BDD and/or ED?
Comorbid v's Differential Diagnosis.
BDD and ED Presentations

DR FRAN BEILHARZ
ANZAED CONFERENCE 2024

EATING DISORDERS - DSM CRITERIA

EATING BEHAVIOURS

- Persistent disruption of eating behaviours that results in the altered consumption of food, or persistent energy intake restriction e.g. restrictive eating, binge eating, inappropriate compensatory behaviours (AN, BN, OSFED)

BODY IMAGE DISRUPTION

- Disturbance in the way one's body weight or shape is experienced, fear of gaining weight, or self evaluation unduly influenced by body shape and weight. Restrictive or compensatory behaviours are intended to prevent weight gain

IMPACT

- Significantly impairs physical health and psychosocial functioning
- Marked distress around eating

SEVERITY

- Based on frequency of binge or compensatory behaviours, or weight for AN
- Specify if in partial or full remission

BODY DYSMORPHIC DISORDER - DSM CRITERIA

PREOCCUPATION

- Preoccupation with one or more perceived defects or flaws in physical appearance, which appear slight or are unobservable to otherse.g. facial features, skin, hair, genitals, body parts, symmetry

COMPULSIVE BEHAVIOURS

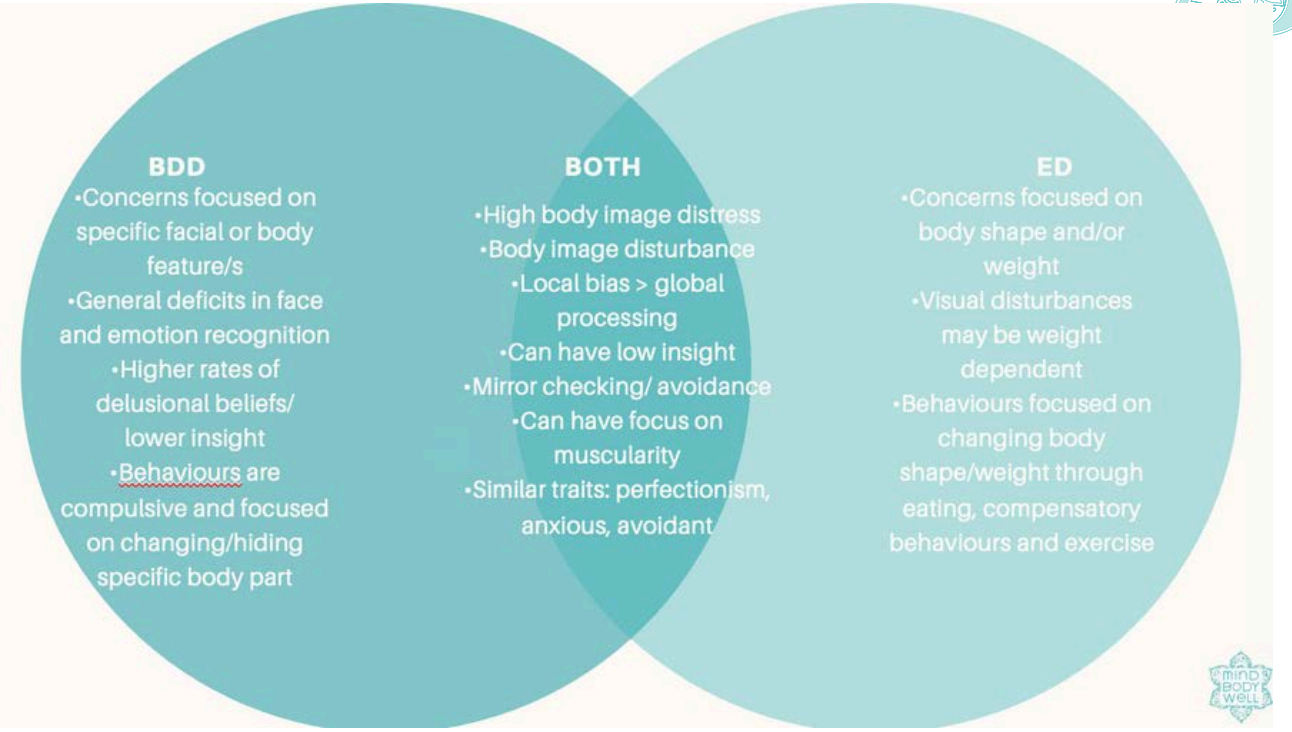
- At some point during the course of the disorder, performance of compulsive or repetitive behaviours or mental acts in response to appearance concerns e.g. checking, camoflaging, comparing, reassurance seeking

IMPACT

- Preoccupation causes clinically significant distress or impairment in important areas of functioning

SPECIFIERS

- Not better explained by concerns with body fat or weight in an individual whose symptoms meet ED criteria
- Insight: good/fair; poor; absent/delusional
- Muscle dysmorphia: preoccupation with appearing insufficiently muscular or slight in build



DIFFERENTIAL ASSESSMENT PROMPTS

PRESENCE OF APPEARANCE CONCERNS

- Are you concerned or distressed about your overall appearance/ shape or specific features of your body or face? E.g. nose, skin, genitals
- How do you describe the area of concern? Do you think others see it in the same way that you do?
- How many hours do you spend thinking about or trying and change your appearance?

FUNCTION OF BEHAVIOUR

- Can you tell me what purpose or function is driving the restrictive eating and exercise?
- Do you have an 'ideal' way you would like your body to look?
- Are there any other behaviours you do to try and change, hide or check your appearance?
- Do concerns about your appearance mean you avoid any important activities or situations?

HISTORY OF APPEARANCE CONCERNS

- Have you previously been very concerned about a particular part of your body or appearance?
- Have you had any cosmetic procedures to change your appearance?

COMORBID DIAGNOSIS

- 32.5% ED lifetime comorbid prevalence in BDD (Ruffolo, 2006)
- In comorbid presentations, 63-94% of clients reported developing BDD prior to AN
- One study highlighted that despite clients with AN expressing that BDD preoccupations were their 'biggest' concern, none of them had been diagnosed with comorbid BDD (Grant,2002)
- Of those with comorbid BDD & ED: 9% AN; 6.5% BN; 17.5% EDNOS (Ruffolo, 2006)
- Among 26.23% of AN with probable BDD, hair, nose, skin, teeth, and height were the most common areas of concern (Cerea, 2018; Kollei 2013)
- 63.93% of patients with AN reported NWRCs and 26.23% of these patients screened positive for BDD (Cerea, 2018)
- BDD comorbidity is actually higher in AN patients than AN comorbidity is in BDD patients
- 39% of AN clients met criteria for BDD (Grant, 2002)
- 15% lifetime BDD prevalence (Kollei, 2013)

OUTCOMES - COMORBID DIAGNOSIS

RISK	CLINICAL	TREATMENT
• Higher rates of suicidality (comorbid AN & BDD had triple the suicide attempt rate of those with AN alone (63% vs. 20%; Grant 2004) • Higher rates of hospitalisations	• Significantly greater body image disturbance (Ruffolo, 2006) • Significantly more preoccupied with appearance (Grant, 2002) • Greater number of psychiatric comorbidities (Ruffolo) • Significantly poorer functioning (Grant, 2002) • Higher levels of delusionality (Grant, 2002)	• Higher number of treatment sessions • Higher number of psychotropic medications (Ruffolo, 2006) • Likely feeling 'stuck' in treatment- both clinician and client

TREATMENT ADAPTATIONS

- Monitor suicidality (3x higher suicide rate in comorbid; Grant 2002)
- Screen all clients with AN for BDD (minimum)
- Individual formulation
- Planning treatment priorities

KEY TAKE AWAYS

SCREEN	INDIVIDUAL FORMULATION	TREATMENT HIERARCHY
High comorbidity	Vicious flower formulation	Adapting treatment for comorbid presentations
Part of body image assessment for every client presenting with an eating disorder or body image concerns	Include all ED & BDD maintaining cycles	Flexibility in treatment approach depending on client's needs, risks, insight and capacity to engage

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)

Cerea, Silvia et al, 'Non-Weight-Related Body Image Concerns and Body Dysmorphic Disorder Prevalence in Patients with Anorexia Nervosa' (2018) 267. *Psychiatry Research* 120

Fairburn, C. G. *Cognitive Behavior Therapy and Eating Disorders*, Guilford Press, New York, 2008

Grant JE, Phillips KA.(2004) 'Is anorexia nervosa a subtype of body dysmorphic disorder? Probably not, but read on..' *Harv Rev Psychiatry*. Mar-Apr;12(2):123-6

Grant, Jon E, Suck Won Kim and Elke D Eckert (2002). 'Body Dysmorphic Disorder in Patients with Anorexia Nervosa: Prevalence, Clinical Features, and Delusionality of Body Image', 32(3). *The International Journal of Eating Disorders,* 291

Hartmann, Andrea S, Jennifer L Greenberg and Sabine Wilhelm (2013) 'The Relationship between Anorexia Nervosa and Body Dysmorphic Disorder', 33(5) *Clinical Psychology Review*, 675

Hartmann, Andrea S et al (2013) 'Insight Impairment in Body Image Disorders: Delusionality and Overvalued Ideas in Anorexia Nervosa versus Body Dysmorphic Disorder'. 210(3) *Psychiatry Research,* 1129

Kollei, Ines et al (2013) 'Body Dysmorphic Disorder and Nonweight-Related Body Image Concerns in Individuals with Eating Disorders', 46(1) *The International Journal of Eating Disorders*, 52

Linehan, Marsha M. (2015). *DBT Skills Training Manua*l, 2nd ed. New York: Guilford Press

Madsen, Sarah K, Cara Bohon and Jamie D Feusner (2013), 'Visual Processing in Anorexia Nervosa and Body Dysmorphic Disorder: Similarities, Differences, and Future Research Directions' (2013) 47(10) *Journal of Psychiatric Research*, 1483

Phillipou, Andrea, David Jonathan Castle and Susan Lee Rossell (2019), 'Direct Comparisons of Anorexia Nervosa and Body Dysmorphic Disorder: A Systematic Review' (2019) 274, *Psychiatry Research,* 129

Ruffolo, JS et al (2006). 'Comorbidity of Body Dysmorphic Disorder and Eating Disorders: Severity of Psychopathology and Body Image Disturbance' (2006) 39(1), *The International journal of eating disorders* , 11

Toh, Wei Lin et al (2020), 'Body Parts of Clinical Concern in Anorexia Nervosa versus Body Dysmorphic Disorder: A Cross-Diagnostic Comparison', 28(2) *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists* ,134

Vaughn, Don A et al (2019), 'Differentiating Weight-Restored Anorexia Nervosa and Body Dysmorphic Disorder Using Neuroimaging and Psychometric Markers', 14(5) *PloS One*, e0213974

Veale, D. (2001), 'Cognitive–behavioural therapy for body dysmorphic disorder'. *Advances in Psychiatric Treatment*, vol. 7, pp. 125–132

Veale, D., Rob, W., and Clarke, A. (2009) *Overcoming Body Image Problems Including Body Dysmorphic Disorder, A Self-Help Guide Using Cognitive Behavioral Techniques*.

Veale, D., Ellison, N., Werner, T., Dodhia, R., Serfaty, M., and Clarke, A. (2012) 'Development of a cosmetic procedure screening questionnaire (COPS) for Body Dysmorphic Disorder'. *Journal of Plastic Reconstructive and Aesthetic Surgery*, 65 (4), 530-532.

Resources

Access Fran's pre-recorded webinar

https://www.mindbodywell.com.au/bddanzaed2024