Understanding and treating Body Dysmorphic Disorder

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ROGERS Behavioral Health

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Disclosures

Brenda Bailey, PhD, and Sanjaya Saxena, MD, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe the four required components of the *DSM-5* diagnostic criteria for BDD and its potential differential diagnosis considerations.
2. Describe and apply three components of the conceptual CBT model for BDD.
3. Describe three medications found to be effective for treatment of BDD.

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What we'll cover in this webinar

Overview of Body Dysmorphic Disorder (BDD)
- Diagnosis
- Clinical presentation, symptoms, level of insight
- Suicidality
- Comorbidity
- Epidemiology
- Assessment

CBT for BDD
- General conceptual framework of CBT for BDD
- Cognitive interventions
- Perceptual retraining
- Exposure and response prevention
- Relapse prevention

Pharmacotherapy for BDD
- First line medications
- Strategies for treatment refractory BDD

Intensive multimodal treatment of severe BDD
- Higher levels of care (LOC)
- Which patients need treatment at higher LOC
- Structure and components
- Rising identity barriers and considerations

Moderated Q&A

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Overview of Body Dysmorphic Disorder

Please use the Q&A feature to send your questions to the moderator.

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Body Dysmorphic Disorder: DSM-5 diagnostic 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.

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DSM-5 diagnostic criteria, continued

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.

Specify if:

With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular.

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DSM-5 diagnostic criteria, continued

Specify if:

Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed").

With good or fair insight: The individual recognizes that BDD beliefs are definitely or probably not true, or that they may or may not be true.

With poor insight: The individual thinks that the BDD beliefs are probably true.

With absent insight / delusional beliefs: The individual is completely convinced that the BDD beliefs are true.

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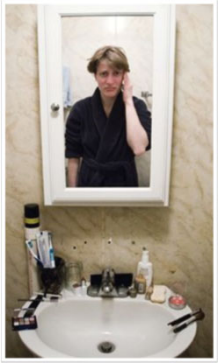
Clinical presentation

- ***BDD is not vanity:*** It is just the opposite. People with BDD believe or fear that they are ugly or deformed
- ***Appearance obsessions:*** Usually about multiple body parts; can be specific or vague; any part of the body can be involved
- ***Most common body parts involved:*** Skin, Face, Hair, Nose, Stomach, Teeth, Breasts, Genitals, Muscles
- ***Intense shame and disgust*** regarding the area of their body with which they are preoccupied

(Phillips 1991; Phillips & Kelly, 2021)



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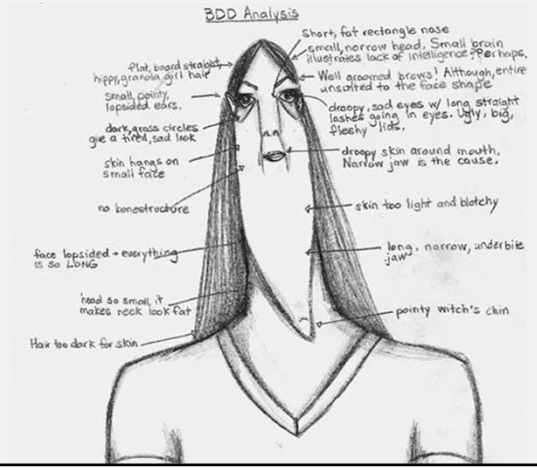
Distorted body image



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Poor insight

- 70% of patients with BDD have ideas of reference (IOR)
- 35-50% are delusional about their appearance
- Poorer insight correlated with higher negative affect, lower positive affect, and lower self-esteem in BDD
- Across time, self-esteem and insight influenced each other reciprocally, with comparatively stronger effects for the prediction of poorer insight by previously lower self-esteem

(Phillips et al, 2014; Schulte et al, 2021)

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Clinical presentation

Compulsions: grooming, mirror-checking, skin-picking, camouflaging, comparing own body to others', reassurance-seeking, etc.

- 70% of patients with BDD have cosmetic, dermatological, or plastic surgery; the vast majority are dissatisfied with its results

Severe avoidance: of school, work, social events; most are unmarried

- Severe functional impairment and low Quality of life (QOL)

(Phillips 1991; Phillips & Kelly, 2021)

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Epidemiology

Prevalence:

- 1.9% point prevalence in community
- Changes with age (2% adolescents, 4% 18-44; 1.4% > 45)
- 10-12% in psychiatric outpatients
- 6-15% in plastic surgery patients
- 3-15% in dermatological settings
- Male : Female = 1:1

(Veale et al, 2016; Phillips & Kelly, 2021)

Onset:

- Mean age 16+/- 7 (range 4-43)
- Usually begins gradually
- Mean onset of Sub-clinical BDD at 12.9
- ? second peak of incidence after menopause?

Course:

- Continuous in 85%
- Very low remission rate

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Suicidality

- 78% lifetime prevalence of SI, 58% per year
- 25-30% make suicide attempts; 2.6% per year
- 0.3% die by suicide each year (Phillips & Menard, 2006)
- Genetic factors account for most of the covariance (72.9 - 77.7%) between BDD symptoms and suicidality at ages 18 and 24 (Krebs et al, 2022)
- Risk factors for SI and suicide attempts in BDD include comorbid Bipolar Disorder, MDD, PTSD, Substance Use Disorder, Borderline PD, but BDD is associated with suicidality even after adjusting for comorbid disorders (Angelakis et al, 2016; Snorrason et al, 2019; Eskander et al, 2020)
- Depression mediates relationship between BDD and suicidal intent

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Comorbidity

Major Depression: 75-80% lifetime prevalence

OCD: 20-35% prevalence in BDD patients; 10-25% of OCD patients have BDD

Substance Abuse: 49% lifetime

Social Phobia: 37-39% lifetime, 31-34% current

Eating Disorders: 20-33% lifetime

Panic Disorder: 20% lifetime

Personality Disorders: 40% (mostly Avoidant and Dependent)

(Phillips et al, 2005)

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Childhood abuse

Reported rates of abuse

- Emotional Neglect or Abuse: 28-68%
- Physical Abuse: 14-35%
- Sexual Abuse: 22-28%
- Severe Maltreatment: 40%

(Didie et al, 2006; Neziroglu et al, 2006; Malcolm et al, 2021)

Self-reported origins

- Being bullied in childhood
- External critique of appearance
- Rejection, Shame, Feeling Inadequate
- Emotional and Physical Abuse

(Craythorne et al, 2022; Longobardi et al, 2022)

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Assessment measures

Body Dysmorphic Disorder Questionnaire (BDDQ)

- Excellent quick screening tool

Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS)

- Rates severity of BDD symptoms

Brown Assessment of Beliefs Scale (BABS)

- Rates insight in multiple domains

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Initial treatment steps

Don't try to talk patients out of their beliefs and concerns about their appearance

- Empathize with their suffering
- Provide psychoeducation about BDD
- Assess insight, motivation for treatment, and readiness to change
  - Motivational Interviewing and Enhancement
- Convey that treatment is effective

(Phillips & Kelly, 2021)

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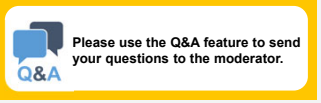
Cognitive behavioral therapy for BDD



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Cognitive behavioral therapy for BDD

Efficacy

- Effective for 60-80% of BDD patients, with average 60% symptom reduction – significantly better than supportive therapy (Wilhelm et al, 2014 and 2021)
- 68% of participants achieved at least partial remission (Weingarden et al, 2021)

Sequence of Treatment:

- Assessment
- Education, Motivational Enhancement
- Cognitive Restructuring of Maladaptive Beliefs and Fears
- Perceptual Retraining
- Exposure & Response Prevention
- Relapse Prevention

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How to deal with poor insight

- Must do extensive psychoeducation about BDD, motivational interviewing and enhancement
- Focus on the distress caused by the beliefs, rather than challenging their accuracy
- Do Cognitive Restructuring and Perceptual Retraining ***prior to*** beginning ERP

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General conceptual framework

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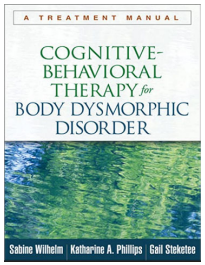
CBT for BDD

Appearance vs body image

- Objective vs subjective
- The focus of treatment is the client's personal evaluation of their features and their responses to the interpretation
  - Responses will reinforce maladaptive interpretation



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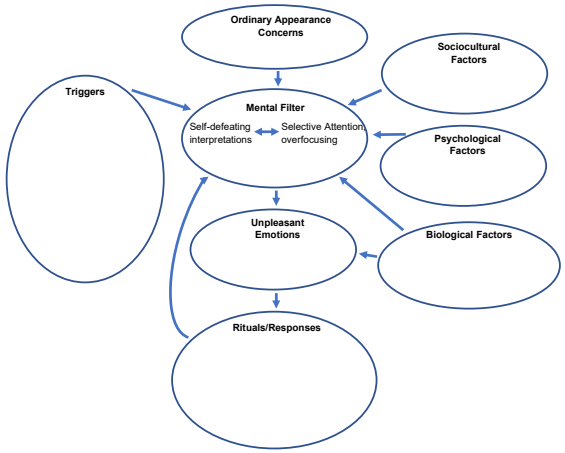

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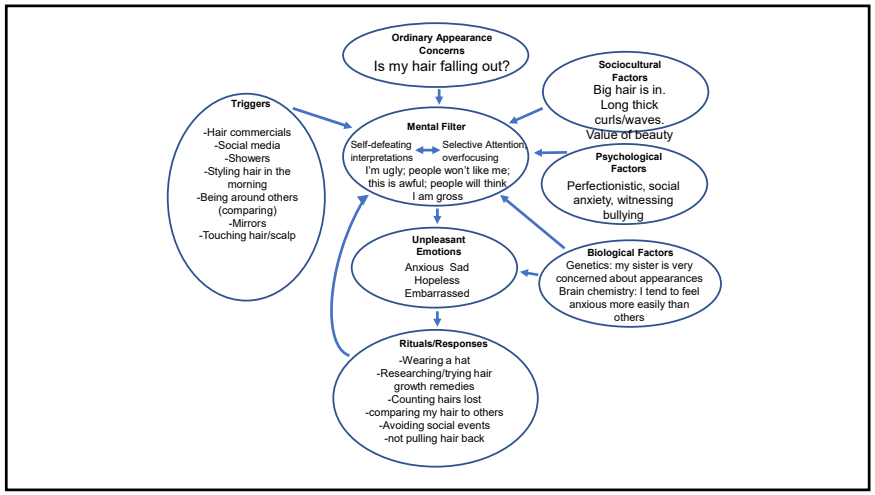

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Interventions

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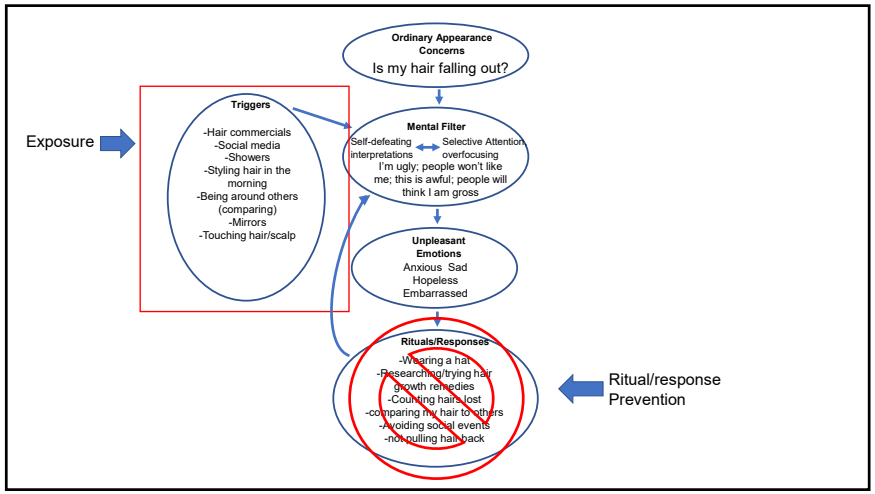

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Ritual prevention

What is the intent of the behavior?

- Start with monitoring
  - Help to identify triggers of concerns
  - Can lead to a reduction in behaviors by itself
- Get supports involved!

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Ritual prevention

Ritual reduction is the realistic goal at the beginning

- Stimulus control
- Protocols for high urge situations
- Postpone rituals
- Competing response

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Exposure

Exposures are gradual, repeated, prolonged

- Create a hierarchy
- Start with challenging, yet manageable
- Do the exposure multiple times
- Remain in the situation long enough to give your anxiety the opportunity to reduce
- Ritual prevention is the *utmost* importance

Follow-up questions:

- What did you learn from the exposure?
- What did you take away from that experience?

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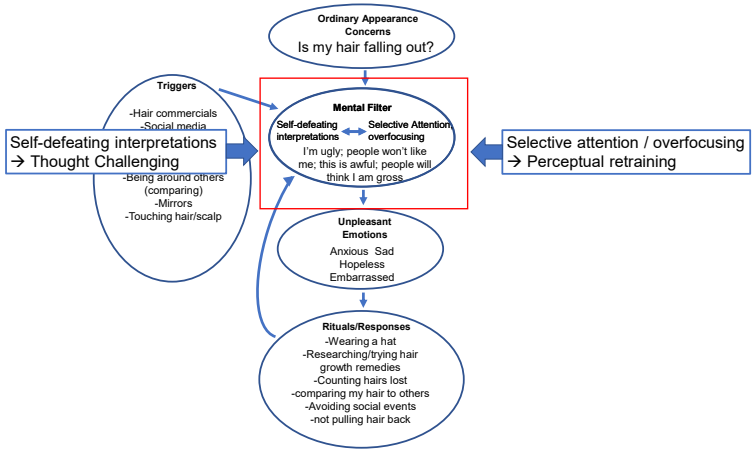

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Thought challenging

Two key points keep in mind…

1. It's not the situation that is upsetting, it's the ***client's interpretation of the situation*** that is upsetting
2. Goal is to think flexibly, not understand the source of truth

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Thought challenging

- Identify a specific situation that led to avoidance to assess if there are potentially more than one interpretation
  - What was the situation?
  - What did you think (interpretation, meaning)?
    - What ran through your mind?
  - How did you feel?
  - Is it possible that your interpretation is just one viewpoint, and there could be others?
    - Try some others out…
- Unpleasant emotions are good indicators of problematic interpretations

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Common cognitive distortions

Black or White Thinking

Also known as All-or-Nothing Thinking; things are viewed in only two categories (a minor imperfection → hideous)

- Unfair comparisons → comparing to models

Labeling

Using negative terms to describe your appearance. (e.g., "look at my 'cankles'!")

Mind-reading

Assuming it is known what other people are thinking ("They think my nose looks huge.")

- *In the moment*

Fortune-telling

Assuming something will go poorly in the future ("I'll gross people out with my scars if I go to class without makeup.")

- *In the near, specific future*

Catastrophizing

Anticipating something will be much worse than it actually is; making a mountain out of a molehill ("I will always be alone because of my appearance.")

- *In the all-encompassing future forever*

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Common cognitive distortions

Discounting the positive

Making positive experiences the exception ("Nothing else about me matters except the size of my ankles.")

Selective Attention/Magnification

Only focusing on the unpleasant aspects of a situation without taking in other features ("My blemishes are the only thing anyone can see.")

Emotional Reasoning

Reasoning that our feelings/emotions are valid evidence of our concerns ("I feel ugly, therefore I am.")

Personalization

Assuming the actions of others are a direct result of our own influence ("Jane did not look at me. It must be she thinks my thin hair is pitiful.")

"Shoulds" or "Musts"

Holding ourselves accountable to standards that would be difficult for most people to uphold ("I *should* never have imperfections in my appearance.")

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Evaluating thoughts

- Not just "thinking positive" or replacing "bad" thoughts with "good" thoughts
- Aim is to think flexibly and "test your theory"

  Is it valid?

  Is it useful / helpful?

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Cognitive restructuring

Where do I start?

- A more frequent, distressing interpretation that has cognitive errors
  - Not a feeling
  - States an outcome

    "They will all think my nose is hideous." ***vs*** *"My nose is hideous, and I hate it."*
  - Hierarchy of negative thoughts to work on

Delusions are <u>not</u> amendable to thought challenging

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Thought challenging

Would other people see this differently?

What would I say to a loved one who was thinking this thought?

Is this a 100% certainty or just one possibility? What are other possibilities?

Is it helpful to have this thought? Regardless of whether it is a "true" thought, is it helping me to think this way? What are some advantages and disadvantages to having this thought?

So, what if….?

What's the best that could happen?

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Behavioral experiments; Exposures +

Exposure plus precise predictions

- Before entering an exposure situation, <u>*make a specific prediction*</u> (quantities, percentages, time) about what will happen

  "People will look at me." ***vs*** *"75% of the people I meet on the street will look at me with disgust / horror."*

  "While in the store, 80% of people will move away from me when they are within 8 feet in less than 5 seconds."

- ***Ensure they are externally focused to accurately assess***
- ***Ensure they "act natural"***

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CBT for BDD

Pre-exposure:

- Exposure situation?
- What causes me anxiety in this situation?
- What rituals do I need to watch out for?
- What are my negative predictions? (be specific)

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CBT for BDD

Post-exposure:

- What happened in the exposure? What did I experience?
- Did my negative prediction come true?
  (Was it as bad as I thought it would be?)
- What did I learn?

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Perceptual retraining

Combats: Ritualistic mirror gazing on preoccupations
Goal: Use mirror for functional purposes and view appearance as a whole

- Non-judgmental and holistic
- Do not fixate on "hotspots"
- 5-10 mins a trial
  - Not necessarily until anxiety decreases
- Can change mirror size and context to make more or less challenging
  - Head and shoulders vs whole body
  - Dim lighting vs ring light
  - 10 ft away vs 3 ft away

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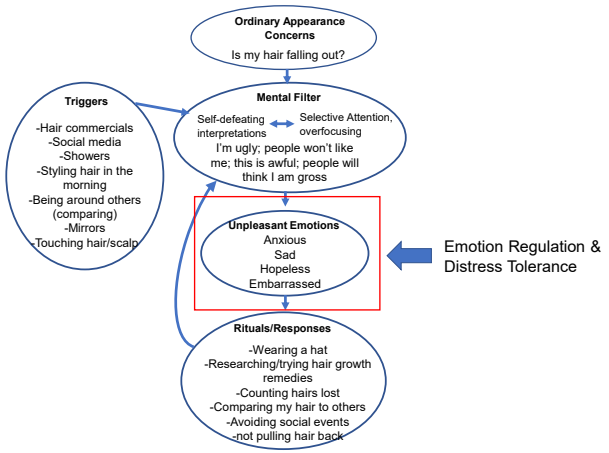

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Managing distress

Distress

- Especially important if leading to unsafe behaviors
  - May need to be addressed before Exposure based treatments can be successfully completed
- Distress protocols
- Skills use vs tolerating anxiety

Caution on "overcorrecting" with exposures

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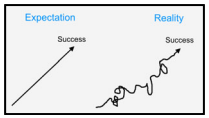
CBT for BDD



Relapse prevention

- Prepare for stressors and "tricky situations"
  - Review the coming months and identify potential stressors/triggers
  - Plan what to do with extra time (BA)

** Share with your supports **	Green (recovery)	Yellow (Lapse)	Red (Relapse)
What behaviors am I engaging in? How frequently?			
What's my plan to stay/return to green? Be specific			
Who would you contact?			
What skills could you use?			

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Pharmacotherapy for BDD

Please use the Q&A feature to send your questions to the moderator.

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Serotonin Reuptake Inhibitors

a. Only three controlled trials:
   Clomipramine > Desipramine.
   Fluoxetine (mean dose 78 mg/day) > Placebo
   Escitalopram > Placebo

b. Fluvoxamine, Citalopram, & Venlafaxine XR were effective in open trials

c. High dose and long duration of treatment required: at least 12 weeks

(Castle et al, 2021; Phillips & Kelly, 2021)

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First-line agents

Drug	Usual daily dose (mg/day)	Maximum dose (mg/day)
Citalopram	40-60	80
Escitalopram	20-40	60
Fluoxetine	40-80	120
Fluvoxamine	200-300	400
Paroxetine	40-80	100
Sertraline	150-300	400
Clomipramine	150-250	300

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Serotonin Reuptake Inhibitors

d. Outcome:

- 50-70% of patients respond to SRIs vs. 18-25% placebo
- Average 35-45% symptom reduction
- Insight, depression, anxiety all improve significantly
- Overall functioning also significantly improves

e. SRIs are equally effective for delusional and non-delusional BDD

(Castle et al, 2021; Phillips & Kelly, 2021)

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Augmentation strategies

Only one controlled study

a. Clomipramine – 4 of 9 patients improved in 1 open trial
b. Buspirone – 6 of 13 of patients improved in 1 open trial
c. Lithium
d. Atypical Antipsychotics – case reports on Olanzapine were mixed
   - We recommend low dose Aripiprazole
e. Neuroleptics (Pimozide = Placebo)
f. Levetiracetam – effective in one open trial

Other antidepressants, antipsychotic monotherapy, and ECT are not effective

(Castle et al, 2021; Phillips & Kelly, 2021)

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Intensive multimodal treatment of severe BDD

Q&A

Please use the Q&A feature to send your questions to the moderator.

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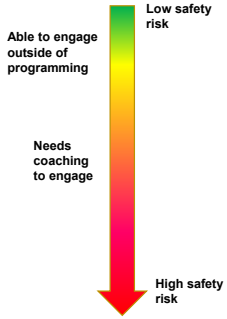
Higher levels of care for BDD

IOP
- 5 days a week, 3 hours a day

PHP
- 5 days, 6 hours a day

Residential *(24/7; unlocked)*
- Voluntary program
  - Safety concerns w/ ability to discuss and address safety
- Medication management

Inpatient *(24/7; locked)*
- Immediate or imminent danger



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Structure and components

- Schedule is important!
- Specialized care
  - Interdisciplinary team
  - Experience a different environment of response
- More oversight of medication changes

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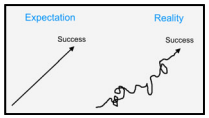
Higher levels of care for BDD



Willingness vs willfulness

- Is the home environment set up to support treatment?
  - Can be addressed, and could limit success and progression

Sitting with open hands

- Is this working?
- Can we agree that you are unhappy?
  - Can we agree that there are things *you* can change to feel better?

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Rising identities barriers and considerations

Symptoms:

- More BDD symptoms endorsed among Causation and Latina women compared to black/African American women (Boroughs, Krawczyk, & Thompson, 2010)
- Sexual minorities endorse more symptoms that heterosexual participants
  - Sexual minority women reported highest overall scores

Access:

- Compared to Caucasian participants, more Latinx participants endorsed more barriers in the following categories (Marques et al., 2011)
  - Logistic and financial barriers controlling for income and insurance shame, stigma, and discrimination
  - Treatment perception and satisfaction barriers
- Asian participants endorsed fewer barriers than Caucasian participants (Marques et al., 2011)

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Rising identities barriers and considerations

Treatment Response:

- Majority of sufferers are seeking treatment from non-mental health providers (Marques et al., 2011)
  - Majority seeking psychological services are receiving “talk therapy”
- Treatment credibility has been found to be a moderator of treatment success (Phillips et al., 2021)
  - No difference in treatment outcome for either CBT or supportive therapy based on demographics

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Time for questions and answers…

- Please use the Q&A button – not the chat – to submit your question
- If we don't get to your question, please feel free to send an email to **webinars@rogersbh.org** and we will follow-up with you

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Key take-home messages

- BDD is a serious condition that has significant impact of quality of life and carries a high suicide risk that can be overlooked in the medical community
- CBT for BDD is an empirically supported psychological treatment for BDD (Wilhelm, Phillips, Fama, Greenberg, & Steketee, 2011) which consists of exposure and response prevention, cognitive restructuring, perceptual retraining, and response prevention
- Effective pharmacotherapy exists and can bolster treatment gains
- Successful alternatives to traditional outpatient treatment are available to provide more intensive CBT for those who have a limited response to treatment or are refractory.

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About the presenters….

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