

Addressing “Psychotic” symptoms in BDD

- Some percentage of people with BDD will be described as having psychotic symptoms such as hallucinations, delusions or ideas of reference.
- The presence of such symptoms may lead to recommendations for treatment based on commonly held beliefs about the nature and treatment of psychosis
- I will be presenting what may seem to be novel ideas about psychotic symptoms in BDD

Hallucinations

- Not part of the typical description of the disorder
- Unknown percentage may have visual hallucinations related to defect including seeing it change
- Auditory hallucinations
 - Command
 - Criticism of appearance
- Olfactory reference syndrome

Hallucinations

- Hallucinations may represent a misinterpretation of intrusive thoughts and that thinking they are from outside may serve to make people less uncomfortable than the idea that they are internally generated.
- Using a cognitive model we can think of the experience of hallucinations as the event, and the distress associated with them as a result of what the person thinks of the event.

Are hallucinations really crazy?

- Samples of college students report 37-39% have auditory hallucinations at some time.
- An estimated 10-25% of the general population report some experience of auditory hallucinations
- In a study recruiting subjects who experienced auditory hallucinations, 39% were not in psychiatric treatment.
- Hallucinations may be experienced by “normal” subjects under predictable circumstances such as sleep deprivation and stimulus deprivation.

Hallucinations

- An unknown percentage of BDD patients have auditory hallucinations often of others saying how ugly they are or commenting on their specific flaw
- Some observations of the concern or flaw may involve visual or tactile hallucinations
- Reports of seeing a feature change while viewing it in the mirror

Visual and Tactile Hallucination

- Reports of seeing major flaws that no one else can see may represent a form of visual hallucination
- Reports of changing size and shape of features during mirror checking
- Reports of feeling defect or flaw e.g. “My face is sagging”

Delusions

- Over 50 % of BDD patients are described as delusional
 - Most common themes are ideas of reference, and ideas about distorted appearance
- Delusional beliefs are subject to the same variation as “normal” beliefs.
- People with delusions tend to jump to conclusions and have a rapid over confident style of reasoning
- People with persecutory delusions tend to have a bias toward attributing negative events to intentional actions of others

Delusion

- A false belief based on incorrect inference about external reality.
- Sustained despite discrepancy with what everyone else believes.
- In BDD the belief about the appearance defect is held with absolute certainty
- Delusional and non-delusional BDD appear to be the same disorder and respond the same to treatment

Are delusions that different?

- What is delusional vs. a “normal” belief is more a matter of cultural validation than the content of the belief.
- Beliefs in possession, control by spirits, abduction by aliens, ghosts, communication with the dead are common in some subcultures and among select groups.
- The difference between delusional patients and the general population appears to be in degree of conviction, distress and preoccupation not content

Referential thinking

- BDD patients typically report beliefs that others are looking at them in unusual ways, reacting to their appearance, disgusted by it or making fun of or talking about them
- They may report people looking at them from a distance, laughing or joking about their appearance pointing it out to others etc.
- 60% of BDD patients have ideas of reference

The Starting Place

- The starting place for cognitive therapy is that people are distressed not by events but what they think of them.
- An event can be something that happens to or around the individual but it can also include internal experiences.
- Examples of events
 - Someone makes a remark
 - A person on TV says something
 - Seeing two people talking and laughing
 - Feeling one's heart beating
 - Hearing a voice

The core assumption of CBT

- It is not the situation or events that upset us but what we think about them.
 - Beliefs, attitudes, assumptions etc. influence our perception of events and thus our emotional reaction to them.
 - It is not what you say but what I think it means that leads to my reaction.
- Everyone has distorted ways of looking at things and biases and beliefs. We tend to interpret experience to fit these pre-existing beliefs.

Thinking and Emotions

- What we think about any event is determined or influenced by many things including past experience and learning, the current setting, mood, and beliefs about ourselves and the world.
- An example
 - ◆ I notice someone looks at me and then looks away and says something to their companion
 - ◆ I have a pre-existing belief that everyone thinks I am ugly
 - ◆ I think they are talking about me and laughing at me because I am ugly
 - ◆ I feel angry and sad and want to run away

A new alternative

- It may be helpful to think of a stress/vulnerability model for the development of psychotic symptoms
- It may be more helpful to think about a symptom based approach rather than an approach based on diagnosis.
 - Hallucinations may be understood as people talking to themselves without realizing it.
 - Delusions are not different from ordinary beliefs.
 - Delusions are the product of jumping to conclusions too quickly
 - They represent an attempt to explain upsetting events

Grounds for hope

- There is now substantial evidence that psychological treatments can produce measurable changes in brain function and that in some cases these are the same as the changes seen in successful drug treatment.
- If the problem in psychosis is understood in terms of biases in reasoning and perception then this would be expected to respond to treatments that address these biases. This is what CBT does successfully do in treatment of other disorders.

Implications of a cognitive model

- If everyone has distortions and bias in their thinking but only some have psychosis the difference is likely to be a difference of degree not type of distortion or bias.
- Delusional beliefs can be changed using the same sort of approaches that work for any other belief.
- Hallucinations represent a misinterpretation of ordinary experiences

Treatment Implications of psychotic symptoms

- The traditional model of psychotic symptoms is that they are qualitatively different from normal experience and are not treatable with psychological methods.
- Typically the presence of psychotic symptoms will lead to the assumption that medication (often antipsychotic drugs) are indicated

What does CBT have to offer?

- Approximately 60% of people treated for psychotic disorders like schizophrenia will continue to have positive symptoms of psychosis (hallucinations and or delusions) when fully compliant with antipsychotic medication regimes.
- There is now a substantial body of literature which shows that CBT can reduce these same psychotic symptoms and the distress associated with them in people diagnosed with schizophrenia or similar disorders.

Collusion vs. Therapy

- We have all been taught that we should not engage in collusion or reinforce delusional beliefs.
- This doesn't mean that we can't respond in an accepting way to statements from patients that involve delusional beliefs or refer to hallucinatory experiences.
- Confrontation of delusional beliefs does not seem to lead to the person abandoning them but does seem to lead to the individual feeling invalidated, and belittled. In some cases it may actually strengthen the delusional belief (especially paranoid ideas)

Confrontation vs. Help

- It is not necessary to believe the delusions are true or that hallucinations are real to recognize that they are distressing.
- We can profitably engage the patient in a collaborative effort to reduce distress.
- Confrontation is unlikely to lead to the patient accepting your explanation.
- Confrontation of delusions and hallucinations is not likely to lead to reduced distress even if it is successful.
- Disproving some delusional beliefs may increase distress or have other adverse effects.

What does Cognitive Therapy do?

- It attempts to engage the patient in a collaborative working relationship.
- Working within this relationship we encourage an empirical approach to understanding experiences.
- Using guided discovery, behavioral experiments or similar ideas we work toward reality testing.
- Hypotheses about the nature of causation and maintenance of symptoms can be evaluated.

The message to give patients

- You are not crazy the problems you have are understandable
- Either your concerns are real or you believe them to be real. (both explain how you feel)
- How you interpret events affects how you feel
- It is important to evaluate beliefs by testing them by making changes in your behaviour
- What you pay attention to and how you pay attention can affect how you feel and what you believe

Normalization

- An important aspect of a cognitive approach to dealing with psychotic symptoms is normalization.
- This takes the form of discussions with the patient about how their experiences are in fact similar to and understandable as variations of “normal” experiences.
- In the case of delusional beliefs this means a discussion of how one might come to believe the delusional idea based on past experiences, context etc.
- In the case of hallucinations this means a discussion of how perceptual experiences can be deceiving, or how normal experiences are similar to hallucinations.