Body Dysmorphic Disorder: Common, Severe and in Need of Treatment Research

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Body dysmorphic disorder (BDD) is common yet very under-recognized. It has a point prevalence of about 2%, making it more common than obsessive-compulsive disorder (OCD), anorexia nervosa or schizophrenia [1]. BDD typically causes tremendous suffering and substantial impairment in psychosocial functioning. The rates of suicidal ideation, suicide attempt and completed suicide appear markedly high. Yet treatment research on BDD lags very far behind that of other common and severe disorders. Thus, the study by Veale et al. [2] is a major contribution to the literature and to patient care.

Individuals with BDD (previously known as 'dysmorphophobia') are preoccupied with one or more perceived defects or flaws in their appearance; these defects, however, are not observable or appear only slight to others (DSM-5 criterion A) [1]. Preoccupations most often focus on skin (e.g. perceived acne, scarring, wrinkles, color), nose (e.g. size or asymmetry) and hair (e.g. too little hair) but may focus on any body area [3]. Patients typically describe the disliked body parts as 'ugly', 'unattractive', 'hideous', or even 'monstrous'. The preoccupations occur, on average, for 3–8 h a day (usually for at least an hour a day). They are intrusive, unwanted, and usually difficult to resist and control [4, 5].

The appearance preoccupations trigger feelings of depression, anxiety, distress, shame, or other painful emotions. These emotions, in turn, trigger repetitive compulsive behaviors that are intended to alleviate the emotional distress [5]. As required by DSM-5 criterion B (which is new to DSM-5), all individuals with BDD perform excessive repetitive behaviors in response to the preoccupations with appearance at some time during the course of the disorder [1]. These repetitive behaviors have many similarities to OCD compulsions, and thus they are commonly referred to as compulsions or rituals. Common excessive behaviors include checking mirrors, excessive grooming, seeking reassurance about the perceived defects, skin picking (to try to minimize perceived blemishes), and tanning (e.g. to darken 'pale' skin) [3]. Some BDD compulsions consist of mental acts, such as comparing one's own appearance with that of other people, rather than observable behaviors [3]. The repetitive behaviors are difficult to control and occur, on average, for 3–8 h a day [4, 5]. Nearly all patients camouflage the perceived defects (e.g. with a hat, makeup, hair, clothes, body position). Although camouflaging is a safety behavior, it can also be done repeatedly (e.g. reapplying makeup 20 times a day), in which case it may be considered a repetitive behavior [3].

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To meet DSM-5 BDD criteria, the appearance preoccupations and resulting repetitive behaviors must cause clinically significant distress or impairment in social, occupational or other important areas of functioning [1]. On standardized measures of these constructs, individuals with BDD typically score several standard deviation units below normative scores [6]. More severe BDD symptoms are associated with poorer functioning and quality of life [6]. Some patients experience only moderate functional impairment because of BDD (e.g. they may avoid only some social interactions and have difficulty concentrating at work but are able to remain employed), whereas many experience severe or extreme impairment in functioning (e.g. dropping out of school, being unable to work, having no relationships, or being housebound because of BDD) [3, 5, 6].

According to DSM-5, if appearance preoccupations involve only excessive body fat or weight, and the patient has an eating disorder diagnosis, the fat or weight concerns should be diagnosed as an eating disorder rather than BDD [1]. However, BDD (consisting of concerns with other body areas) and eating disorders commonly co-occur [3].

Once the clinician has diagnosed BDD, he/she should consider the following two specifiers, which are new to DSM-5 and identify important subgroups of individuals with BDD:

(1) Muscle dysmorphia: this specifier identifies individuals (usually men) who are preoccupied with the belief that their body build is too small or insufficiently muscular, even though they look normal or even very muscular because of excessive weight lifting or anabolic steroid use [1, 4]. This specifier is used even if a patient has additional, nonmuscle-focused preoccupations, which is usually the case.

(2) Insight: this specifier indicates the level of insight regarding BDD beliefs (e.g. 'I look ugly'). Levels of insight in DSM-5 are 'with good or fair insight', 'with poor insight', and 'with absent insight/delusional beliefs'. This new insight specifier in DSM-5 is important for several reasons [7]: (i) it clarifies that individuals who are completely convinced that their BDD belief is true should be diagnosed with 'BDD with absent insight/delusional beliefs' rather than a psychotic disorder; (ii) it implies that delusional and nondelusional BDD should be treated similarly – indeed, studies indicate that both delusional and nondelusional BDD respond to serotonin reuptake inhibitor (SRI) monotherapy and to cognitive-behavioral therapy (CBT), and (iii) specifying the level of insight allows the iden-

tification of patients with poorer insight, who may be more reluctant to accept the idea that they have a mental disorder (BDD) rather than actual physical deformities. Such patients may need more motivational interviewing and attention to the therapeutic alliance in order to engage and retain them in mental health treatment.

The rates of suicidal ideation and suicide attempts are very high in adults and youth with BDD; greater BDD severity independently predicts greater suicidal ideation and suicide attempts [8–10]. Although completed suicide in BDD has been only minimally studied, the rate appears markedly elevated and may be even higher than that in other serious mental disorders such as bipolar disorder and major depressive disorder [10].

What do patients with BDD actually see? We have no firm answers to this intriguing question. However, emerging evidence suggests that individuals with BDD actually see things differently than those without BDD. People with BDD appear to have abnormalities in visual processing that consist of a bias for encoding and analyzing details of faces and nonfacial objects (such as houses or complex figures) rather than using holistic visual processing strategies (i.e. seeing 'the big picture') [11, 12]. Preliminary data also suggest abnormalities in executive functioning [13], increased total white matter volume [14] and compromised white matter fibers (reduced organization) and inefficient connections between different brain areas, which is associated with poorer BDD-related insight [15, 16]. However, studies are few, and some findings are inconsistent across studies. Individuals with BDD also appear to have difficulty identifying emotional facial expressions and a bias toward interpreting neutral faces and scenarios as threatening (consistent with BDD-related ideas/delusions of reference) [17]. Preliminary data suggest that past teasing and high rates of childhood neglect and/or abuse are also associated with BDD [18, 19]. Taken together, these emerging findings indicate that, like other psychiatric disorders, the etiology/pathophysiology of BDD is likely to be multifactorial and complex. In addition, these findings indicate that BDD is a brain-based disorder – not vanity.

Perhaps the most important question for clinicians is how can we successfully treat these very ill patients, and why is a separate treatment needed? Why not just treat BDD as if it were OCD, social anxiety disorder, major depressive disorder, or schizophrenia? The reason is that BDD differs in some important ways from its 'near-neighbor disorders' – e.g. in terms of clinical features and treatment response [5, 20]. Although it is likely that BDD

is related to OCD (e.g. BDD is more common in first-degree relatives of OCD probands than control probands, suggesting shared etiology/pathophysiology [21]), BDD is characterized by greater comorbidity with major depressive disorder, greater suicidality, poorer insight, and information-processing differences [5, 20, 22]. In addition, clinical experience indicates that simply treating BDD with exposure and response prevention for OCD or another disorder is unlikely to be successful.

Thus, it is important to accurately diagnose BDD and to implement treatment for BDD specifically. Measures are available to screen for, diagnose, and assess the severity of BDD and to assess insight in BDD (www.bodyimageprogram.com) [23–26].

A few basics about treatment are as follows: (1) because BDD-related insight is usually absent or poor, motivational interviewing is often needed to encourage patients to accept and remain in mental health treatment; (2) focusing on patients' suffering and functional impairment rather than trying to convince them that they actually look normal, which they usually do not accept because their insight is typically poor or absent, may help them agree to mental health treatment, and (3) patients should be discouraged from getting dermatological, surgical, dental, and other cosmetic treatments for BDD concerns. Available data suggest that cosmetic treatment is almost never effective for BDD, can make symptoms worse, and can trigger legal action or even violent behavior towards clinicians who provide such treatment [27–29].

CBT is currently considered the psychotherapy of choice for BDD [5]. Case series and three studies that used a wait-list control group found that BDD-focused CBT (an additional study used metacognitive therapy) is often efficacious and that subjects improve more with CBT than with no treatment [30–33]. However, this type of control group does not control for therapist time and attention, and thus the study by Veale et al. [2] is of particular importance. This study found that BDD-focused CBT was more efficacious for BDD than anxiety management after 12 weeks of treatment. Outcomes improved even further after 4 additional CBT sessions, and gains were maintained at the 1-month follow-up. Importantly, CBT was as efficacious for participants with delusional BDD as for those with nondelusional BDD.

Two CBT treatment manuals with some published evidence to support their efficacy are now available for therapists to use when treating BDD [34, 35]. Their effectiveness has not been compared, but the good news for patients is that if one manual is not adequately helpful, the other may be. Because BDD can be difficult to treat, and because its treatment differs in important ways from that of other disorders, the use of a treatment manual is highly recommended for all patients with BDD, especially those with more severe BDD.

The study by Veale et al. [2] has many methodological strengths, including the use of a therapy control group, evaluators of treatment outcome who were blinded to treatment conditions, and equally credible treatments. However, this study (like all studies) has some limitations. One is the brief duration of treatment – only 12 weeks for the controlled portion of the study, and only 16 weeks for the total duration of CBT. Many published studies used a longer treatment, e.g. weekly treatment for 24 weeks [30] or even as many as 90 h of treatment [36], reflecting how ill and impaired many patients are; patients continue to further improve with treatment after 12 or 16 weeks [30]. It is likely that the finding of Veale et al. [2] that only 48% of patients responded to CBT after 12 weeks reflects the brief treatment duration and the need for longer treatment. An important question is whether treatment gains are maintained for longer than a month, as was found by Veale et al.; other studies have found that this is often the case [30, 37].

It should be mentioned that SRIs are also often efficacious for BDD; they are currently considered the first-line somatic treatment for BDD [5, 38]. Two blinded controlled trials [39, 40] and four methodologically rigorous open-label trials indicated that SRIs are efficacious for the majority of patients with BDD [38]. Importantly, SRIs may protect against worsening of suicidality and decrease suicidal ideation in individuals with BDD [41, 42]. SRIs appear more efficacious than non-SRI antidepressants or other types of psychotropic medication [5, 38, 39]. However, data are limited, and published efficacy trials are limited to acute trials of no more than 16 weeks. SRI monotherapy appears as efficacious for patients with delusional BDD beliefs as for those with nondelusional beliefs [5, 38–40].

Although rigorous dose-finding studies are lacking, effective SRI doses needed to successfully treat BDD appear to often be substantially higher than those typically needed to treat many other disorders such as depression [5, 38]. Not uncommonly, response is optimized when the maximum SRI dose recommended by the manufacturer is exceeded (although this dose should not be exceeded for clomipramine or citalopram) [5, 38]. To determine if an SRI is efficacious, patients should receive a trial of 12–16 weeks, while reaching a high dose (if needed and tolerated) for at least 3–4 of those weeks [5, 38].

Small open-label trials suggest that the SNRI venlafaxine and the antiepileptic medication levetiracetam may be helpful for BDD; however, these medications are not currently recommended as first-line treatments for BDD [5, 38]. The use of medications should be considered within a broader framework of their potential benefits and adverse effects [43].

In summary, the CBT study by Veale et al. [2] (in this issue) is a substantial and meaningful contribution to the literature and should encourage the use of BDD-focused CBT for BDD. However, additional treatment development and efficacy studies are urgently needed, including larger CBT studies, CBT studies with control groups that receive treatments commonly used in the community (e.g. supportive psychotherapy), studies of CBT augmentation of SRIs and vice versa, and studies of other psychotherapies, non-SRI medications, and other somatic treatments. Treatment studies in youth are especially needed; two thirds of individuals with BDD have an onset of the disorder before the age of 18, yet no manualized psychosocial treatment is available for youth with BDD [44]. BDD is common enough and severe enough that such studies should be done. Without appropriate treatment, BDD is usually chronic and associated with substantial morbidity and mortality [10, 45, 46].

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