

## **Crooked Mirrors: Externalization of Self Image in BDD**

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BDD has only recently been diagnostically adopted into the family of OCD spectrum disorders. The condition is characterized by abnormally persistent preoccupation with one's body part or overall appearance. It is an unruly disorder for it has the tendency to wander from one body part to another creating a focal point of anxiety which in reality remains grossly generalized. It manifests as the abnormal dissatisfaction with one's physical appearance and correcting one unsatisfying aspect of the body leads to the perceived need to correct others.

Very often rout leads a person into plastic surgery and into more than one such procedure. The cruelty of this condition is that the BDD patient may obtain proper treatment only after the profoundly painful dissatisfaction with results of multiple invasive procedures sets in and social and professional life becomes seriously affected. Thus, detection and diagnoses of BDD occurs only after its consequences have been suffered through and paid for.

Unfortunately, it is reported that this dissatisfaction routinely pours out as anger directed towards the plastic surgeon, and ranges from verbal confrontations to litigation. Experienced practitioners in the cosmetic surgery field learn how to detect "problem patients" and often refuse to take them. Undeterred, the patients turn to less sophisticated providers or even self-surgery and thus further escalate the miserable cycle of surgery and self-rejection.

The search for early detection and diagnoses of BDD must go hand in hand with a simple protocol for its correction and treatment. The "simplicity" of course refers to the protocol, not to its implementations which has to overcome the triple hurdles of patient's unawareness of his/her underlying condition, the shame and fear of revealing the rituals and delusions, and the lack of knowledge within the family physicians and the cosmetic surgery industry of the extent and depth of this disorder.

While studies suggest various degrees of success in response to medications increasing levels of serotonin, cognitive-behavioral therapy methods (CBT) may be better suited to the task of early intervention and prevention. First, patients for studies of SSRI effects are typically recruited from psychiatric population with already lengthy treatment histories

and high levels of comorbidity. Second, there is the logistics of defining and managing medication protocol by physicians other than competent psychopharmacologists which is likely to meet great resistance and fear of dealing with medication side effects.

BDD patients present a special challenge to CBT practitioners, especially those that follow intensive treatment protocols developed by Dr. Edna Foa and others which rely firmly on methods of exposure and response prevention. Most of BDD patients are adolescents (the typical onset age is 17 years) although BDD now shows in much younger patients undergoing significant physical transformations and dealing with normal stresses of adjustment. This group and their parents may necessarily have the insight and resources to see their body-image preoccupation as symptoms of a psychological disorder. The majority of those afflicted with BDD (over 50%) meet DSM IV criteria for delusional disorder and may be treatment refractory. While several studies have shown significant clinical improvements in BDD patients treated with CBT techniques, there is a lot more data on SSRI's efficacy.

Creating individualized exposure and response prevention protocols for this group of BDD patients is a difficult and arduous task requiring highly developed skills and intuition. Psychiatric/psychological referrals for specialized CBT intervention may be deferred indefinitely by family physicians and surgeons out of concerns of losing a patient to follow-up. Still, the complexity of the problem and the growing awareness of its toll on young people should spur and not deter the search for tools of early diagnostic and prevention.

One such method developed and adopted at the Westwood Institute for Anxiety Disorders is the use of distorted mirrors to counter the false beliefs and ritualistic obsessions associated with BDD. A set of distortion mirrors made out of highly reflecting (anodized) aluminum surfaces bent in different directions is inexpensive and is easily concealed behind curtains while occupying little space.

Our thinking behind the use of this technique is fairly simple. BDD patients suffer from a body image distortion internalized through social factors (peer pressure, parental critique, etc) or developed through the yet undefined neurological deficits (although it is not clear what constitutes the case and what represents the effect of abnormal levels of neurotransmitters). This internalized perception of distortion prompts them to ritualize their behavior as in constantly checking the "problem part" in mirrors and reflective surfaces before they seek help in "fixing the problem." How do you habituate such a patient to the internalized irrational stimuli? It is a well established fact that the internalization of mental processes is greatly enhanced by operations with external objects (e.g. the use of counting sticks or matches in developing mathematical skills). The use of distorted reflective surfaces reverses the process. By externalizing the distorted image of one's body, we create outside processes that aid in habituation to the person's exaggeratedly deformed physical image and through that we can control concurrent anxiety and even prevent responses to the feared internal self-image. In simple language, we inform the patients that if they learn how to control their anxiety of seeing their grotesquely misshaped image in mirror, they can gradually learn how to control their

anxiety and responses to the internal images of their “unruly hair,” “beaked nose” and “tiny breasts.” Patients are trained to move up the hierarchy of exposure, building up the degree of distortion and the exposure time to reduce perfectionistic concerns and to allow for acceptance of oneself with an imperfectly shaped body.

While our experience with this techniques do not allow for any significant generalizations, we have been successful in dealing with a small population of BDD patients. The distorted mirror exposure technique resulted insignificant improvement in 4 patients with BDD over a period of three weeks. In one case which we reported at the American Psychiatric Association 156<sup>th</sup> Annual Meeting, a 45-year-old female patient was exposed to the distorted mirror protocol following 17 plastic surgeries done in order to perfect her appearance for a period of 15 days. Prior to coming to UCLA, the patient has undergone several treatments for her OCD and BDD conditions. She has been tried on all SSRIs available at the time, however, her BDD symptoms were still severe. When I meet her, she appeared to be demoralized by living with disorder for many years and never receiving CBT with other practitioners. At the time, patient has meet criteria for severe BDD and OCD. She scored 32 on Yale-Brown Obsessive-Compulsive Scale for Body Dysmorphic Disorder (BDD-Y-BOCS). Patient was afraid of getting old, being ugly, and not looking perfect. She was excessively concerned with her appearance. Therefore, her rituals were done to protect herself from aging and getting to be ugly. She did 20-30 facial wraps a day, washed her face 40 times daily, compared and contrasted her limbs, eyes, and other paired parts of the body, put cosmetics on in the particular order, looked into mirrors and asked for reassurance that she was pretty and looked good constantly. Her rituals of perfections and facial rubs would take more than 8 hours a day. To make the picture vivid, she had described that she had missed her 35<sup>th</sup> birthday party and appeared to the place of the party 32 hours later because she was perfecting her facial appearance.

During the treatment, the patient was exposed to distorted mirrors, instructed to wear mismatching jewelry, clothes, put makeup on one eye but not another, etc. While looking in distorted mirrors, she was being exposed to her imperfections which were exaggerated by the mirrors. At the end of the treatment, the severity of patient’s symptoms as measured with Yale-Brown Obsessive-Compulsive Scale for Body Dysmorphic Disorder (BDD-Y-BOCS) decreased from 32 to 10 following the above treatment. In addition, after a five year follow-up patient reported that she has not gotten any plastic surgeries in that period of time.

In addition to this case I had three successful cases that I worked with using a new technique with crooked mirrors. Patients were instructed to look into the crooked mirrors. Therefore, they were actually seeing distorted reflection of themselves. In on of them the patient had two plastic surgeries and like most of the other people with BDD was dissatisfied with the results. Another patient did not have any plastic surgeries. However, she had a number of surgeries to reconstruct and fix body parts that were destroyed and distorted due to her OCD (e.g., obsessively working out to the point that the knee caps break). And yet another patient did not have any plastic surgeries at all. In all those cases the technique with using crooked mirrors for exposure exercises was successful. The

patients improved significantly and their scores on YBOCS-BDD scale decreased at least 75 – 80 %. At the follow-up interviews patients indicated that they did not have any plastic surgeries done since the treatment.

These initial successes should be followed with a formal representative study to determine, inter alia, the effect of variables, such as age, gender, length of exposures, and co-morbidity on the reflective surface treatment and exposure technique. Easy to use protocols and kits with manual for self-use and for use at physician offices can then be developed.