Body Dysmorphic Disorder

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Teaching Points

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

Outline

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

Pre-Lecture Exam
Question 1

- What class of medications appears efficacious for BDD?

  A. MAOIs

  B. Tricyclics (excluding clomipramine)

  C. SRIs

  D. Neuroleptics

Question 2

- What class of medications appears efficacious for delusional BDD?

  A. Typical antipsychotics

  B. Atypical antipsychotics

  C. SRIs

  D. Benzodiazepines

Question 3

- 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

Question 4

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

  A. Always effective

  B. Usually effective

  C. Rarely effective

Question 5

- The following behaviors may occur in patients with BDD:

  A. Excessive mirror checking

  B. Questioning of others and reassurance seeking

  C. Skin picking

  D. All of the above

  E. None of the above

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

Demographic Features

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

Male	39%
Female	61%

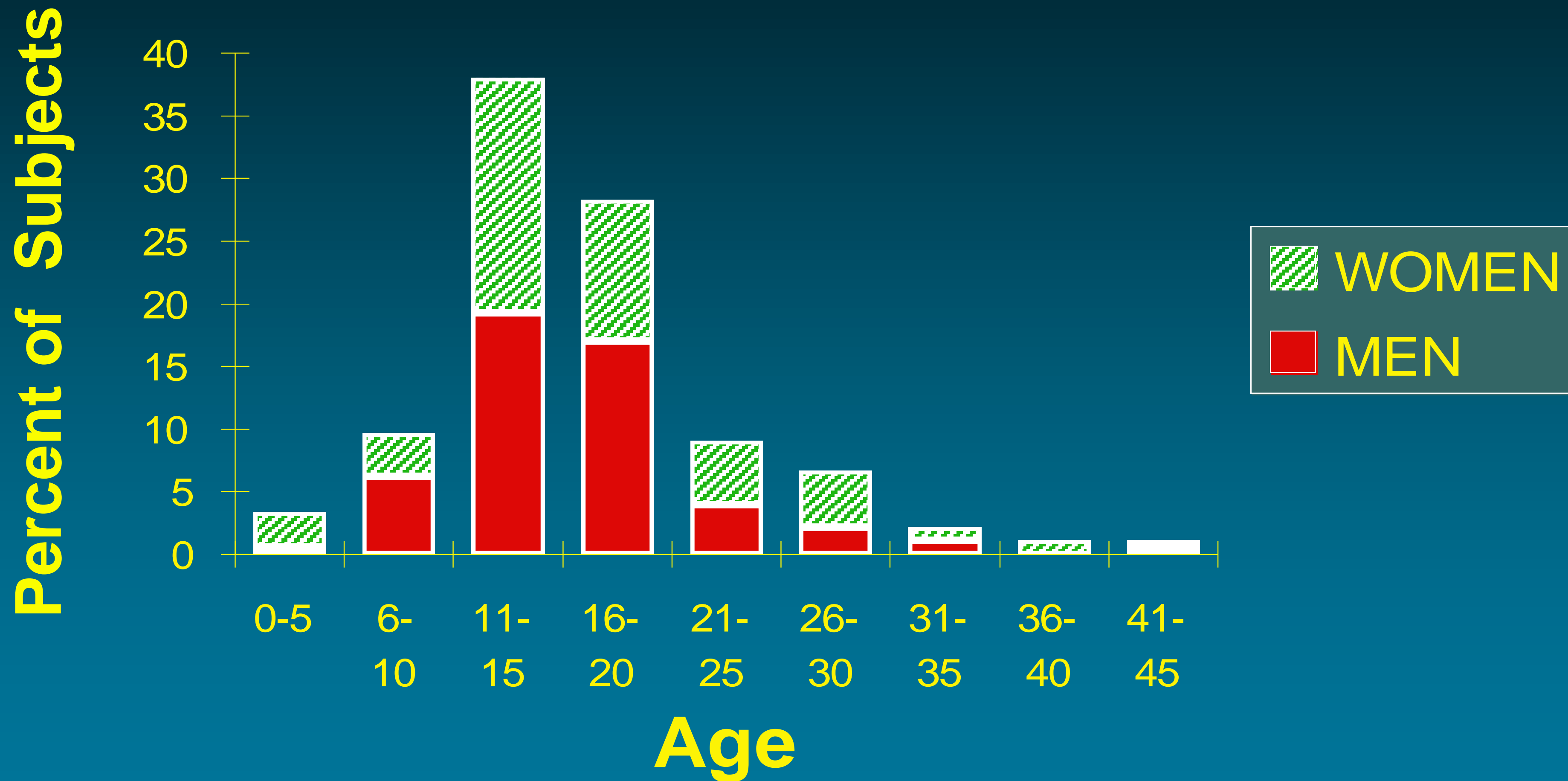
- Marital status:

Single	67%
Married	20%
Divorced	12%

Phillips KA, 1993, 1997, 2005

N=434

BDD Age of Onset



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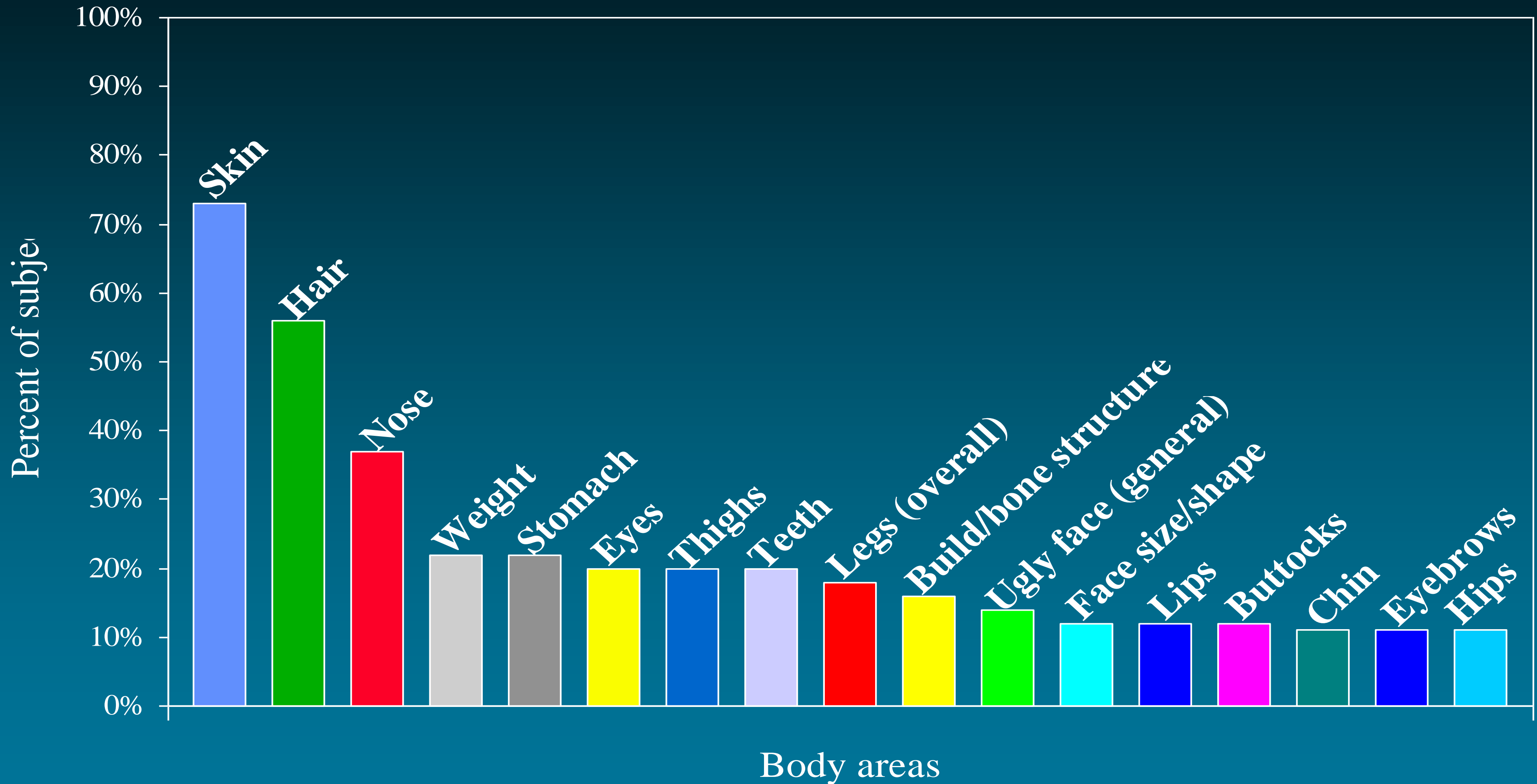
Cognitions

- 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 usually absent or poor (nearly half are delusional)
- Ideas or delusions of reference common (68%)

Body Areas of Concern



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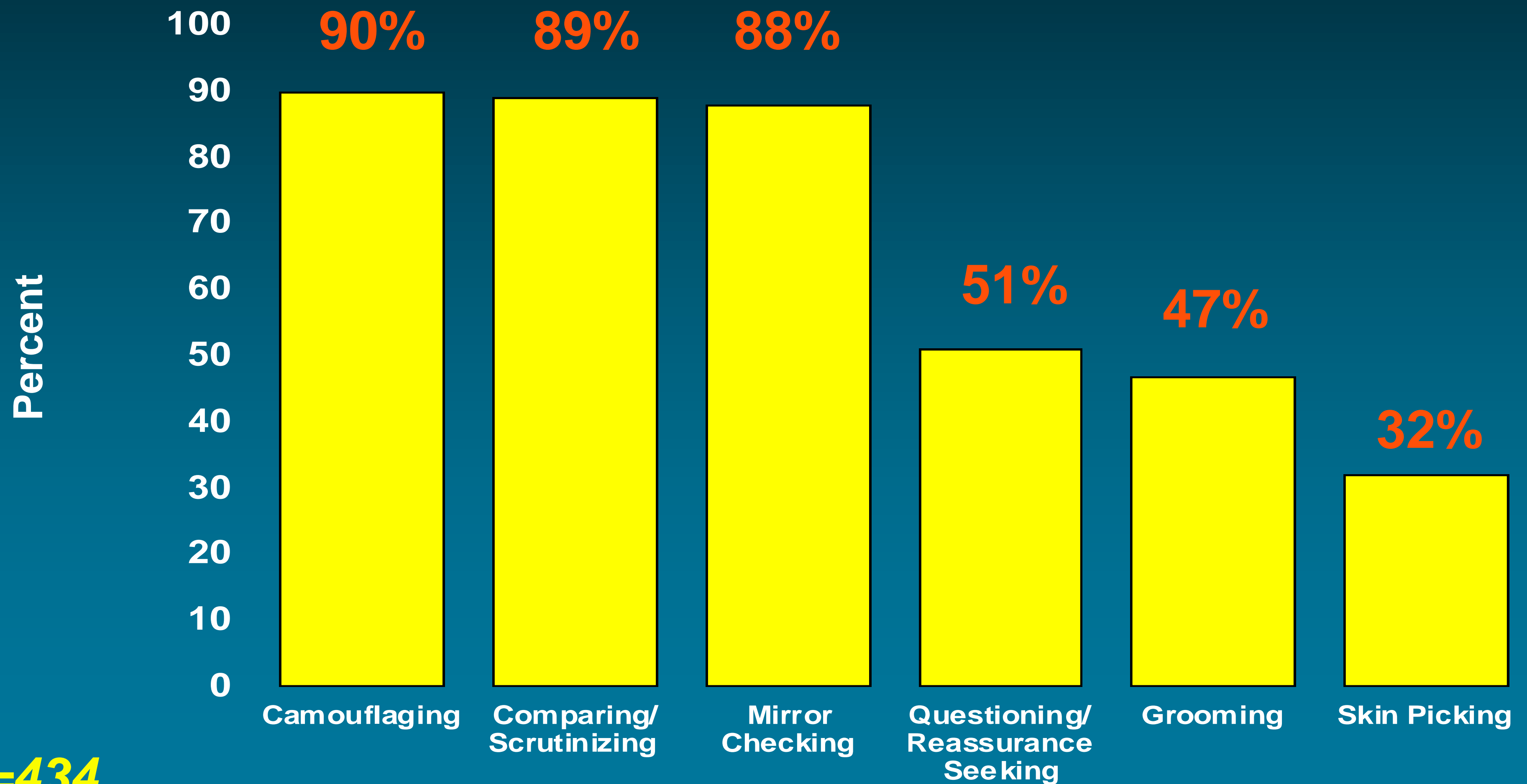
Common Behaviors



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Complications (lifetime)

- Social impairment 99%
- Occupational/academic impairment 90%
- Hospitalization 46%
- Housebound 29%
- Suicidal ideation 80%
- Suicide attempts 25%

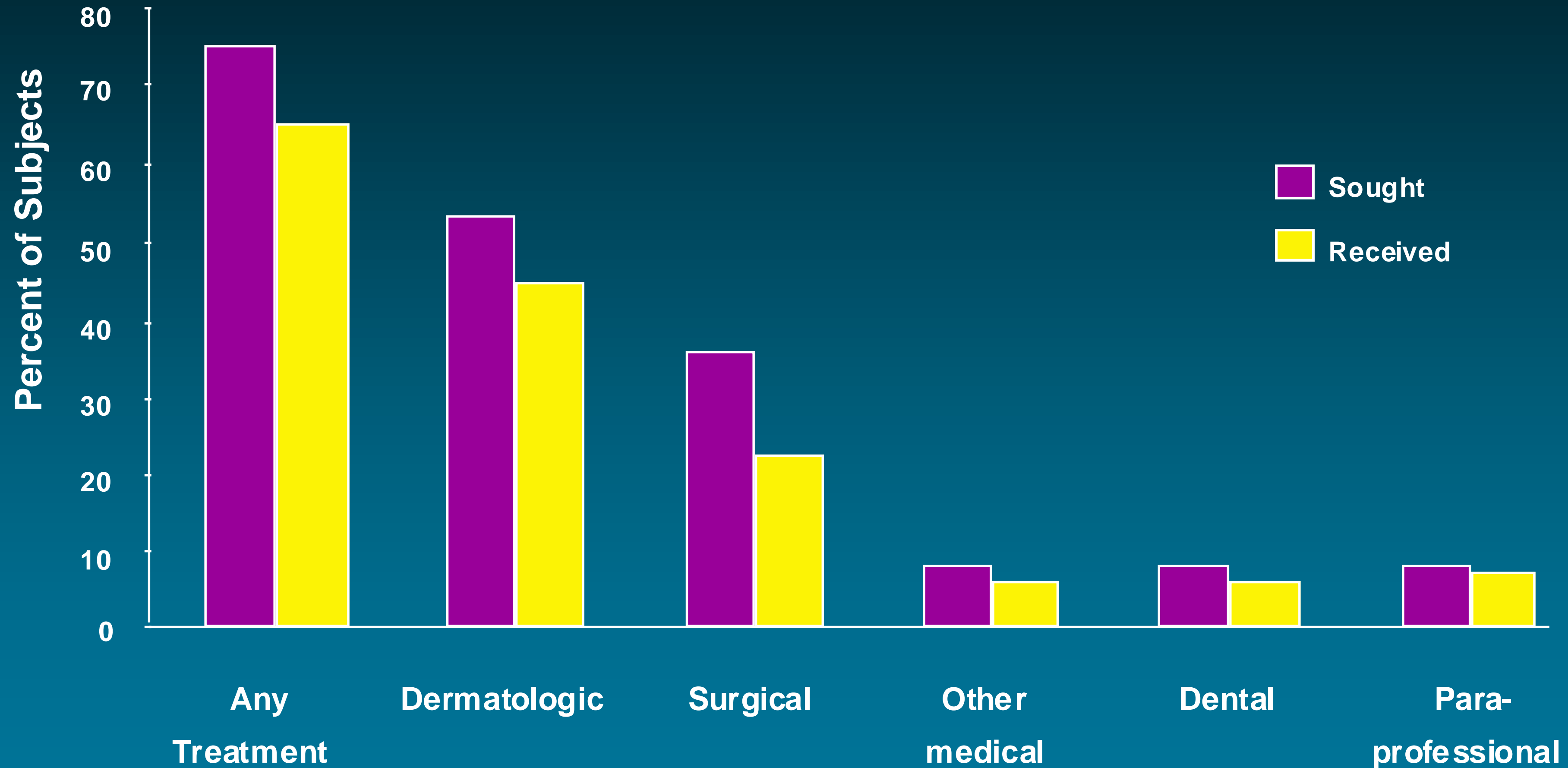
Phillips KA, 1993, 1997, 2005

N=434

SF-36: Mental Health-Related Quality of Life

Phillips KA, 2000 and 2005

Surgery and Medical Treatment



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

N=450

Outcome of Nonpsychiatric Treatment

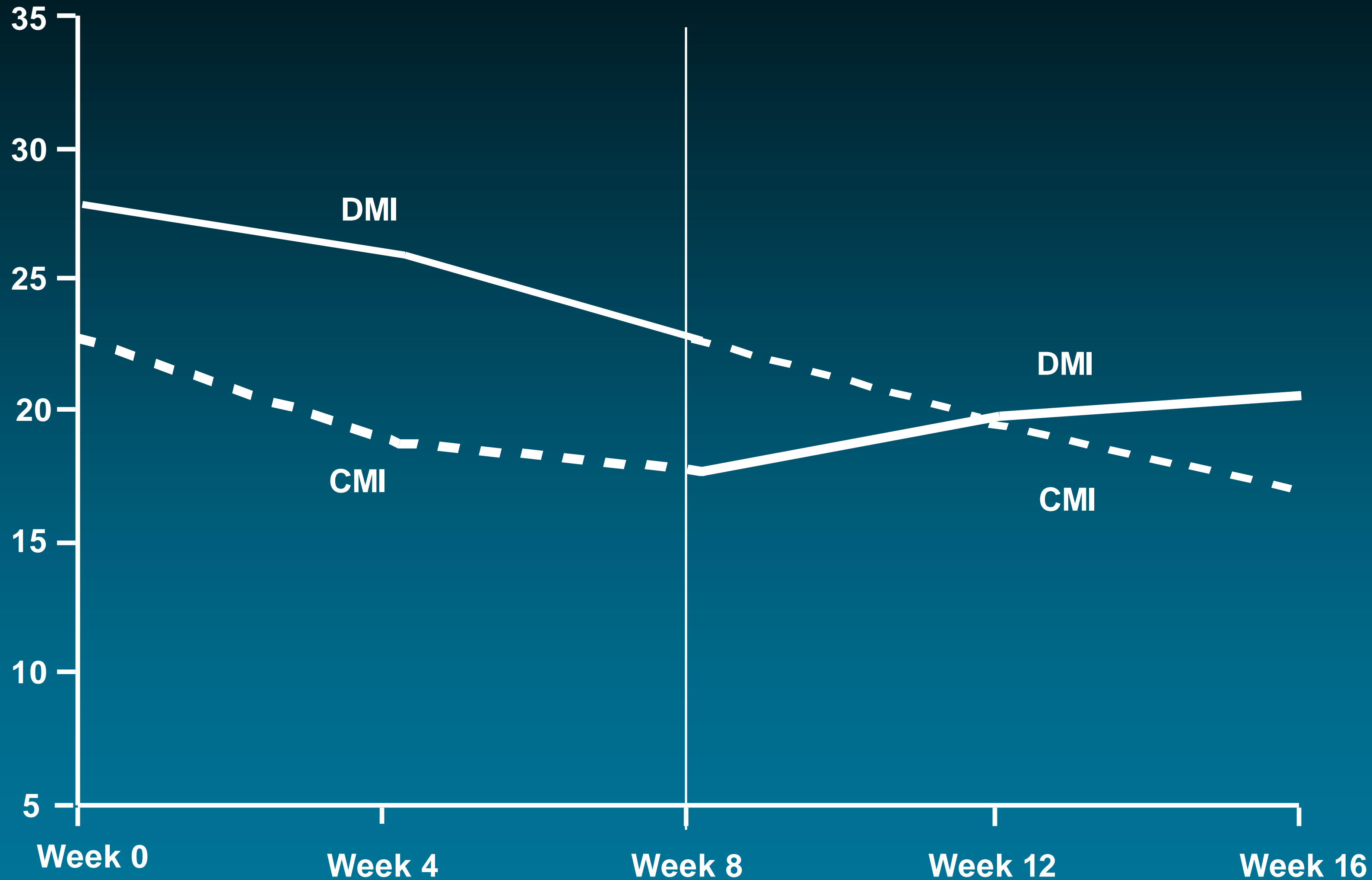
Total number of treatments = 1,313

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

Efficacy of SRIs for BDD

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

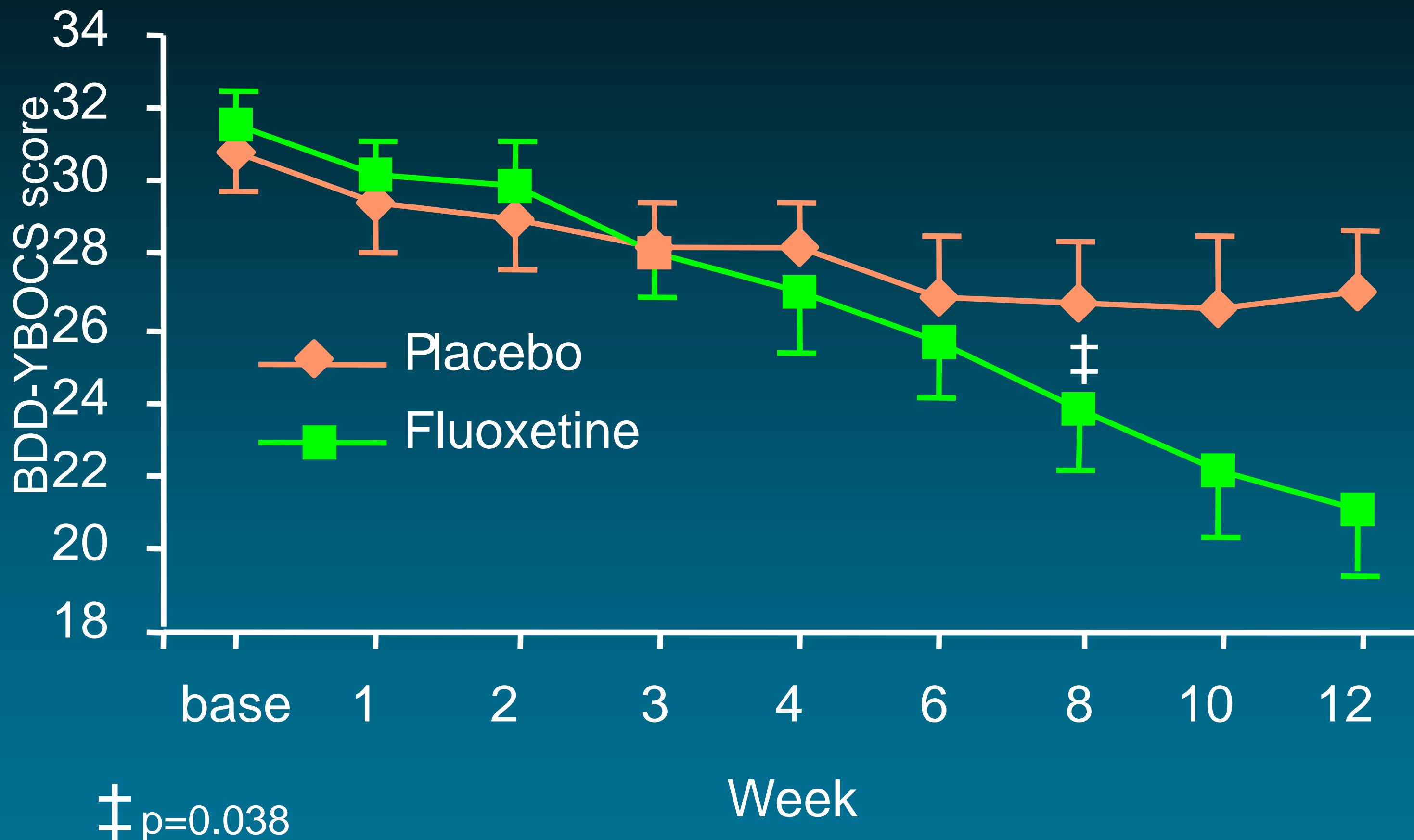
Clomipramine vs Desipramine



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

Hollander et al, Arch Gen Psychiatry, 1999

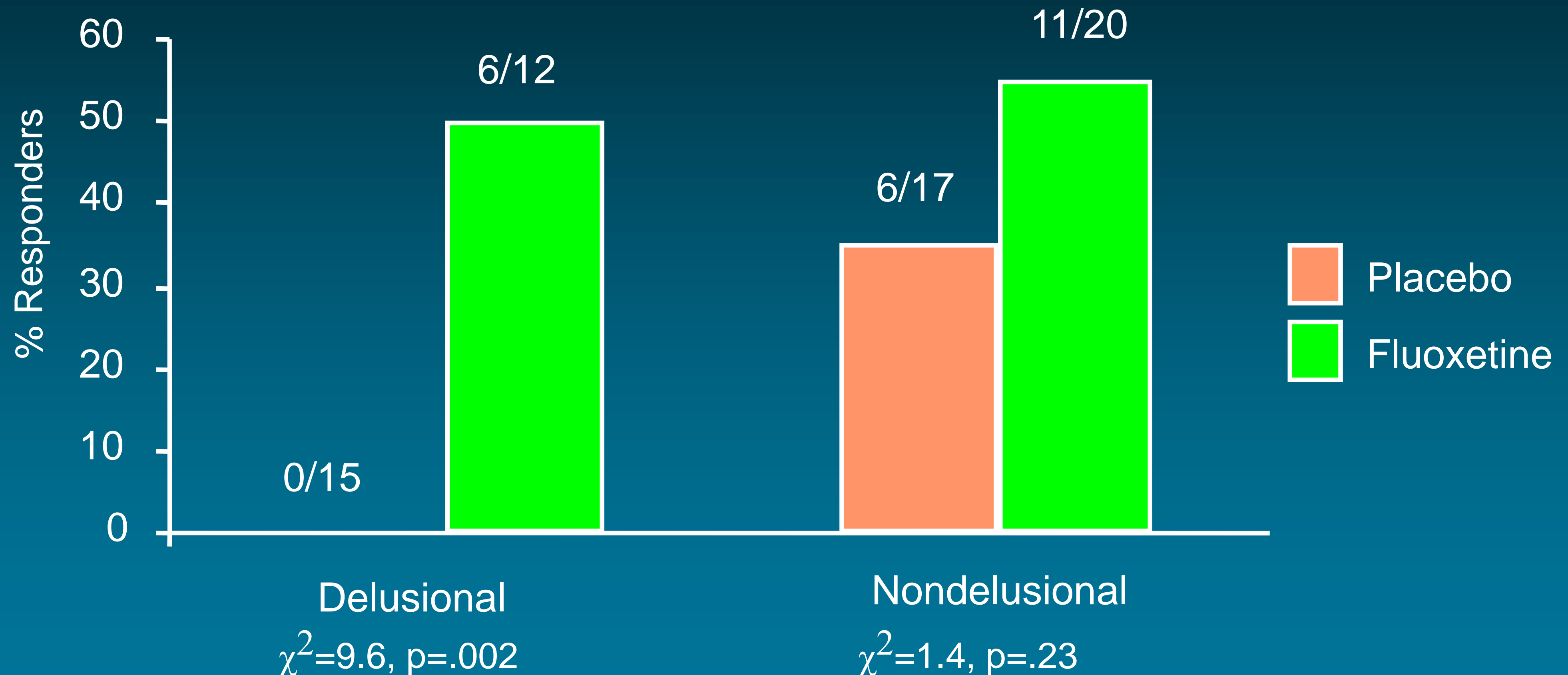
Fluoxetine vs Placebo (n=67)



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

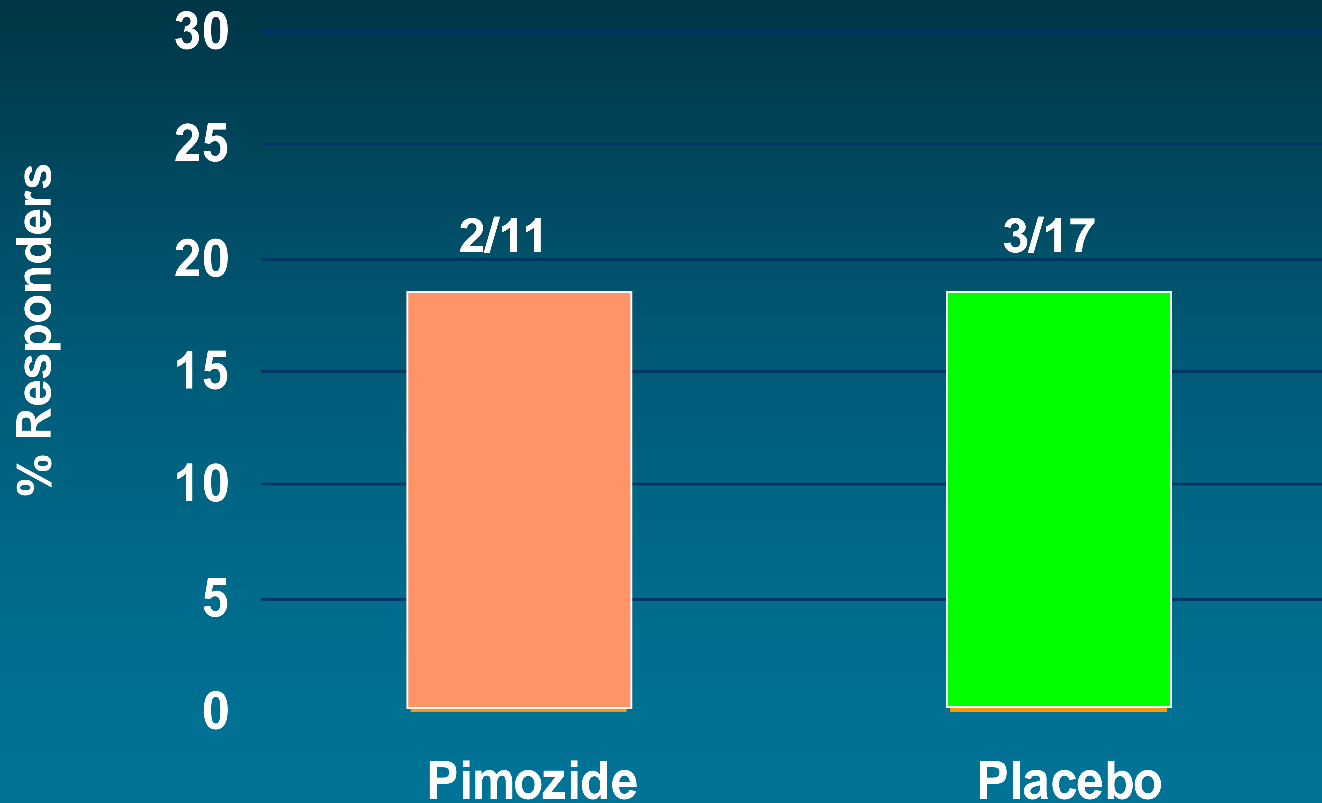
Phillips KA, et al. Arch Gen Psychiatry, 2002

Response of Delusional vs Nondelusional Subjects (n=67)



Phillips KA, et al. Arch Gen Psychiatry, 2002

Pimozide vs Placebo Augmentation of Fluoxetine (n=28)



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

Phillips KA. Am J Psychiatry, 2005

Pharmacotherapy: Suggested Approach

- Use an SRI, even for delusional patients
- Reach the maximum dose recommended by the manufacturer or the highest tolerated dose; in some cases, exceed the maximum recommended dose
- Treat for 12-16 weeks before making a final assessment of efficacy; if no response, switch to another SRI or augment

Suggested Approach (continued)

- If one SRI doesn't work, try another….and another
- Consider SRI augmentation with buspirone, clomipramine,venlafaxine, bupropion, or an atypical antipsychotic
- Continue effective medication for at least 1-2 years
- Discontinue carefully, as relapse appears likely (87%)

Efficacy of CBT for BDD

- Case series (n=5): 4 patients improved with 12 to 48 individual 90-minute sessions (Neziroglu, 1993)
- Case series (n=10): BDD improved with 30 individual 90-minute sessions (McKay, 1997)
- Case series (n=13): BDD improved in 12 90-minute group sessions (Wilhelm, 1999)
- No-treatment waiting list control (n=27): 77% of 27 women improved in 8 2-hour group sessions (Rosen, 1995)
- No-treatment waiting list control (n=19): Improvement was greater in CBT group over 12 weeks (Veale, 1996)

Cognitive Approaches

- **Cognitive Restructuring**
  - Identify: 1) Unrealistic negative automatic thoughts
    2) Unrealistic underlying core beliefs and attitudes
    3) Cognitive errors
  - Challenge irrational thinking/beliefs and generate more accurate and helpful alternatives
- **Behavioral Experiments:** Empirically test hypotheses (dysfunctional thoughts and beliefs)

Exposure and Response Prevention

- **Graded Exposure:** Face feared and avoided situations (often social) without ritualizing and with the defect visible if possible; construct an exposure hierarchy; combine with hypothesis testing and cognitive restructuring
- **Response (Ritual) Prevention:** Resist and cut down on excessive mirror checking, grooming, and other repetitive behaviors

Other Potentially Helpful CBT Approaches

- Mirror retraining
- Mindfulness
- Habit reversal (for skin picking and hair pulling)
- Activity scheduling; scheduling pleasant activities

SRI or CBT (or Both)?

- No comparison or combination studies
- Use either (or both) for mild-moderate BDD
- Always use an SRI for:
  - More severe BDD
  - Very depressed patients
  - Suicidal patients

Psychodynamic and Supportive Psychotherapy

- Not well studied, but not recommended as the only treatment for BDD; research is needed
- May be a helpful addition to an SRI or CBT for some patients:
  - Life stressors
  - Relationship problems
  - Problematic personality traits
  - Poor treatment compliance

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

Most patients don’t spontaneously reveal their BDD symptoms, even when they’re the patient’s major problem

Diagnosing BDD

- **Appearance concerns:** Are you very worried about your appearance in any way? (*OR:* Are you unhappy with how you look?) *If yes*, What is your concern?
- **Preoccupation:** Does this concern preoccupy you? That is, 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/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
- Social phobia, depression, OCD
- Excessively seeking and/or nonresponse to nonpsychiatric treatment--e.g., dermatologic or surgical

Summary

- BDD is relatively common but often goes unrecognized
- BDD causes significant distress and impaired functioning, and individuals with BDD have unusually poor quality of life
- To detect BDD, you usually need to ask specifically about BDD symptoms
- SRIs and CBT are often effective; additional treatment research is needed!

Post-Lecture Exam
Question 1

- What class of medications appears efficacious for BDD?

    C. SRIs

Question 2

- What class of medications appears efficacious for delusional BDD?

  C. SRIs

Question 3

- What type of psychotherapy appears efficacious for BDD?

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

Question 4

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

  C. Rarely effective

Question 5

- The following behaviors may occur in patients with BDD:

    D. All of the above

Answers to Pre & Post Lecture Exams

1. C
2. C
3. B
4. C
5. D