by a multidisciplinary team, including a medical doctor, psychiatrist, psychologist and dietitian (Gorla and Mathews, 2005). If their physical health status becomes very severe, some ED patients will require hospitalisation, and in these cases physical health is the priority in treatment. Otherwise, treatment strategies include psychoeducation, nutritional management, cognitive-behavioural therapy (CBT) and psychopharmacology.

Psychoeducation

Increasing awareness via psychoeducation in both of these disorders will help patients understand their disorder and is one of the first steps to recovery. BDD and anorexia are both characterised by a lack of insight to the disorder (Arbel et al, 2014; Eisen et al, 2004). For example, BDD patients see defects in their appearance that others do not see, and anorexia patients think that they are overweight when, in reality, they are underweight. Mindful awareness training can help patients to identify emotions/situations (cues) that lead them to perform ritualistic behaviours. Psychoeducation for family members can help them understand healthy, beneficial ways in which they can support the patient. Involving family members is especially necessary if the patient is a young adolescent who is living with family members.

Nutritional management

Patients who have EDs have unhealthy eating behaviours, which can eventually have dangerous consequences. Stabilising eating behaviours becomes a priority to ensure that the patient's weight, vital signs and electrolytes are restored within the normal level. Nutrition management is typically included in the treatment plan for these individuals, and the role of nutritionists is to advise patients about proper eating and introduce healthy eating regimens (Rock and Curran-Celentano, 1996).

Cognitive-behavioural therapy

The primary purposes of CBT are to target abnormal thoughts and behaviours, provide coping resources for stress management and teach strategies to prevent unhealthy behaviours from occurring. Cognitive restructuring can help target negative self-image, feelings of helplessness and negative thinking patterns that lead to overeating or purging. CBT has shown to be effective for individuals with BDD (Veale et al, 2014). Research has suggested that a transdiagnostic CBT intervention that targets ED psychopathology exclusively and other problems, such as perfectionism and low self-esteem, can be effective in treating EDs (Fairburn et al, 2009).

Exposure and response prevention (ERP) is a technique used in CBT that can be used to confront the distorted body image that is associated with BDD and block any behaviours that may be performed due to the anxiety. For BDD, exposing patients to mirrors to face their 'ugliness' can help them to handle their anxiety and habituate to the feeling of being ugly. ERP can also be used to tackle eating behaviours, such as in exposing patients to feelings of fullness after meals and preventing any maladaptive behaviours after inducing fullness.

Psychopharmacology

Psychopharmacology depends on the diagnosis of each individual. Psychopharmacology for BDD and bulimia primarily consist of antidepressants, specifically selective-serotonin reuptake inhibitors (SSRIs) (Walsh et al, 1997; Phillips, 2002). There are mixed results in studies about effective medication management for anorexia, and, therefore, more research is needed in this area (Gorla and Mathews, 2005; Aigner et al, 2011). The US Food and Drug Administration (FDA) approved the medication lisdexamfetamine dimesylate (LDX) for moderate-to-severe BED, and other medications, such as anticonvulsants and antidepressants, are also used in treatment of BED (Reas and Grilo, 2015).

Key points

- Body dysmorphic disorder (BDD) is the disease of self-perceived ugliness and is characterised by obsessions in flaws in appearance and compulsions to alleviate the anxiety from these obsessions
- Eating disorders (EDs), including anorexia nervosa, bulimia nervosa, and binge-eating disorder (BED), are psychiatric disorders that are associated with abnormal eating behaviours that lead to a decline in physical health and psychosocial functioning
- Common features of BDD and EDs include negative body image, low self-esteem, checking behaviours, perfectionistic concerns, reassurance-seeking and associated depression
- To differentially diagnose BDD and EDs, the presence of abnormal eating behaviours and the subject of focus on appearance should be examined
- The primary treatment strategies for BDD and eating disorders may include psychoeducation, nutritional management, cognitive-behavioural therapy and psychopharmacology

Conclusion

When negative body image significantly impedes on daily functioning, a psychiatric disorder may be the underlying cause of distress. Both BDD and ED are associated with negative body image, perfectionistic concerns, depression, checking behaviours and reassurance-seeking, all of which contribute to an overall impediment on psychosocial functioning. Even though BDD and EDs share multiple characteristics, they have different diagnostic criteria (for example, eating behaviours and subject of focus), and can occur in different rates across the population. Differentially diagnosing BDD and EDs has significant treatment implications that must be addressed. There is a higher likelihood that EDs can lead to detrimental medical consequences, since there is a disturbance in eating behaviours and food intake, and, if this is the case, patients must primarily be treated medically in order to address these issues. If any of these disorders are detected, it is critical for practitioners to refer these individuals to professionals in mental health, where the patient's condition will be assessed and a treatment strategy designed based on the diagnosis. With medical and psychiatric help, individuals living with BDD and/or EDs can receive the treatment required to stabilise their physical health and promote their overall wellbeing. JAN

CPD questions

- What are some behaviors that are common to both body-dysmorphic disorder (BDD) and eating disorders?
- What are the key differences between BDD and eating disorders?
- How does the treatment of eating disorders differ from the treatment of BDD?

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