Body Dysmorphic Disorder

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Disclosures

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Obsessive-Compulsive Related Disorders (OCRDs)

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

NUMBER OF PUBMED ENTRIES

- OCD: ~19,000
- BDD: ~1,700
- Skin-Picking: ~500
- Hair-Pulling: ~1,400
- Hoarding: ~700

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
Clinical features (cont.)

- **Repetitive behaviors**
  - Mirror checking
  - Excessive grooming
  - Camouflaging
  - Comparing
  - Reassurance seeking

- **Avoidance, may be housebound**

- **SI common**
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

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**
### 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**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Target Dose</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escitalopram</td>
<td>20 mg/d</td>
<td>well-tolerated</td>
<td></td>
</tr>
<tr>
<td>Sertraline</td>
<td>200 mg/d</td>
<td>well-tolerated</td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>80 mg/d</td>
<td>well-tolerated, long half-life, activating</td>
<td>drug interactions</td>
</tr>
<tr>
<td>Citalopram</td>
<td>40 mg/d</td>
<td>well-tolerated</td>
<td>potential ↑QTc, Reduced max dose may not be sufficient in BDD</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>60 mg/d</td>
<td></td>
<td>sedation, weight gain, short half-life</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>300 mg/d</td>
<td></td>
<td>sedation, weight gain</td>
</tr>
</tbody>
</table>
Improving a partial SSRI response

PARTIAL RESPONSE TO SSRI

AUGMENTATION

INCREASE SSRI>MAX
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
Above max SSRI dosing in BDD

<table>
<thead>
<tr>
<th>Drug</th>
<th>FDA Max Dose</th>
<th>Reported BDD &gt;max dosing</th>
<th>My max dosing</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escitalopram</td>
<td>20 mg/d</td>
<td>Up to 50 mg/d</td>
<td>30 mg/d</td>
<td>Check EKG</td>
</tr>
<tr>
<td>Sertraline</td>
<td>200 mg/d</td>
<td>Up to 400 mg/d</td>
<td>300 mg/d</td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>80 mg/d</td>
<td>Up to 100 mg/d</td>
<td>120 mg/d</td>
<td></td>
</tr>
<tr>
<td>Paroxetine</td>
<td>60 mg/d</td>
<td>Up to 100 mg/d</td>
<td>80 mg/d</td>
<td></td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>300 mg/d</td>
<td>Up to 400 mg/d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>40 mg/d</td>
<td>Up to 100 mg/d</td>
<td>80 mg/d</td>
<td></td>
</tr>
<tr>
<td>Clomipramine</td>
<td>250 mg/d</td>
<td></td>
<td></td>
<td>Above max dosing not recommended due to seizure risk</td>
</tr>
</tbody>
</table>

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

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

- **NO RESPONSE TO SSRI**
  - **SWITCH TO DIFFERENT SSRI** (at least 2)
  - **SWITCH TO CLOMIPRAMINE OR VENLAFAXINE**

- **PARTIAL RESPONSE TO SSRI**
  - **INCREASE SSRI > MAX**
    - Escitalopram, 30 mg/d
    - Sertraline, 300 mg/d
    - Fluoxetine, 120 mg/d
  - **AUGMENT**
    - Buspirone
    - Antipsychotic
    - Clomipramine

**INCREASE SSRI UNTIL SX RESOLVE OR TO MAXIMUM/HIGHEST TOLERABLE DOSE FOR 12WKS**

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

Prescriptions

“I’ve been taking this medication for 50 years and I’m going to sue! The side effects made me wrinkled, fat and bald!”
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

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

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**

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

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**
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...