

Body Dysmorphic Disorder

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The Free Press

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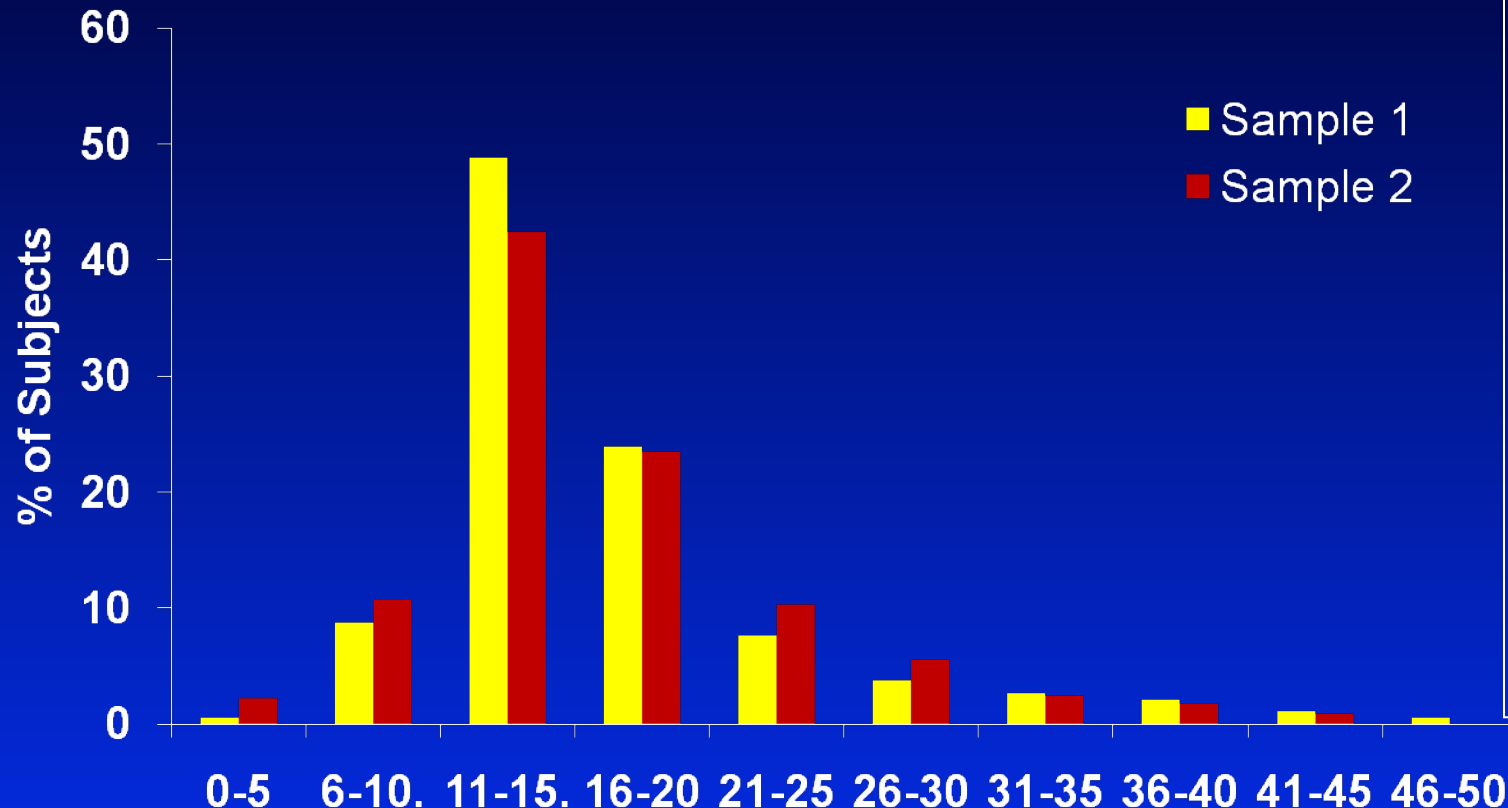
BDD DSM-5 Criteria

- A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others
- B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns – **NEW CRITERION**
- C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder

Prevalence of BDD

- **Nationwide epidemiologic studies** 1.7-2.4%
(N = 2,048 – 2,552)
- **Inpatient psychiatry (U.S.)**
 - » Adult 13-16%
 - » Adolescent 7%
- **Students (non-clinical)**
 - » Adult 2-13%
 - » Adolescent 2%
- **Dermatology** 6-15%
- **Cosmetic surgery** 3-53%

BDD Age at Onset in Two Adult Samples



Mean age at onset:
Sample 1: 16.7 ± 7.3
Sample 2: 16.7 ± 7.2

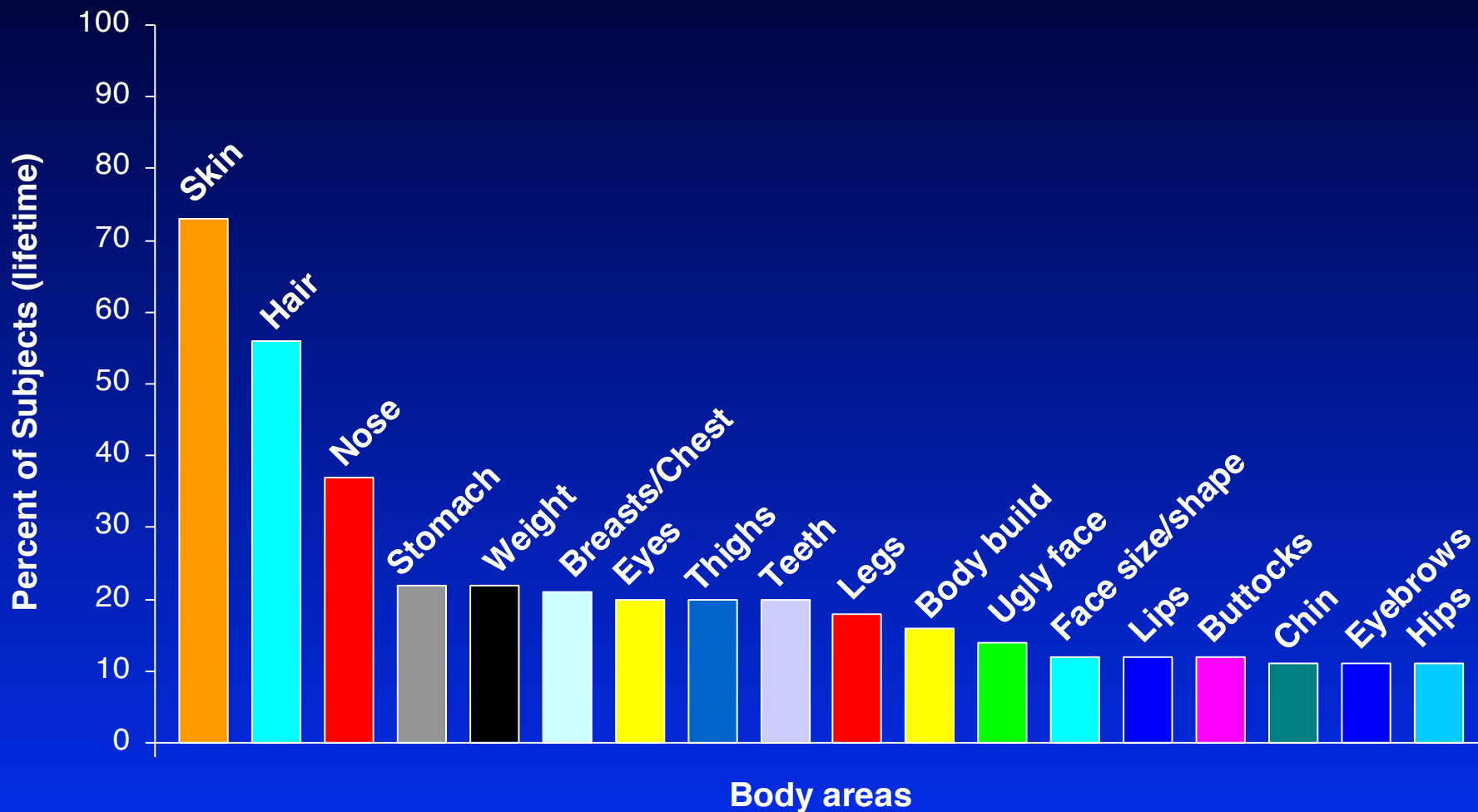
Modal age at onset:
Sample 1: 12.0
Sample 2: 13.0

Onset < age 18:
Sample 1: 66.3%
Sample 2: 67.2%

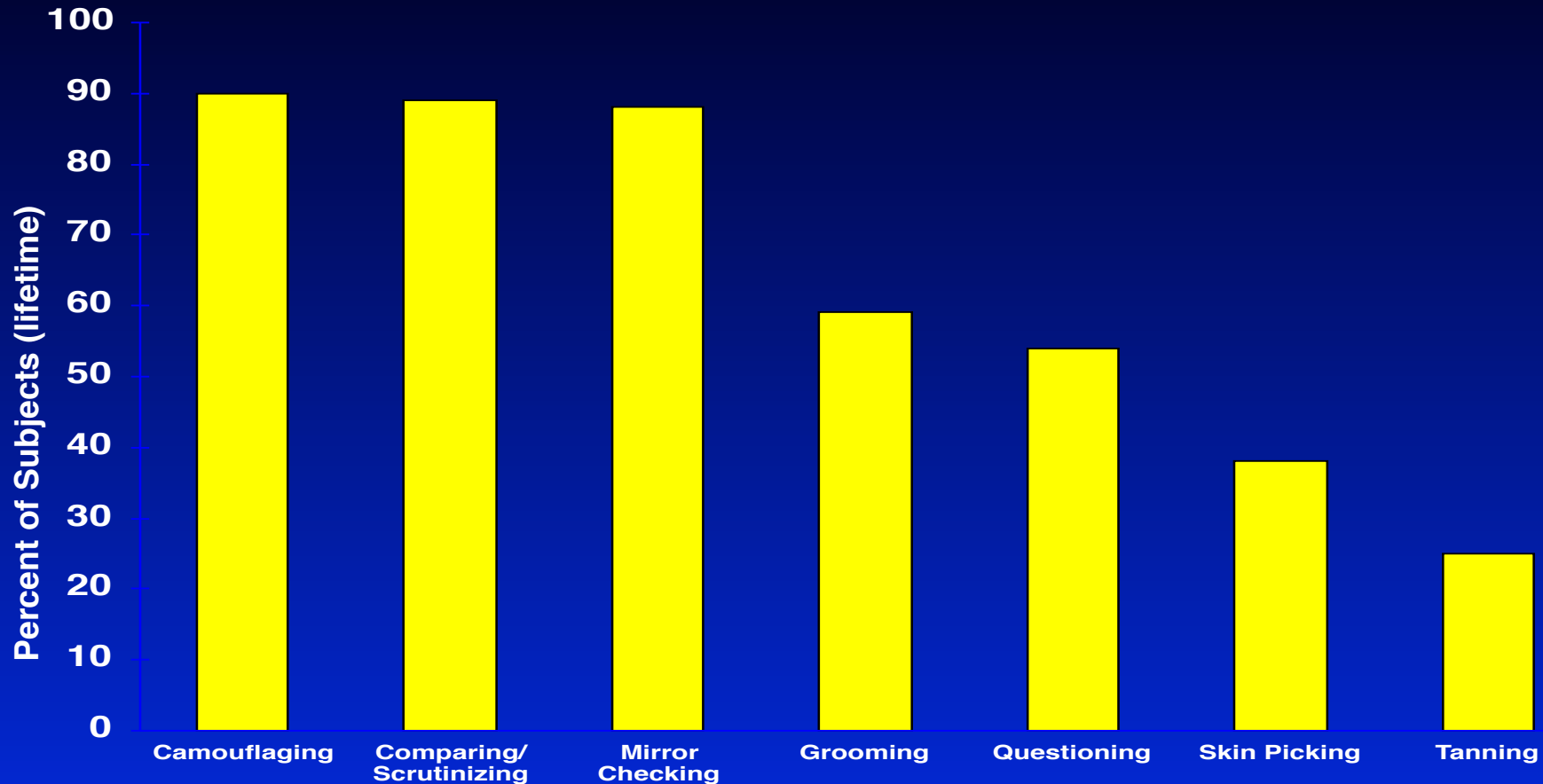
BDD Cognitions

- Obsessional, distressing preoccupations about perceived defects in appearance (involving any body area)
- Difficult to resist or control
- Time consuming (average 3-8 hours a day)
- Insight is usually absent or poor (~35% currently have delusional BDD beliefs – for example, “I look deformed”)
- BDD-related ideas or delusions of reference are common

Body Areas of Concern



Compulsive Repetitive Behaviors



Repetitive behaviors are not limited to these!

Functional Impairment and Suicidality

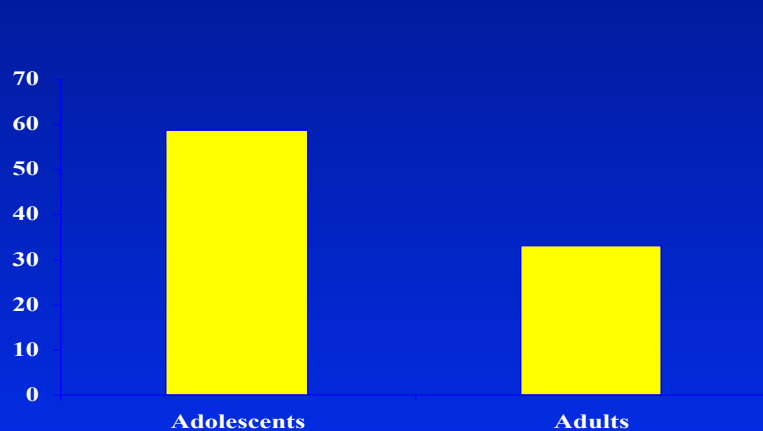
- High rates of functional impairment (social, academic, occupational) and very poor quality of life
- High rates of psychiatric hospitalization: 38%
- High rates of suicidality (lifetime):
 - » Suicidal ideation: 80%
 - » Suicide attempts: 24-28%
 - » Completed suicide: markedly elevated -- more common than in major depressive disorder and bipolar disorder?

N=141, N=507

Youth vs Adults with BDD

- Youth and adults are similar across a broad range of BDD features
- Youth have a higher rate of lifetime suicide attempts: 44% vs 24% ($p=.01$)
- Youth have more delusional BDD beliefs

% with delusional BDD beliefs



59% vs 33%, $p=.006$

Mean BABS score



$p<.001$

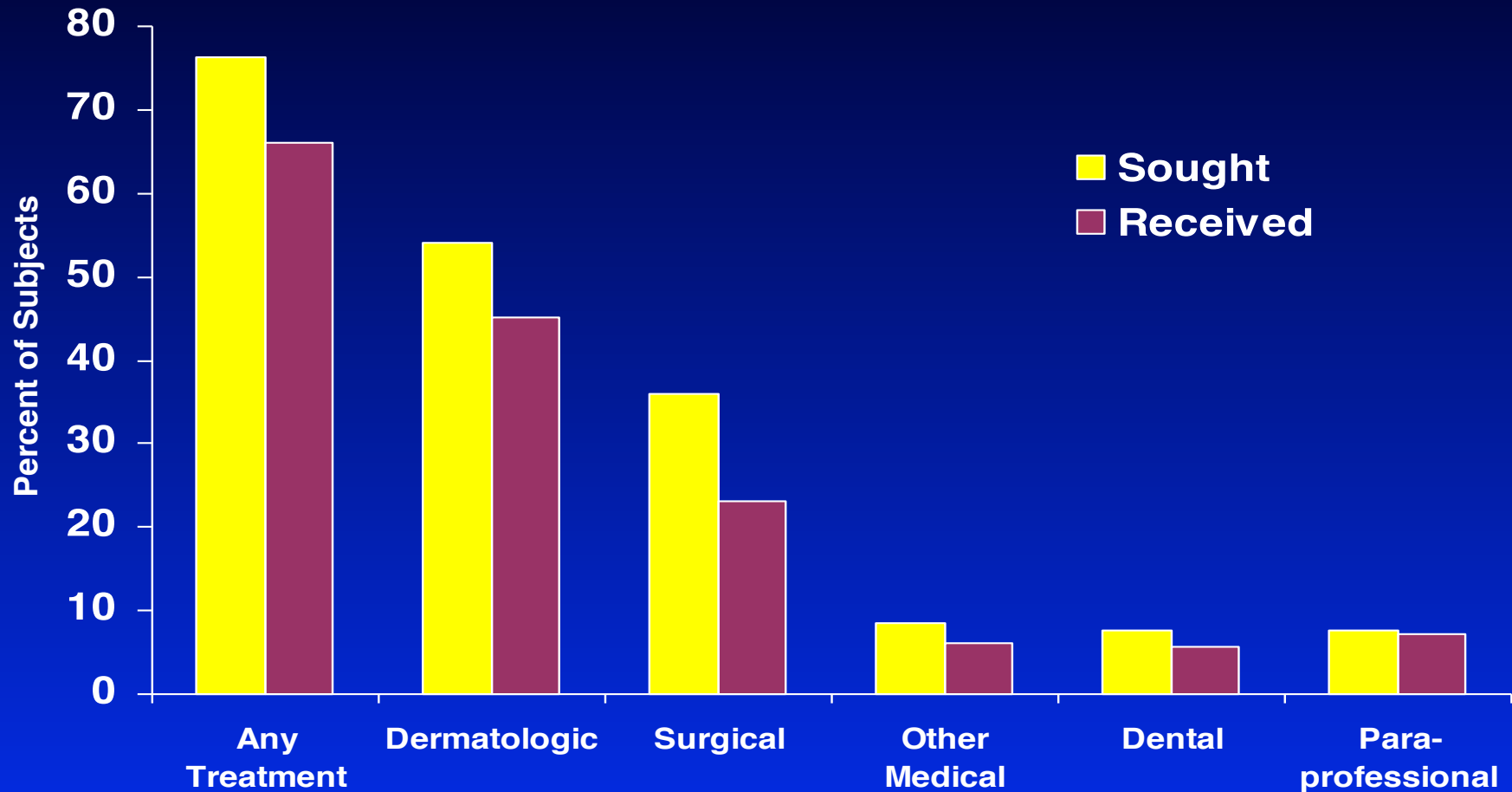
$N=36$ youth, 164 adults

Phillips et al, 2006

Body Image Disturbance in BDD

- A core feature of BDD: decreased satisfaction, distorted body image, over-attention to details of physical appearance, difficulty seeing the “big picture” (holistic visual processing)
- Subclinical BDD concerns/appearance dissatisfaction often precede the onset of BDD, by an average of 2-4 years. Do they increase the risk of developing BDD?
- Might early intervention for subclinical appearance concerns decrease the risk of developing BDD??

Cosmetic Treatment for BDD



Serotonin-Reuptake Inhibitors (SRIs) for BDD

- **Case series:** SRIs appear more effective than other medications (n=5-130)
- **Open-label trials (ITT analyses):**
 - » **Fluvoxamine (Luvox):** Response in 83% and 63% (n=15 and 30)
 - » **Citalopram (Celexa):** Response in 73% (n=15)
 - » **Escitalopram (Lexapro):** Response in 73% (n=15)
- **Controlled cross-over trial:** SRI **clomipramine (Anafranil)** is more efficacious than the non-SRI antidepressant **desipramine** (n=29)
- **Placebo-controlled trial:** **Fluoxetine (Prozac)** is more efficacious than placebo (n=67)

No medication is FDA-approved for the treatment of BDD

SRI for BDD

- SRIs are the first-line medication treatment – for delusional BDD, too
- To determine if a particular SRI is efficacious, a total trial duration of 12-14 weeks, while reaching a high dose if needed and tolerated, is recommended
- No studies have compared SRI doses. However, high SRI doses appear to often be needed for BDD

Cognitive-Behavioral Therapy for BDD

- The best-studied psychosocial treatment for BDD
- Must be modified to specifically target BDD's unique symptoms
- Use of a BDD-specific treatment manual is recommended (Wilhelm, Phillips, & Steketee or Veale and Neziroglu)
- 3 studies of CBT vs a no-treatment waiting list control condition (N=54, N=36, N=19): CBT more efficacious than no treatment
- CBT vs anxiety management (n=46): CBT more efficacious
- We are currently doing a study of CBT vs supportive therapy for BDD and appreciate referrals!

CBT Strategies for BDD

- Psychoeducation and case formulation
- Cognitive restructuring
- Exposure with behavioral experiments
- Ritual prevention
- Perceptual retraining/mindfulness
- Advanced cognitive strategies
- Motivational interviewing
- Relapse prevention
- Optional treatment modules for: cosmetic treatment seeking, muscle dysmorphia, skin picking/hair plucking, and depression



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?)

Repetitive behaviors: Is there anything you feel an urge to do over and over again in response to your appearance concerns? (Give examples)

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?

Summary

- BDD is a common yet underrecognized body image disorder
- Suicidality rates appear very high, and psychosocial functioning and quality of life are typically very poor
- It's important to ask about BDD symptoms, make the diagnosis, and treat it if present
- SRIs and CBT tailored to BDD are the currently recommended treatments and appear to often be efficacious

Thank you!

