MASSACHUSETTS GENERAL HOSPITAL

PSYCHIATRY ACADEMY

Body Dysmorphic Disorder

Lisa Zakhary, MD PhD
Medical Director, OCD and Related Disorders Program
Director of Psychopharmacology, Excoriation Clinic and Research Unit
Massachusetts General Hospital
11/07/2020

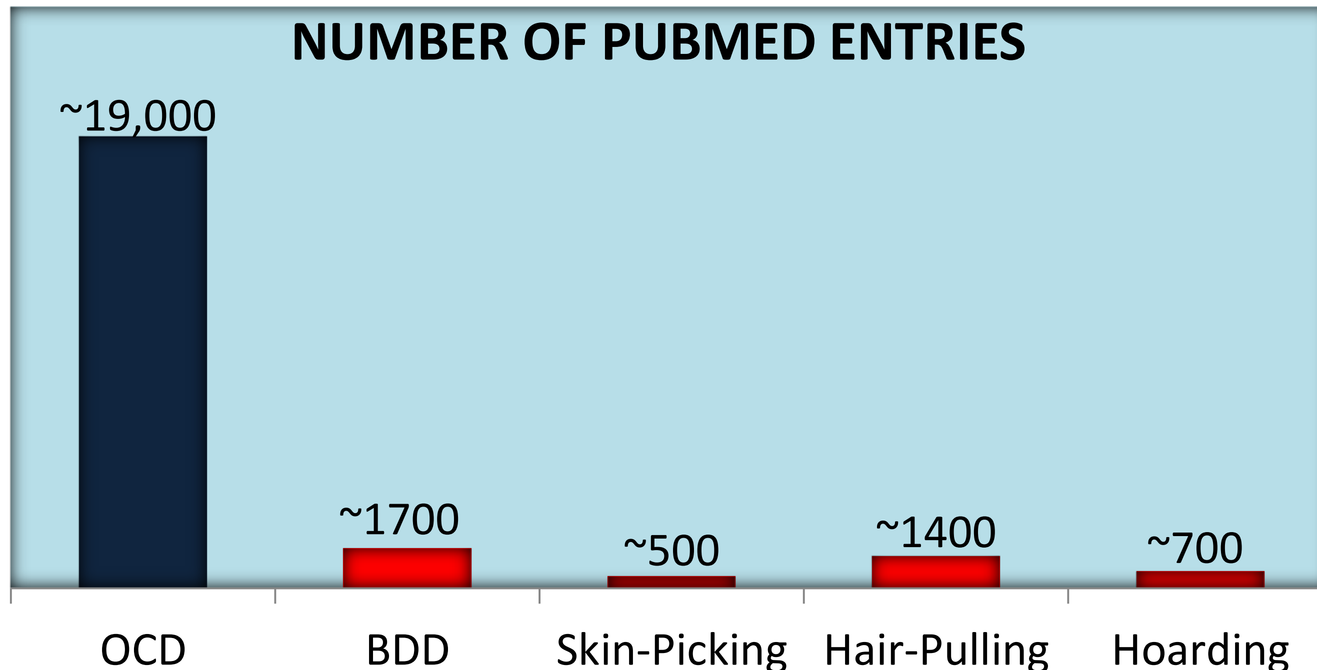
Disclosures

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

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**

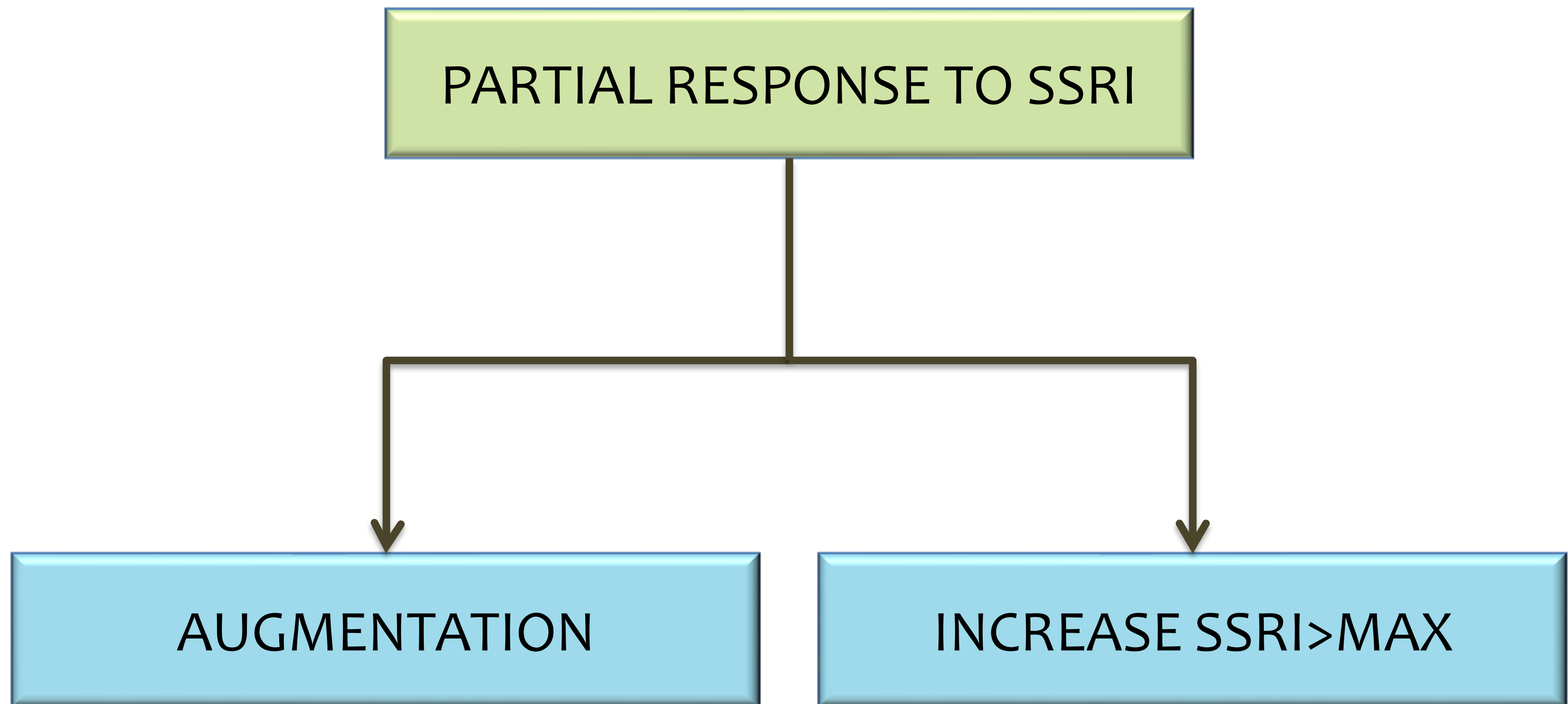
Phillips & Hollander. *Body Image*. 2008; Phillips. *Am J Psychiatry*. 2016

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
SSRI	**Sertraline**	200 mg/d	Up to 400mg/d	300mg/d	
SSRI	**Fluoxetine**	80 mg/d	Up to 100mg/d	120 mg/d	
SSRI	**Paroxetine**	60 mg/d	Up to 100mg/d	80 mg/d	
SSRI	**Fluvoxamine**	300 mg/d	Up to 400 mg/d		
SSRI	**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

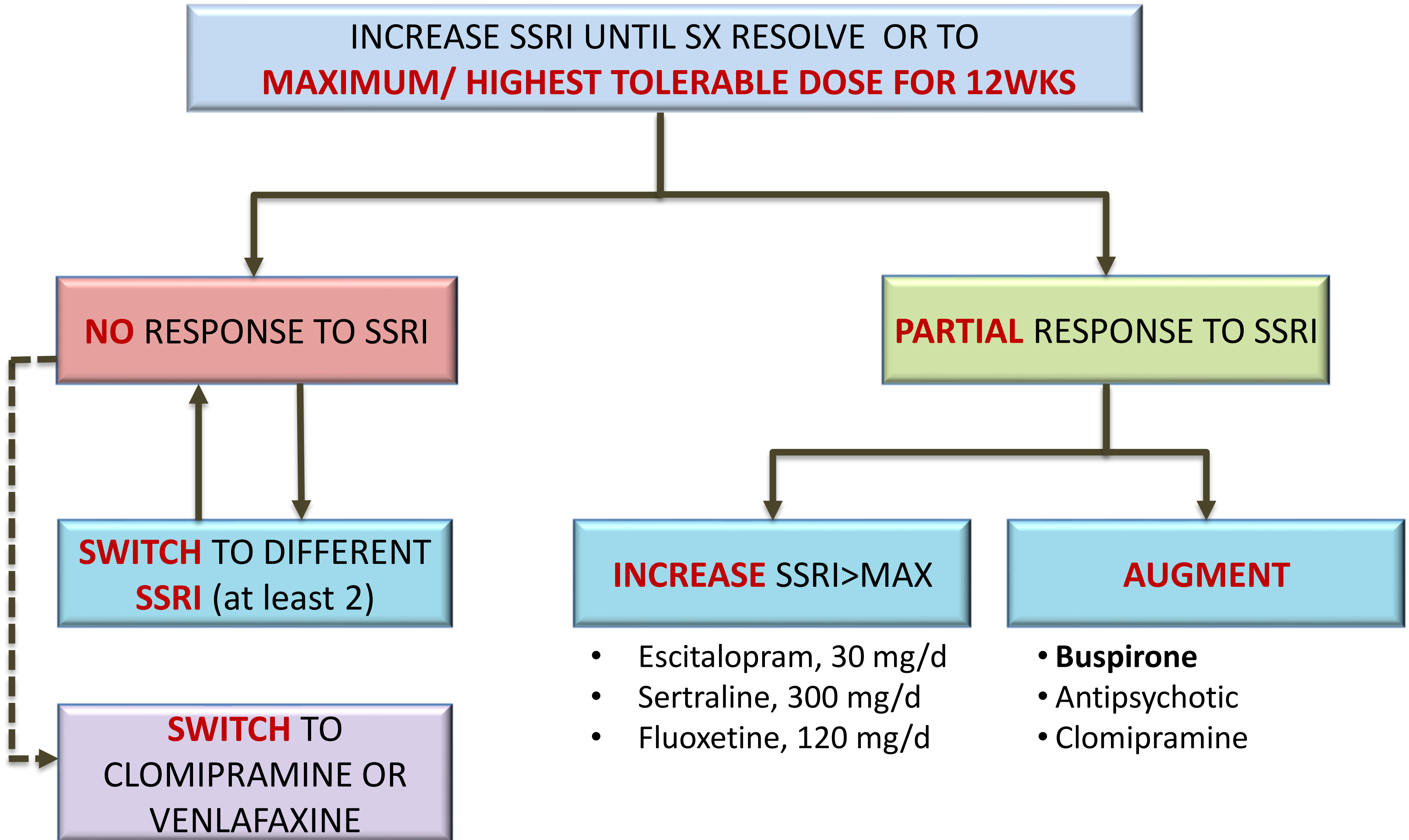
Phillips. *The Broken Mirror.* 2005

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*

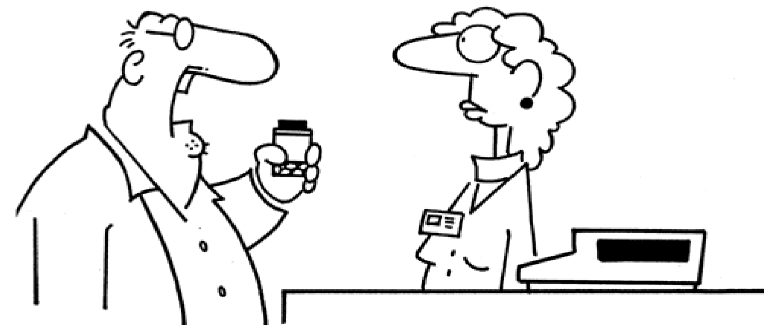
Suggested medication approach to BDD



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

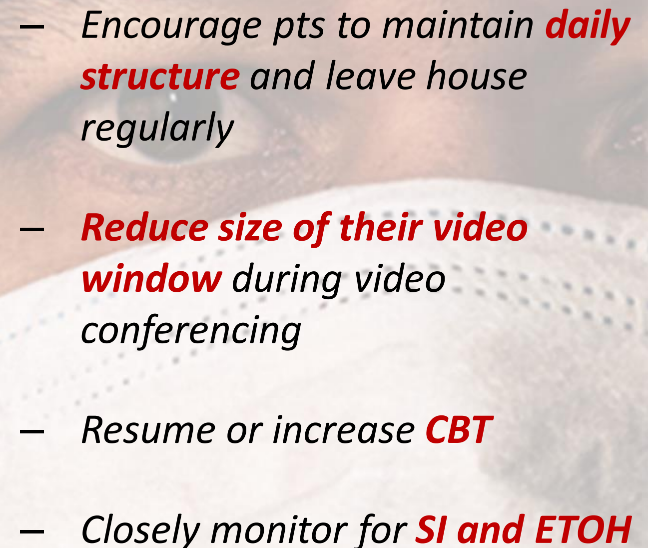
Delusional BDD

- 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***

Copyright 2020, iStock.com/Eranicle

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…