Body Dysmorphic Disorder

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11/07/2020

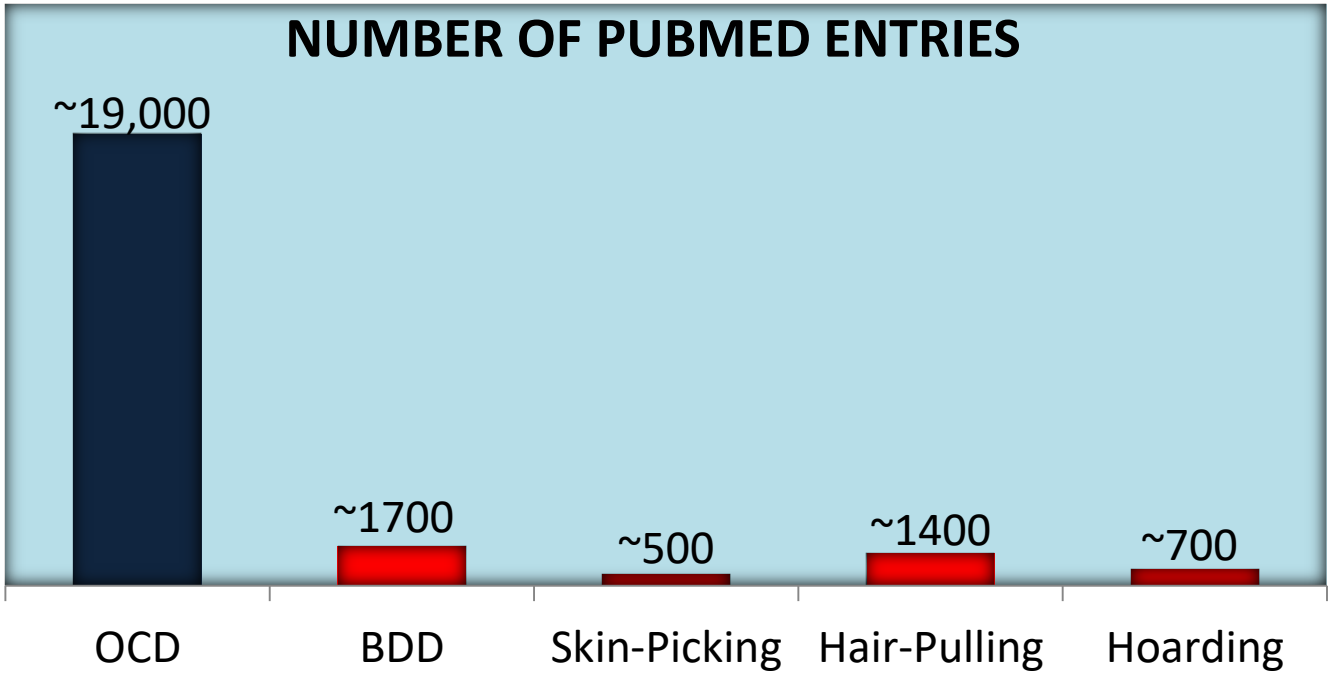
Disclosures

Research Support: Promentis Pharmaceuticals, Inc.

Obsessive-Compulsive Related Disorders (OCRDs)

- Body Dysmorphic Disorder
- Excoriation (Skin-Picking) Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Hoarding Disorder

Off-label



Obsessive-Compulsive Related Disorders (OCRDs)

- Body Dysmorphic Disorder
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Clinical features

- Distressing preoccupation with **imagined or slight defect in appearance**
- Usually involves skin, hair, nose, but can involve any body part
- Variable insight, may be **delusional**
- Pts often present to a dermatologist or cosmetic surgeon

- **Common:** 2.4 % prevalence in general population, 12 % in outpatient dermatology clinic, and 33% in pts seeking rhinoplasty

Phillips. *Understanding body dysmorphic disorder : an essential guide*. 2009; Bjornsson. *Dialogues Clin Neurosci. 2010*; Pope. *Body Image*. 2005; Phillips. *J Psychiatr Res.* 2006; Mancuso. *Compr Psychiatry*. 2010; Koran. *CNS Spectr,* 2008; Phillips. *J Am Acad Dermatol,* 2000; Picavet. *Plast Reconstr Surg,* 2011; Job_Doctor. (2011). Bigorexia. [Photo]. From https://www.flickr.com/photos/51806296@N05/5430306239/

Clinical features (cont.)

- **Repetitive behaviors**
  - Mirror checking
  - Excessive grooming
  - Camouflaging
  - Comparing
  - Reassurance seeking
- Avoidance, may be housebound
- **SI** common

Phillips. *Understanding body dysmorphic disorder : an essential guide*. 2009; Bjornsson. *Dialogues Clin Neurosci. 2010*; Phillips. *J Clin Psychiatry.* 2005; Didie. *Compr Psychiatry.* 2008

Diagnosis of BDD in DSM-5

- Preoccupation with perceived defects in physical appearance that are not observable or appear slight to others
- Individual performs repetitive behaviors (e.g. mirror checking) or mental acts (e.g. comparing appearance) in response to concerns
- Causes significant distress or impairment
- **Not better explained by an eating disorder** (e.g. concerns with body fat or weight

*Specify **insight:** good/fair, poor, or absent/delusional*

Treatment

- Studies limited
- **~75% of BDD pts seek cosmetic treatments** which only rarely improve BDD sx
- Pts with BDD much **more likely to sue** their surgeons
- 4 surgeons murdered by pts with BDD
- **SSRIs** and **CBT** are first-line treatments

Phillips. *Psychosomatics.* 2001; Crerand. *Psychosomatics.* 2005; Sarwer. *Aesthet. Surg. J.* 2002; Crerand. *Plast. Reconstr. Surg.* 2006; Yazel LT. *Glamour.* 1999

SSRI trial in BDD

- **High doses** (max or >max) often required
- **Response delayed** (4-6 wks for initial effect, 10-12 wks for full effect)
- **Trial length: 12 wks** (4-6 wks at the maximum tolerable dose)
- **Rapid titration** recommended
- Duration of treatment (not well-studied)
  - Only one relapse study to date, 40% relapse if SSRI stopped <6 mo
  - given lethality of BDD, **SSRI recommended several years or longer**

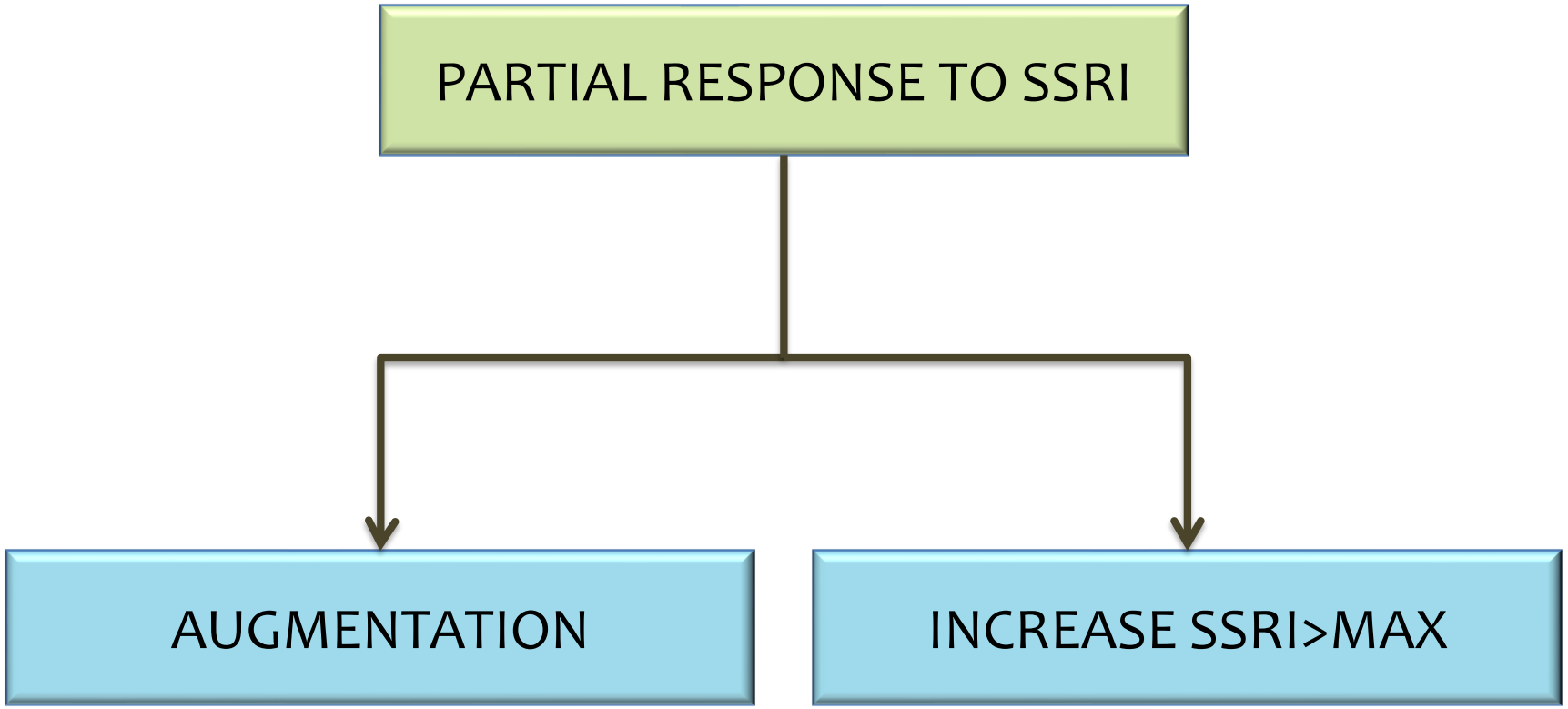
Phillips & Hollander. *Body Image*. 2008; Phillips. *Am J Psychiatry*. 2016

Which SSRI for BDD?

SRIs thought to be equally effective but due to **high dose** requirements in BDD, SRIs with **lower side effect profiles typically trialed first**

Drug Name	Target Dose	Advantages	Disadvantages
Escitalopram	20 mg/d	well-tolerated	
Sertraline	200 mg/d	well-tolerated	
Fluoxetine	80 mg/d	well-tolerated, long half-life, activating	drug interactions
Citalopram	40 mg/d	well-tolerated	potential ⇧QTc, Reduced **max dose may not be sufficient in BDD**
Paroxetine	60 mg/d		**sedation, weight gain, short half-life**
Fluvoxamine	300 mg/d		**sedation, weight gain**

Improving a partial SSRI response



SSRI augmenting agents in BDD

- Limited studies, very **few options**
- **Buspirone** (60 mg TDD) shows benefit in open-label & chart-review study
- Atypical antipsychotics-not well studied but often used
  - **Aripiprazole**, beneficial in 1 case report, 10 mg/d
  - **Risperidone,** beneficial in 1 case report, 4 mg/d
  - Olanzapine, mixed case reports (2 robust, 6 no effect), ~5 mg/d
  - In chart review study, only 15% respond to antipsychotic augmentation but effect size large
  - Typical antipsychotic pimozide, not efficacious in RCT
- **Clomipramine**, beneficial in 4 case reports, ~125 mg/d
  - Start low dose (25-50 mg) and monitor EKG and level while titrating

Phillips. *Psychopharmacol Bull.* 1996; Uzun. *Clin Drug Investig*. 2010; Grant. *J Clin Psychiatry*. 2001; Phillips. *Am J Psychiatry*. 2005; Goulia. *Hippokratia.* 2011: Nakaaki. *Psychiatry Clin Neurosci*. 2008; Phillips. *Am J Psychiatry.* 2005; Phillip. *J Clin Psychiatry.* 2001

Above max SSRI dosing in BDD

	Drug	FDA Max Dose	Reported BDD >max dosing	My max dosing	Notes
SSRI	**Escitalopram**	20 mg/d	Up to 50 mg/d	30 mg/d	Check EKG
	Sertraline	200 mg/d	Up to 400mg/d	300mg/d	
	Fluoxetine	80 mg/d	Up to 100mg/d	120 mg/d	
	Paroxetine	60 mg/d	Up to 100mg/d	80 mg/d	
	Fluvoxamine	300 mg/d	Up to 400 mg/d		
	Citalopram	40 mg/d	Up to 100mg/d	80 mg/d	**High dosing controversial** given QTc prolongation risk, I consider with EKG, h/o failed medication trials, pt consent
	Clomipramine	250 mg/d			Above max dosing not recommended due to seizure risk

No guidelines on above maximum dosing in BDD exist – doses circled are generally well-tolerated in my practice

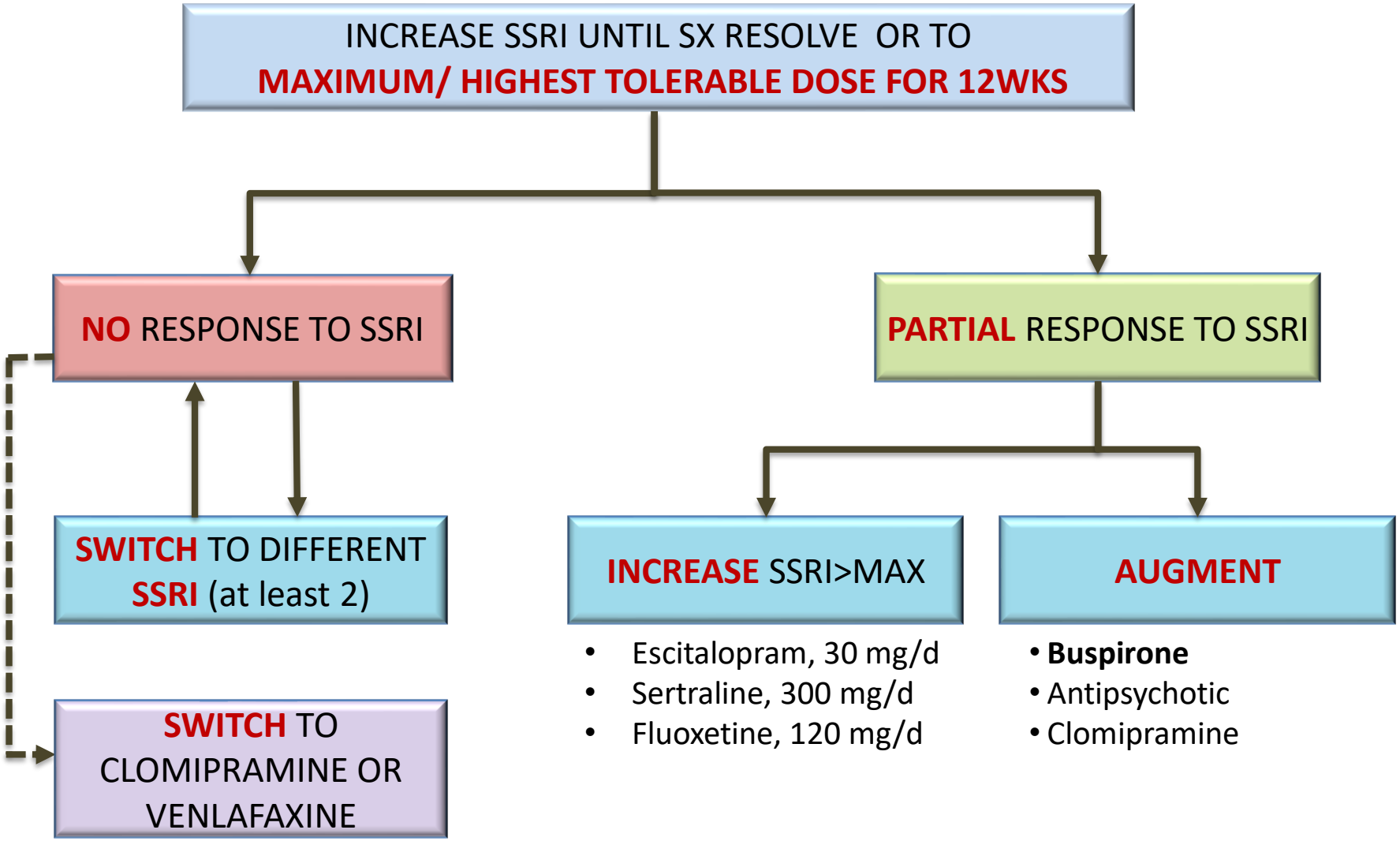
Phillips. *The Broken Mirror.* 2005

Limited alternatives to SSRIs in BDD

- **Clomipramine,** beneficial in RCT, ~140 mg/d, but second-line due to AEs
- SNRIs
  - Being evaluated in BDD given efficacy in OCD but studies limited
  - **Venlafaxine,** effective in small open-label study, ~150-225 mg/d
  - **Duloxetine**, not yet studied, sometimes used, option for pts with pain

Hollander. *Arch Gen Psychiatry*. 1999; Allen. *CNS Spectr. 2008*

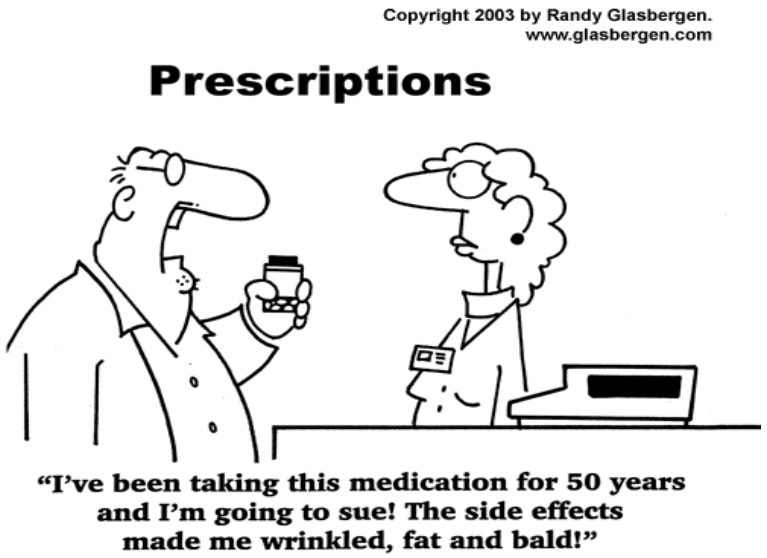
Suggested medication approach to BDD



Phillips. *Psychiatr Ann.* 2010

Managing SSRI adverse effects

- AEs more likely in OCD/BDD due to **high SSRI dose requirements**
- **Consider management of AEs** before switching to different agent
- Most common/bothersome include:
  - **Weight gain**
  - **Sexual dysfunction**
  - GI sx
  - Fatigue
  - Sweating



Treatment of weight gain

- **Exercise**
- Refer to **nutrition**
- Add **weight loss medication**
  - Bupropion, particularly if depressed
  - Topiramate 50-100 mg PO QHS
  - Refer to weight center for more weight loss med options
- **Reduce SSRI** dose
- **Switch to an antidepressant** with less weight gain potential

No weight gain
- Bupropion

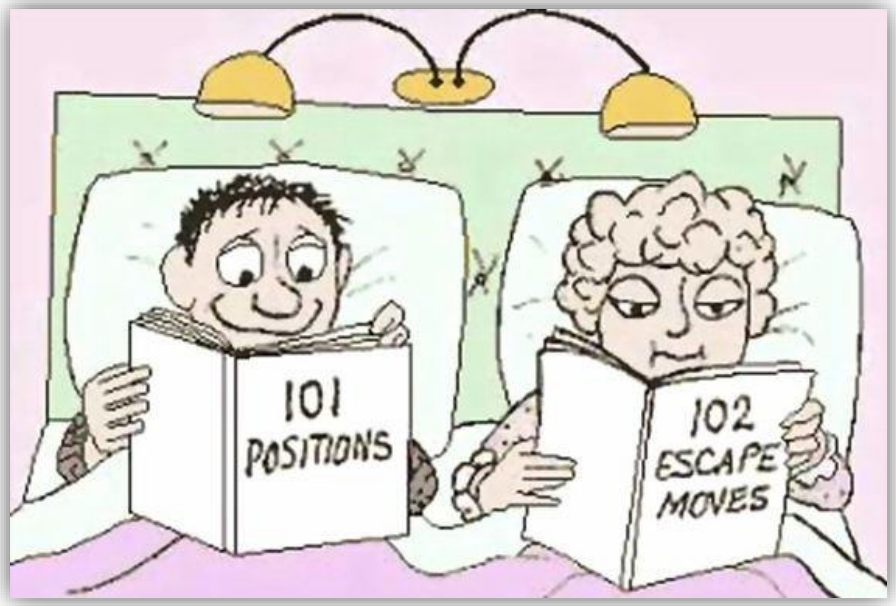
Minimal weight gain
- Sertraline
- Fluoxetine
- Buspirone

Major weight gain
- Paroxetine
- Fluvoxamine
- Clomipramine
- Mirtazapine

Cates. Ann Pharmacother. 2008; Fava. *J Clin Psychiatry.* 2000; Uguz. *Gen Hosp Psychiatry.* 2015; Dent. *PLoS One.* 2012; Maina. *J Clin Psychiatry.* 2004

Sexual AEs

- One of the **most common reasons for SSRI d/c**
- Occurs in **30-50% of patients** taking SSRIs
- Sx
  - Men/women
  - Reduced libido
  - Erectile dysfunction (ED)
  - Difficulty achieving orgasm



Reviewed in Balon R. Am J Psychiatry. 2006; Image by Staples 101 from http://blingee.com/blingee/view/113581518-101-positions-and-102-escape-moves-

Sexual AEs

- **Wait** (sexual AEs can take 1-2 mo to improve)
- **Add bupropion** (not FDA-approved)
  - Dose-dependent, 2 RCTs, bupropion SR 150 mg daily ineffective, but 150 mg PO BID beneficial
  - Bupropion should not be combined with clomipramine given seizure risk
- **Add Maca root** (not FDA-approved), OTC
  - 2 RCTs for antidepressant-induced sexual dysfunction (men, women)
  - 500 mg PO BID x7d, then 1000 mg PO BID x7d, then 1500 mg PO BID
  - Check TSH ~1 mo after starting

- **Add buspirone** (not FDA-approved)
  - Beneficial in RCT, ~48 mg TDD
- For ED, **add sildenafil** (or equivalent)
- **Reduce SSRI** or **switch** to different SSRI
- **Flibanserin should not be combined with an SSRI**

DeBattista. *J Clin Psychiatry.* 2005; Masand. *Am J Psychiatry.* 2001; Safarinejad. *J Psychopharmacol.* 2011; Landén. *J Clin Psychopharmacol.* 1999; Dording. *CNS Neurosci Ther.* 2008; Dording. *Based Complement Alternat Med*. 2015

CBT for BDD

Cognitive restructuring

- Challenge negative thoughts related to appearance

Response (ritual) prevention

- **Limit BDD repetitive behaviors** (e.g. mirror checking)

Behavioral experiments

- **Carry out experiments** to evaluate the accuracy of beliefs about appearance

Exposures

- **Face situations** which might normally be avoided

➢ RCT comparing CBT to waitlist shows 81% responder rate with CBT

Rosen. *J Consult Clin Psychol. 1995*; Veale. *Behav Res Ther,* 1996; Wilhelm. *Cognitive and Behavioral Practice, 2010;* Wilhelm S. *Behav Ther, 2010*; Wilhelm. *Cognitive-behavioral therapy for body dysmorphic disorder : a treatment manual*. 2013; Wilhelm. *Behav Ther.* 2014

Delusional BDD

- Medication:
  - **Antipsychotic monotherapy NOT proven to be effective**
  - **SSRIs are effective** for pts with delusional BDD and considered first-line
  - For those lacking insight into BDD, pitch SSRI to other psychiatric sx (e.g depression, anxiety)
- Monitor closely for **SI**
- Try to **delay planned cosmetic procedures**

Phillips & Feusner. *Psychiatr Ann.* 2010; Phillip. *Psychopharmacol Bull.* 1994; Hollander. *Arch Gen Psychiatry.* 1999; Phillips. *Arch Gen Psychiatry.* 2002; Phillips. *Int Clin Psychopharmacol.* 2006; Phillips. *J Clin Psychiatry*. 2003; Phillips. *J Clin Psychiatry.* 2001

BDD and COVID-19

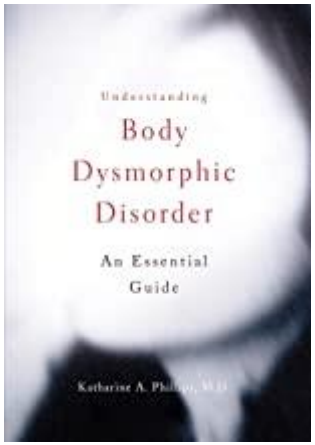
- ↑BDD w/ pandemic
  - **Prolonged view of self** during video meetings
  - **Zoom filters** can create idealized images **("snapchat dysmorphia")**
  - Reduced structure/working from home can increase time for **repetitive behaviors**
    - Excessively researching cosmetic treatments
    - Comparing oneself to online images
    - Increased mirror checking
  - **Reduced exercise** due to gym closures
  - Isolation, increases risk for **SI/substance use**

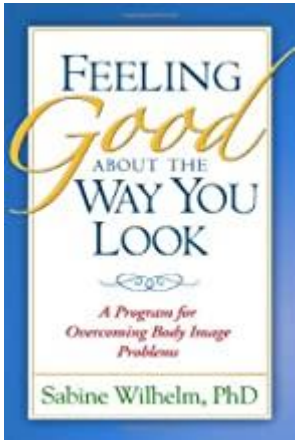
Recommendations

- *Encourage pts to maintain **daily structure** and leave house regularly*
- ***Reduce size of their video window** during video conferencing*
- *Resume or increase **CBT***
- *Closely monitor for **SI and ETOH***

Resources for BDD

- ***Understanding Body Dysmorphic Disorder*** by Katharine Phillips (comprehensive overview for pts, families, and clinicians)
- ***CBT for BDD, Treatment Manual*** by Sabine Wilhelm et al. (therapist guide)
- ***Feeling Good About the Way You Look*** by Sabine Wilhelm (self-guided CBT)
- **Perspectives** (free BDD mobile app coached by live BDD CBT experts, currently enrolling participants for clinical trial), https://perspectives.health/try-perspectives-app/
- **Finding specialists**
  - International OCD Foundation, www.iocdf.org
- **Residential treatment**
  - McLean OCDI Institute, www.mcleanhospital.org/programs/ocd-institute-ocdi
  - Rogers OCD Center, rogersbh.org/what-we-treat/ocd-anxiety/ocd-and-anxiety-residential-services/ocd-center
  - Others…





Perspectives