Body Dysmorphic Disorder

Katharine A. Phillips, M.D.

Professor of Psychiatry and Human Behavior
The Warren Alpert Medical School of Brown University
Director, BDD Program, Butler Hospital
Providence, RI

Questions

- What class of medications appears efficacious for BDD?

  A. MAOIs

  B. Tricyclics (excluding clomipramine)

  C. SRIs

  D. Neuroleptics

Questions

- What class of medications appears efficacious for delusional BDD?

  A. Typical antipsychotics

  B. Atypical antipsychotics

  C. SRIs

  D. Benzodiazepines

Questions

- What type of psychotherapy appears efficacious for BDD?

  A. Supportive therapy

  B. Exposure/behavioral experiments, response prevention, and cognitive restructuring

  C. Psychodynamic psychotherapy

  D. Relaxation techniques

Questions

- Cosmetic treatment (e.g., surgery, dermatologic treatment) for BDD appears to be:

  A. Always effective

  B. Usually effective

  C. Rarely effective

Questions

- The following behaviors are common in patients with BDD:

  A. Excessive mirror checking

  B. Compulsive grooming

  C. Skin picking

  D. All of the above

  E. None of the above

Teaching Points

- BDD is relatively common but often goes unrecognized
- BDD causes significant distress and impaired functioning, and individuals with BDD have very poor quality of life
- SRIs and CBT are often effective; additional treatment research is greatly needed

Outline

- Diagnostic criteria
- Prevalence
- Clinical features
- Treatment
- Diagnosis

BDD DSM-IV Criteria

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

Prevalence of BDD

- **Community:** 0.7% - 1.7%
- **Nonclinical student samples:** 2.2% - 13%
- **Dermatology:** 9% - 12%
- **Cosmetic surgery:** 6% - 15%
- **Inpatient psychiatry:** 13% - 16%
- **Outpatient psychiatry:**
  - » OCD: 8% - 37%
  - » Anorexia: 39%
  - » Social phobia: 11% - 13%
  - » Major depression: 0% - 42%

BDD Is Underdiagnosed

- In 5 of 5 studies, no patient with BDD had the diagnosis in their clinical record
- In 2 studies, patients with BDD had revealed their symptoms to only 15% and 41% of providers
- BDD is underdiagnosed:
  - » Embarrassment and shame
  - » Fear of being misunderstood or negatively judged
  - » Don’t know it’s a treatable disorder
  - » Patients aren’t asked

Phillips et al 1993, Phillips et al 1996, Zimmerman & Mattia 1998, Grant et al 2001, Grant et al 2002, Phillips et al 2006, Conroy et al, in press

Demographic Features

- Age: 32.1 ± 11.7 (range 6 to 80)
- Sex:

Male	39%
Female	61%

- Marital status:

Single	67%
Married	20%
Divorced	12%

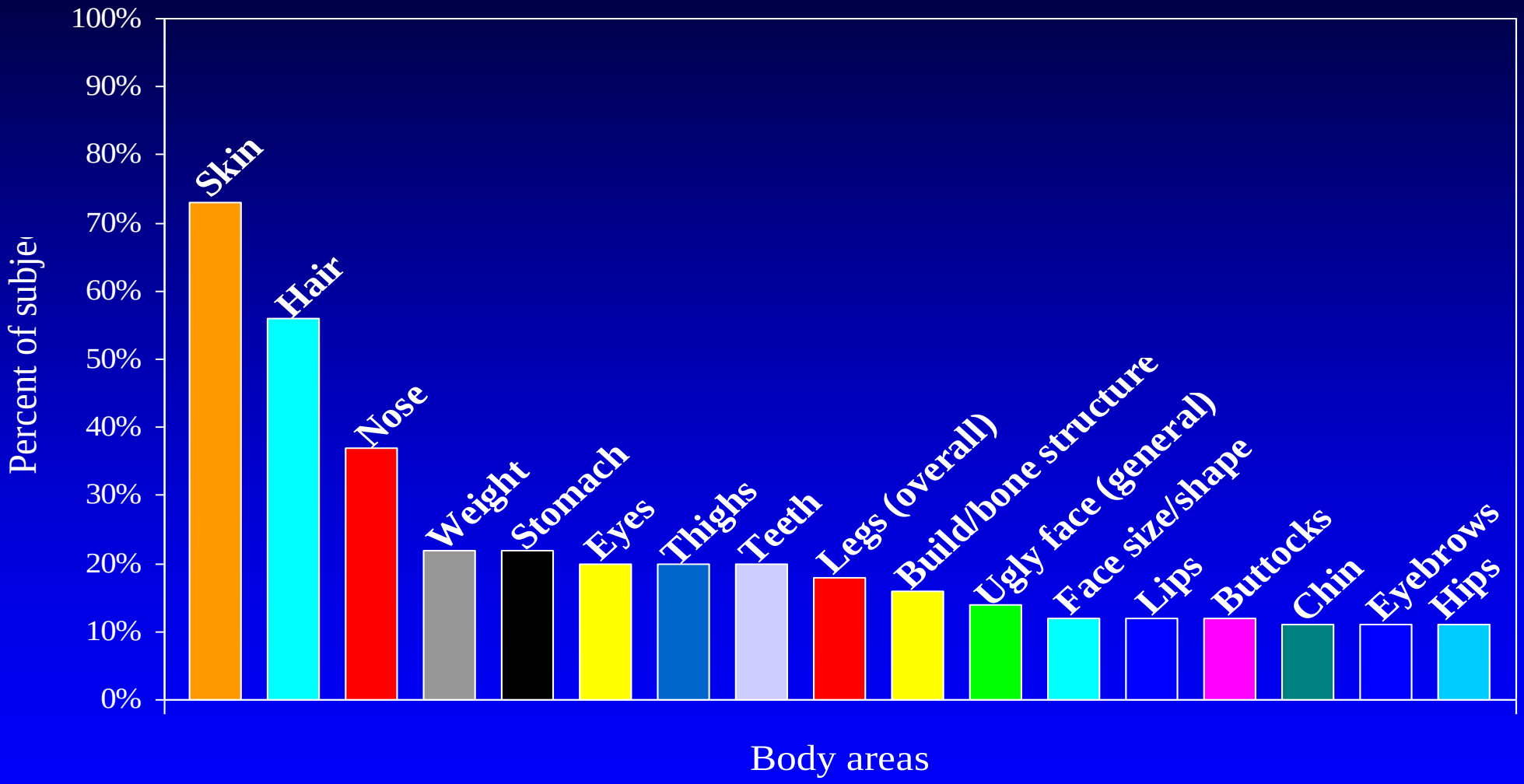
Phillips et al, 1993, 1997, 2005

N=434

Cognitions

- Obsessional, embarrassing, shameful preoccupations
- Difficult to resist or control
- Time consuming (average 3-8 hours a day)
- Associated with low self-esteem, depressed mood, anxiety, introversion, rejection sensitivity
- Insight is usually absent or poor (~35% currently have delusional beliefs about their appearance)
- Ideas or delusions of reference are common (68%)

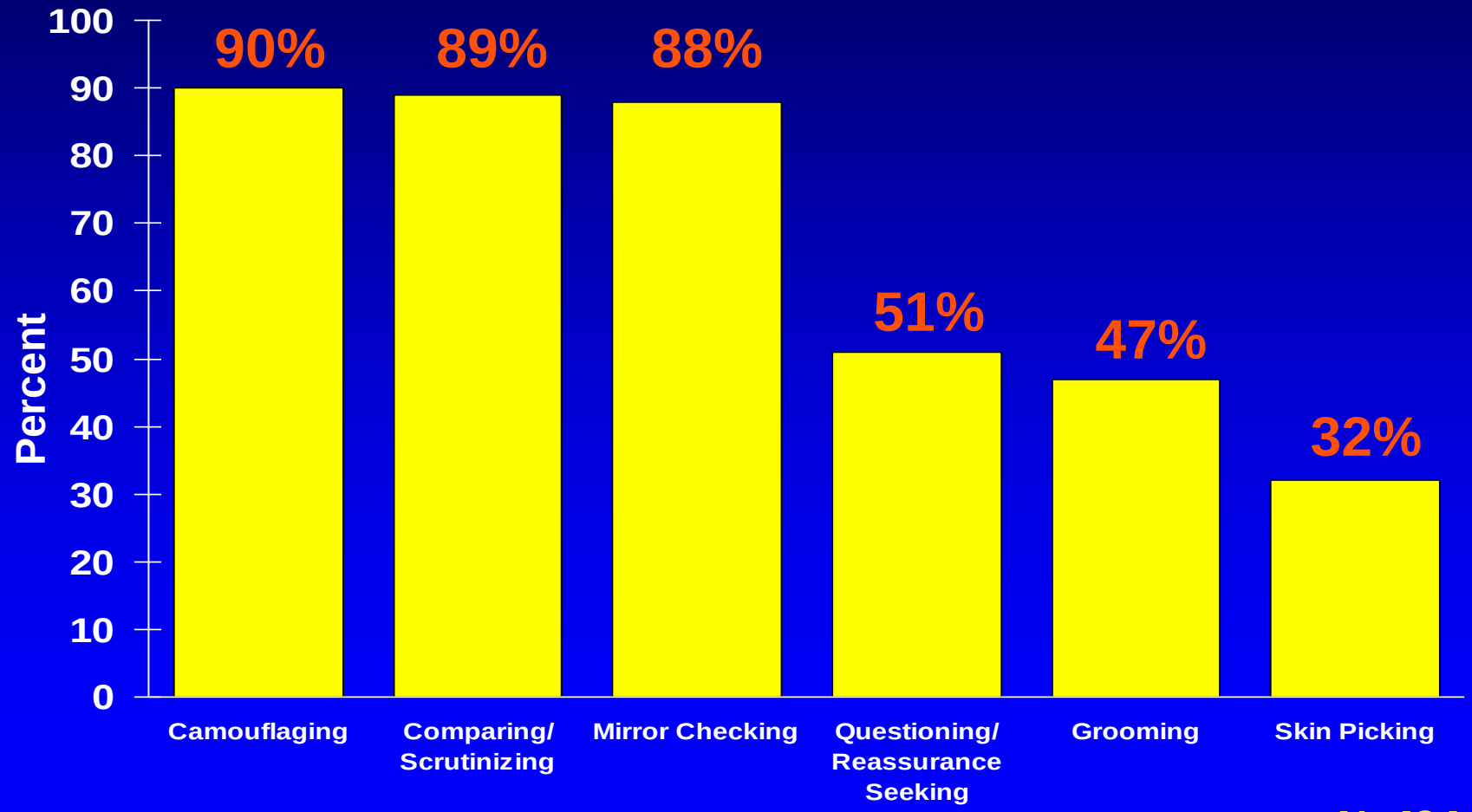
Body Areas of Concern



N=434

Phillips et al, 1993, 1997, 2005

Compulsive and Safety Behaviors

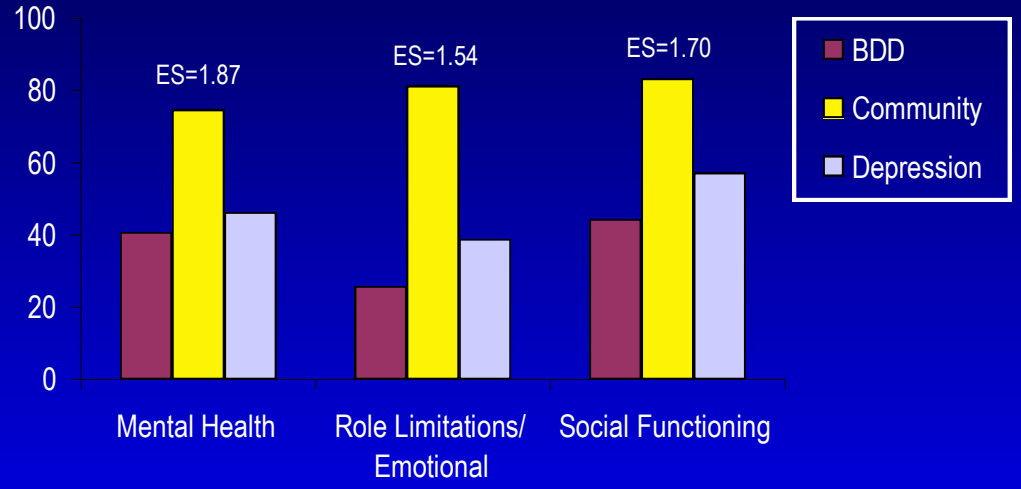


Phillips et al, 1993, 1997, 2005

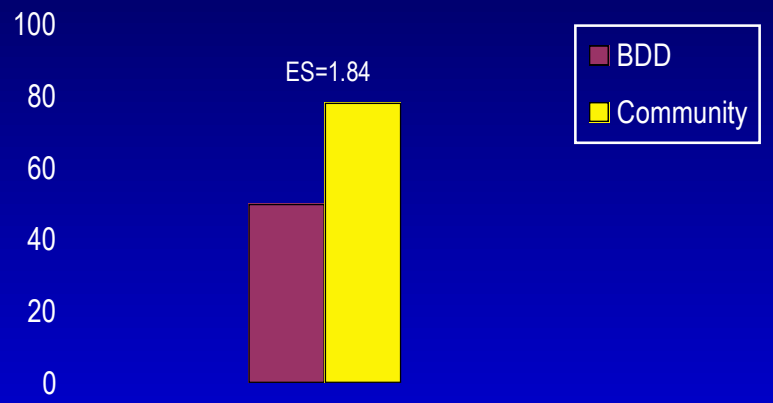
N=434

Functioning and Quality of Life

SF-36

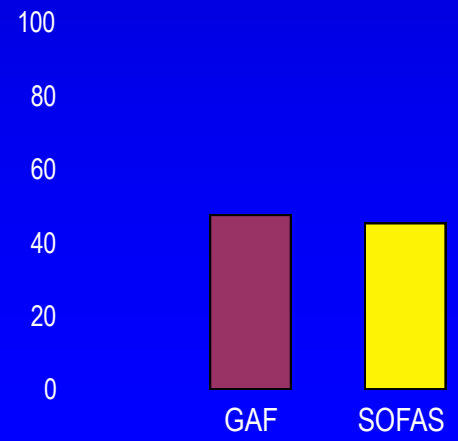


Q-LES-Q



Social Adjustment Scale-SR

GAF/SOFAS



N=176

Phillips et al, Comp Psychiatry, 2005

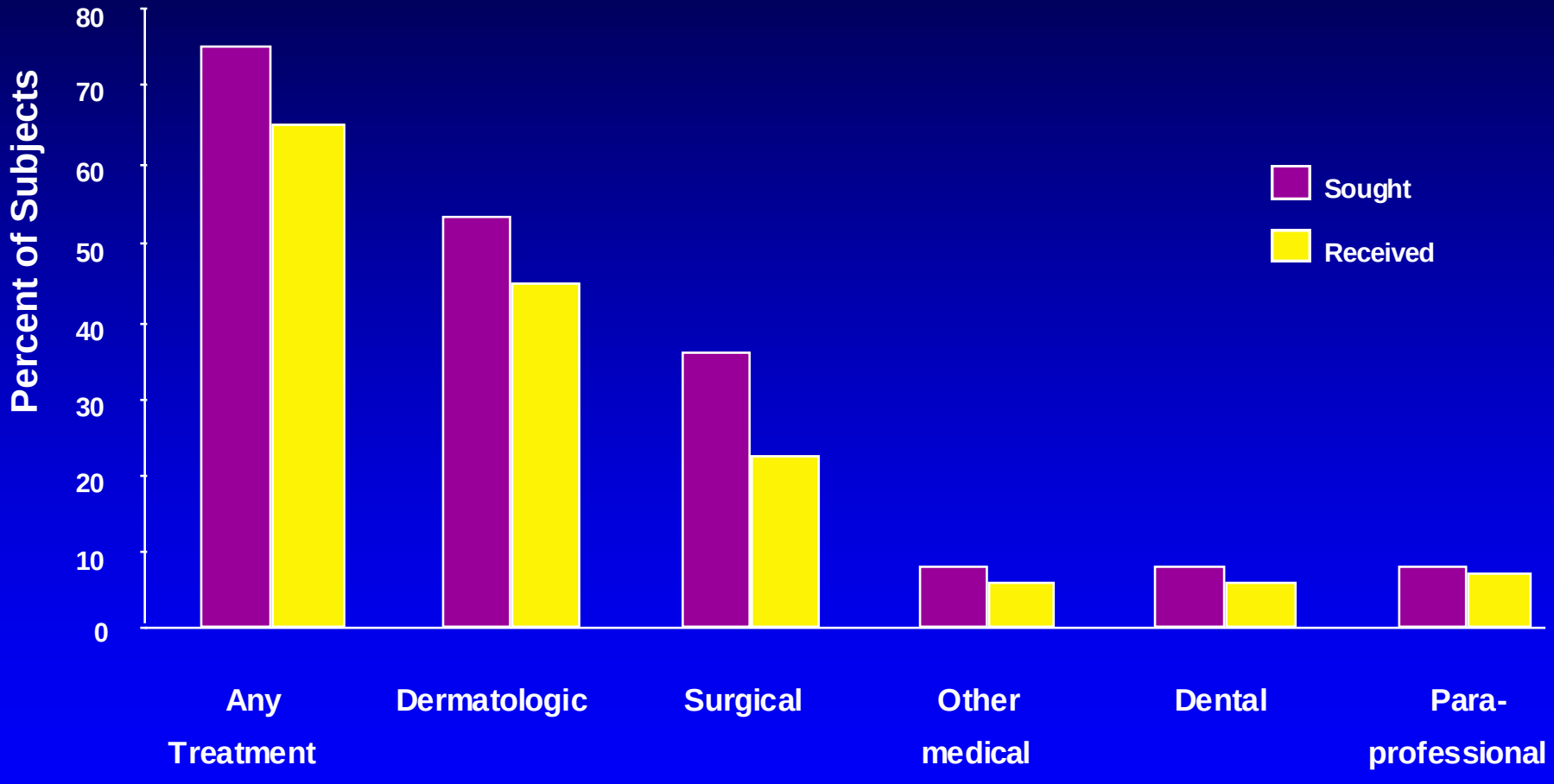
Prospective Suicidality Data Over 3 Years

Variable	Annual Weighted Mean
• Suicidal ideation	57.8%
• Suicide attempt	2.6%
• Suicide attempt attributed to BDD	1.5%
• Number of attempts	2.5 ± 2.1
• Number of attempts attributed to BDD	2.0 ± 2.9
• Completed suicides	0.35% (SMR=45)

N=185

Phillips KA, Menard W: Am J Psychiatry 2006

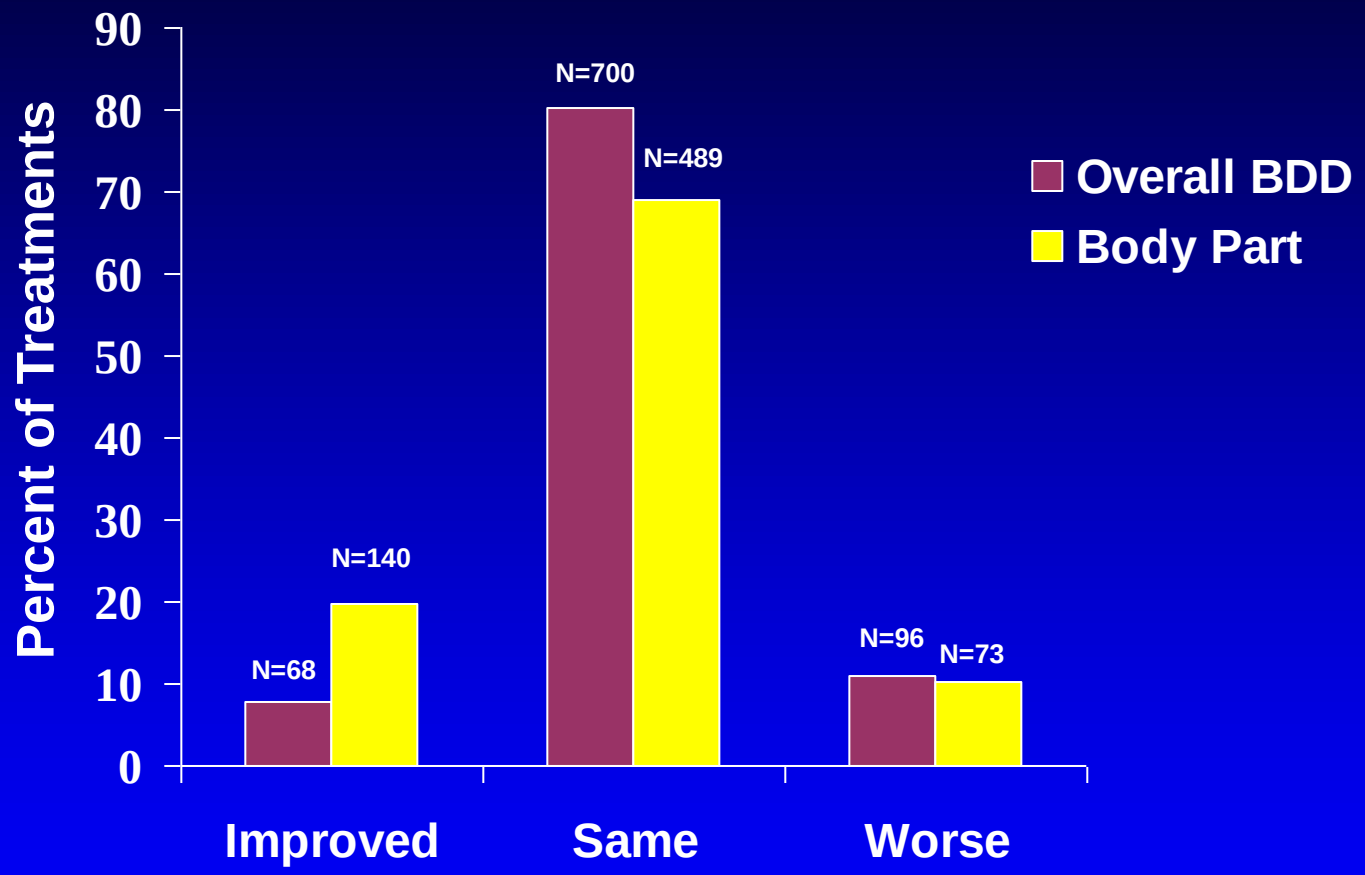
Cosmetic Treatment



Phillips et al, Psychosomatics 2001; Crerand et al, Psychosomatics 2005

N=450

Outcome of Cosmetic Treatment



Total number of treatments = 872

Phillips et al, Psychosomatics 2001; Crerand et al, Psychosomatics 2005

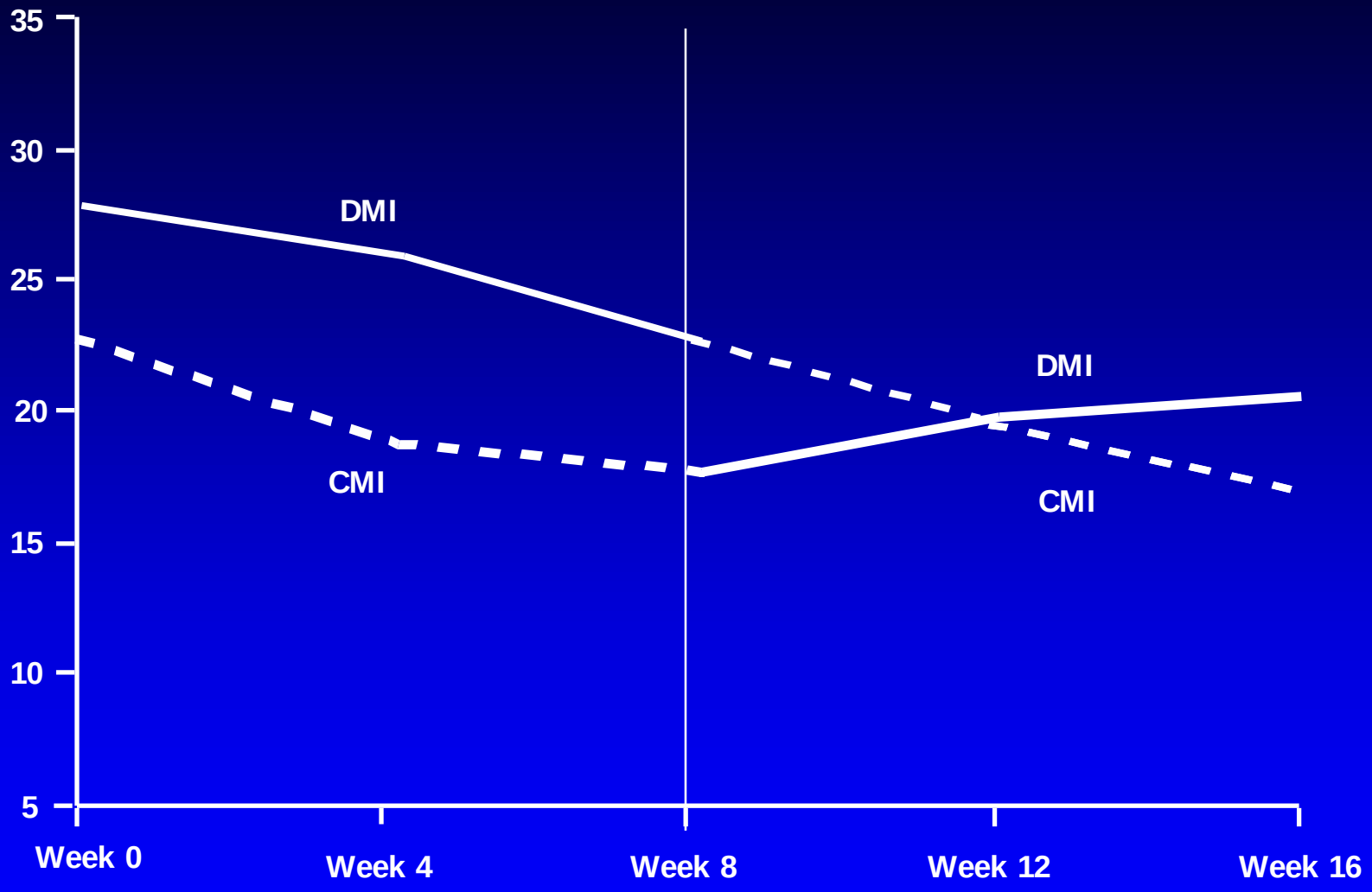
N=450

Efficacy of SRIs for BDD

- **Case series:** SRIs appear more effective than other psychotropics (n=5, Hollander et al 1989; n=30, Phillips et al 1993; n=130, Phillips 1996)
- **Open-label trials**
  - » Fluvoxamine: Response in 83% and 63% (n=15, Perugi et al 1996; n=30, Phillips et al 1998)
  - » Citalopram: Response in 73% (n=15, Phillips & Najjar 2003)
  - » Escitalopram: Response in 73% (n=15, Phillips 2006)
- **Controlled cross-over trial:** Clomipramine is more effective than desipramine (n=29, Hollander et al 1999)
- **Placebo-controlled trial:** Fluoxetine is more effective than placebo (n=67, Phillips et al 2002)

No medication is FDA-approved for the treatment of BDD

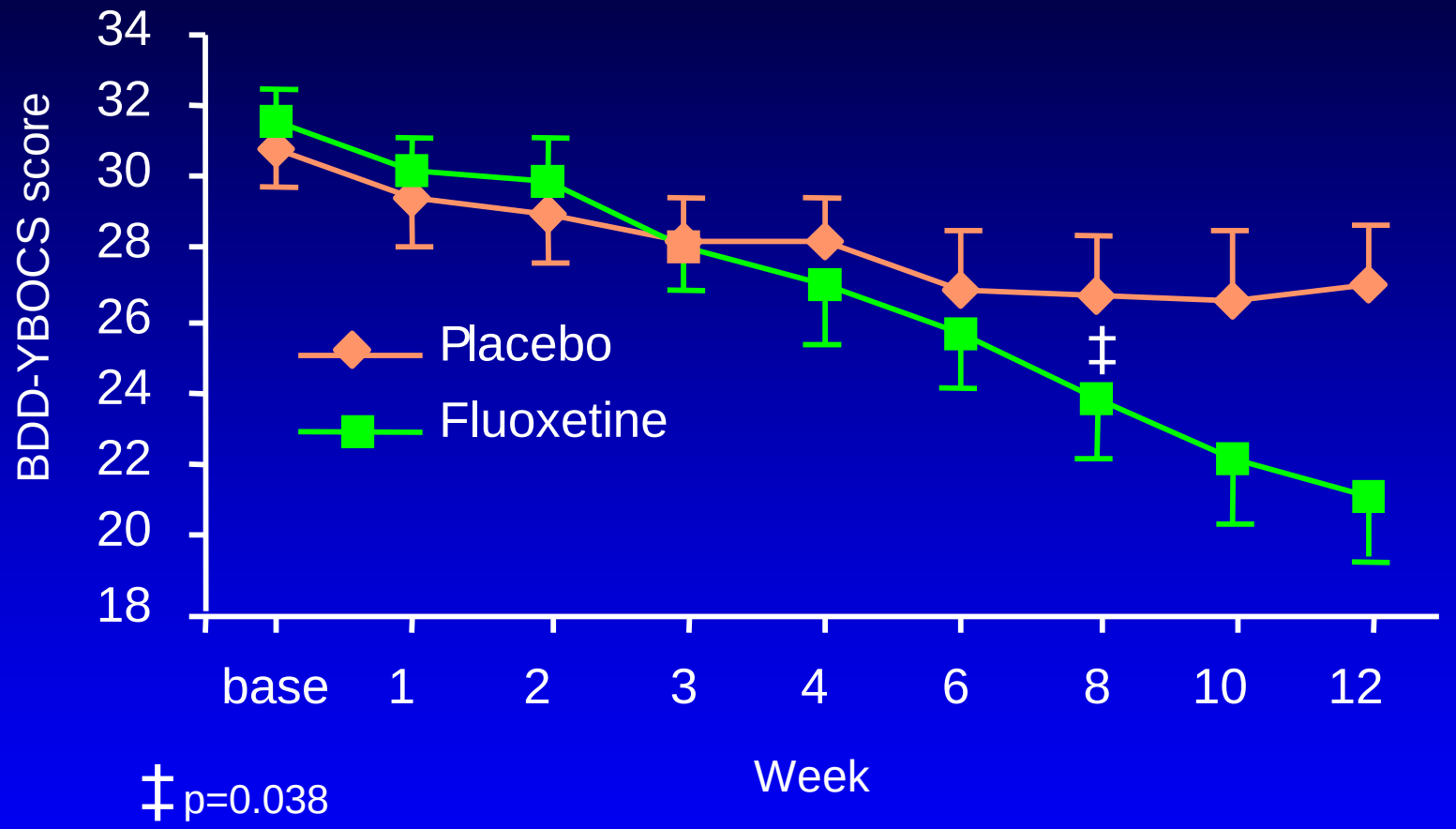
Clomipramine vs Desipramine



N=23; F=11.02; df=1,21; p=.003

Hollander et al, Arch Gen Psychiatry, 1999

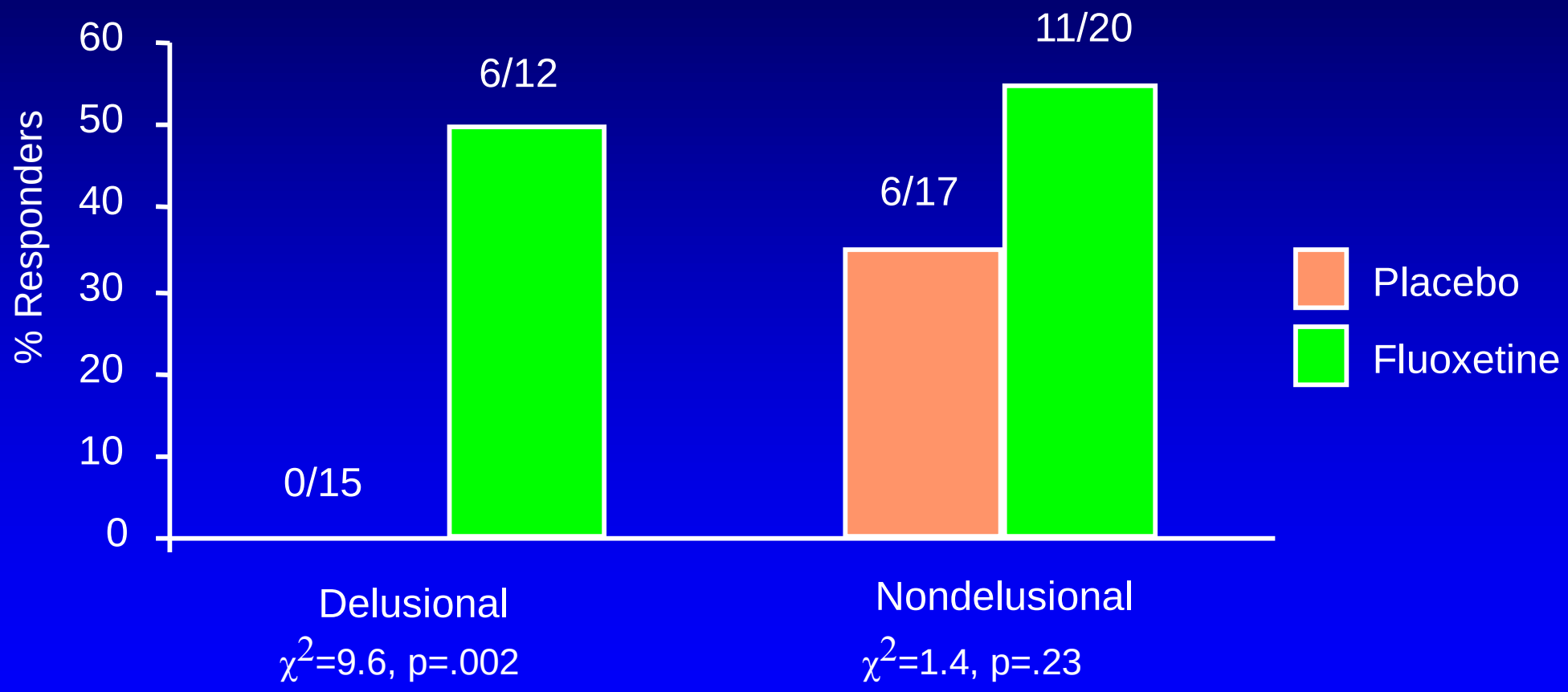
Fluoxetine vs Placebo (n=67)



Response to placebo = 6/33 (18%) vs fluoxetine = 18/34 (53%); $\chi^2 = 8.8$, p = .003
F (1,64) = 16.5, p<.001

Phillips et al, Arch Gen Psychiatry, 2002

Response of Delusional vs Nondelusional Subjects (n=67)



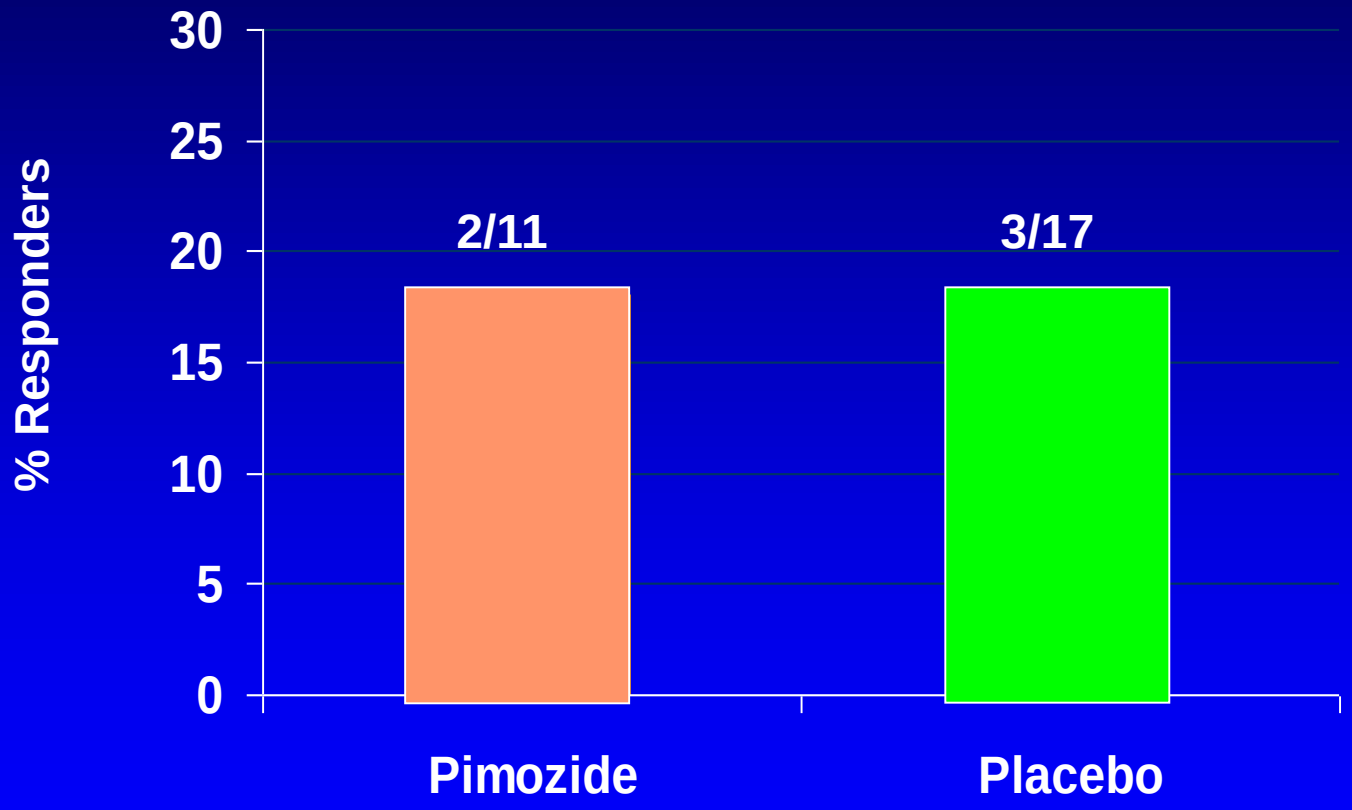
Phillips et al, Arch Gen Psychiatry, 2002

SRI Dosing and Trial Duration

- Use an SRI -- for delusional patients, too
- No trials have compared SRI doses. Relatively high doses appear often needed. Some patients benefit from doses exceeding the maximum recommended (not CMI).
- Average time to response is 4-9 weeks; some patients need 12-16 weeks
- If no response or partial response after 12-16 weeks → augment or switch SRIs

Phillips et al, 2006

Pimozide vs Placebo Augmentation of Fluoxetine (n=28)



Chi-square=.001, df=1, p=.97

Phillips, Am J Psychiatry, 2005

Other Medication Considerations

- SRI augmentation options: buspirone, clomipramine, venlafaxine, bupropion, atypical neuroleptics, antiepileptics, lithium, stimulants
- Switching to another SRI
- Other agents as monotherapy (e.g., venlafaxine, levetiracetam)?
- Much more pharmacotherapy research is needed – e.g., augmentation, relapse prevention, pediatric studies

Allen et al, 2003; Phillips, 2002; Phillips and Hollander, in press

Efficacy of CBT for BDD

- **Case series (n=5-17)**
  - » BDD improved with eight to sixty 90-minute individual sessions or in twelve 90-minute group sessions (Neziroglu & Yaryura-Tobias, 1993; McKay et al, 1997; Wilhelm et al, 1999)
- **No-treatment waiting list control (n=54)**
  - » Group CBT provided in eight weekly 2-hour sessions was more effective than no treatment (Rosen et al, 1995)
- **No-treatment waiting list control (n=19)**
  - » Individual CBT provided in twelve weekly 1-hour sessions was more effective than no treatment (Veale et al, 1996)

Core CBT Strategies for BDD

- **Cognitive Restructuring:**
  - » Identify: 1) Unrealistic negative thoughts
    2) Cognitive errors (e.g., mind reading)
    3) Unrealistic underlying core beliefs and attitudes
  - » Develop more accurate and helpful beliefs

- **Behavioral Experiments**
  - » Design and do experiments to empirically test dysfunctional thoughts and beliefs

Core CBT Strategies for BDD

- **Graded Exposure**
  - » Construct an exposure hierarchy
  - » Gradually face feared and avoided situations (often social) without ritualizing or camouflaging
  - » Combine with behavioral experiments and cognitive restructuring
- **Ritual Prevention**
  - » Stop or cut down on excessive mirror checking, grooming, and other compulsive behaviors

Additional CBT Strategies

- Perceptual retraining
- Mindfulness skills
- Habit reversal (for skin picking and hair pulling)
- Activity scheduling; scheduling pleasant activities
- Motivational interviewing
- Structured daily homework is essential

Other Types of Psychotherapy

- Not well studied; not currently recommended as the only treatment for BDD
- May be helpful in addition to an SRI or CBT for some patients – e.g., those with:
  - » Life stressors
  - » Relationship problems
  - » Problematic personality traits
  - » Poor treatment compliance

Usually, to diagnose BDD you have to ask specifically about BDD symptoms

Diagnosing BDD

- **Appearance concerns**: Are you very worried about your appearance in any way? (*OR:* Are you unhappy with how you look?) *If yes*, Can you tell me about your concern?

- **Preoccupation**: Does this concern preoccupy you? Do you think about it a lot and wish you could think about it less? (*OR:* How much time would you estimate you think about your appearance each day?)

- **Distress or impairment**: How much distress does this concern cause you? Does it cause you any problems -- socially, in relationships, or with school or work?

Clues to the Presence of BDD

- Behaviors such as mirror checking, reassurance seeking, skin picking, grooming, or camouflaging (e.g., with a hat)
- Ideas or delusions of reference
- Avoidance of activities; being housebound
- Comorbid social phobia, depression, OCD, substance abuse/dependence
- Excessive seeking and/or nonresponse to cosmetic treatment--e.g., dermatologic or surgical

Questions

- What class of medications appears efficacious for BDD?

  A. MAOIs

  B. Tricyclics (excluding clomipramine)

  C. SRIs

  D. Neuroleptics

Questions

- What class of medications appears efficacious for delusional BDD?

  A. Typical antipsychotics

  B. Atypical antipsychotics

  C. SRIs

  D. Benzodiazepines

Questions

- What type of psychotherapy appears efficacious for BDD?

  A. Supportive therapy

  B. Exposure/behavioral experiments, response prevention, and cognitive restructuring

  C. Psychodynamic psychotherapy

  D. Relaxation techniques

Questions

- Cosmetic treatment (e.g., surgery, dermatologic treatment) for BDD appears to be:

  A. Always effective

  B. Usually effective

  C. Rarely effective

Questions

- The following behaviors are common in patients with BDD:

  A. Excessive mirror checking

  B. Compulsive grooming

  C. Skin picking

  D. All of the above

  E. None of the above

Answers to Questions

1: C. SRIs

2: C. SRIs

3: B. Exposure/behavioral experiments, response prevention, and cognitive restructuring

4: C. Rarely effective

5: D. All of the above