Body dysmorphic disorder: General principles of treatment

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INTRODUCTION

Body dysmorphic disorder (BDD) is characterized by preoccupation with nonexistent or slight defects in physical appearance, such that patients believe that they look abnormal, unattractive, ugly, or deformed, when in reality they look normal. The preoccupation with perceived flaws leads to repetitive behaviors (eg, checking their appearance in mirrors), which are usually difficult to control and not pleasurable. BDD is common but usually underrecognized, causes clinically significant distress and/or impaired functioning, and is often associated with suicidal ideation and behavior.

Patients with BDD may present to mental health professionals as well as other clinicians, such as dermatologists, plastic surgeons, otolaryngologists, primary care clinicians, pediatricians, gynecologists, and dentists. Most patients seek nonpsychiatric cosmetic treatment (most commonly dermatologic and surgical) for their perceived physical defects; this treatment appears to be ineffective for most patients and can be risky for clinicians to provide. By contrast, pharmacotherapy (ie, selective serotonin reuptake inhibitors or clomipramine) and/or cognitive-behavioral therapy tailored specifically to BDD are often efficacious.

This topic reviews the general principles of treating BDD. Choosing treatment and the prognosis of BDD are discussed separately, as are the epidemiology, pathogenesis, clinical features, assessment, diagnosis, and differential diagnosis of BDD.

- (See "Body dysmorphic disorder: Choosing treatment and prognosis".)
- (See "Body dysmorphic disorder: Epidemiology and pathogenesis".)
- (See "Body dysmorphic disorder: Clinical features".)
- (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis".)

DIAGNOSIS OF BODY DYSMORPHIC DISORDER

Body dysmorphic disorder (BDD) is diagnosed in patients who meet each of the following criteria (table 1) [1]:

- Preoccupation with at least one nonexistent or slight defect in physical appearance (eg, thinks about the perceived defects for at least one hour per day).
- At some point during the course of the disorder, concerns about appearance lead to repetitive behaviors (eg, mirror checking, excessive grooming, or skin picking) or mental acts (eg, comparing one's appearance to that of others).
- Clinically significant distress or psychosocial impairment that results from the appearance concerns.
- Appearance preoccupations are not better explained by an eating disorder.

Additional information about the diagnosis and clinical features of BDD is discussed separately. (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Diagnosis' and "Body dysmorphic disorder: Clinical features", section on 'Clinical manifestations'.)

GENERAL PRINCIPLES

The sections below describe some general principles and issues that are involved in treating body dysmorphic disorder (BDD). Information about choosing a specific treatment regimen is discussed separately. (See "Body dysmorphic disorder: Choosing treatment and prognosis".)

Approach to the patient — Before initiating treatment for BDD, it is important to lay some essential groundwork to educate and engage patients, and to establish a therapeutic alliance by expressing empathy and providing hope that evidence-based treatment usually helps [2]. Most patients have little to no insight regarding their appearance and may doubt whether psychiatric treatment can help them. In addition, some find it difficult to leave their house to see clinicians.

Educate patients about BDD — Patients benefit from education about BDD and a rationale for recommended treatment [2-4]. Although many patients are relieved to learn that they have a known and treatable disorder, some may resist the diagnosis.

Focus of treatment — Address how concerns with appearance cause patients to obsess about their appearance and perform repetitive BDD behaviors/rituals (eg, check mirrors) excessively, which in turn impair psychosocial functioning and cause patients to suffer [2]. In addition, emphasize how recommended treatment can improve these problems.

Avoid focusing on how the patient looks — It usually is not helpful to comment on the patient's looks. Even reassuring comments are often misinterpreted in a negative way. We do not try to convince patients that they look normal (one cannot impose insight), nor do we agree with them that there is something wrong with their appearance [2-4]. Instead, clinicians might say that patients with BDD see themselves very negatively and differently from how other people see them, for reasons that are not well understood (the tendency to overfocus on tiny details of appearance can be mentioned). (See "Body dysmorphic disorder: Epidemiology and pathogenesis", section on 'Pathogenesis'.)

Educate patients about effective psychiatric treatments for BDD — Patients can benefit from education about cognitive-behavioral treatment (CBT) and pharmacotherapy, especially the expected benefits, prognosis, and misconceptions that surround these treatments [2]. If patients fear that CBT will be too anxiety-provoking, clinicians can reassure patients that CBT exercises will be generated collaboratively by the patient and clinician, and that patients will not be asked to perform CBT exercises that are intolerable.

It may also be helpful to emphasize that selective serotonin reuptake inhibitors (SSRIs) and clomipramine are usually well tolerated, not addictive, and appear to normalize brain functioning (rather than cause brain damage) [2,3]. Clinicians can manage negative expectations about medications by [5]:

- Explaining the desired therapeutic effects when discussing potential side effects (eg, "Response to just one trial of these types of medication occurs in one-half to two-thirds or more of patients"). Response rates are even higher in patients who complete the medication trial with good adherence. If the first medication that is tried is not sufficiently helpful, other medications may be effective. It may be helpful to elicit potential benefits that are meaningful and specific to the patient. Explain that it may take time (eg, one to four months) for the benefits to manifest, but that symptoms may start improving sooner than this.

- Ensuring that patients understand that many side effects are transient and benign, and the clinician can often minimize them (eg, by switching a medication that causes fatigue to bedtime). In addition, side effects can be reframed as an indication that the medication is having an effect.

- Discussing techniques for coping with side effects other than stopping the drug.

In addition, it may help to ask patients to try a medication for three to four months, with the understanding that they will be monitored throughout treatment [6]. If the medication trial is successful, they can (and should) continue the drug, and if not, then next step treatment will be discussed.

The US Food and Drug Administration (FDA)'s warnings about suicidal ideation and behavior in children, adolescents, and young adults who are treated with SSRIs must be acknowledged. However, studies indicate that in adults aged 18 years and older with BDD, fluoxetine protects against worsening of suicidality more than placebo [7], and that suicidality decreases with other SSRIs. In addition, other studies indicate that SSRIs decrease suicidal ideation and behavior in depressed adults, and that the risk of suicidality in depressed children and adolescents is comparable for fluoxetine and placebo [8]. Thus, it appears that the substantial risk of suicidal ideation and behavior posed by BDD and comorbid disorders such as depression exceeds the small potential risk posed by the use of SSRIs for children, adolescents, and young adults [3]. (See "Effect of antidepressants on suicide risk in adults", section on 'Reduction of existing suicidal ideation' and "Effect of antidepressants on suicide risk in children and adolescents", section on 'Randomized trials'.)

Individualize treatment for each patient — Treatment for BDD should be individualized for each patient. Factors to evaluate include [2]:

- Severity of illness. (See "Body dysmorphic disorder: Choosing treatment and prognosis", section on 'Mild to moderate illness' and "Body dysmorphic disorder: Choosing treatment and prognosis", section on 'Severe illness'.)

- History of prior treatment for BDD.

- Comorbid disorders – Although some comorbid disorders such as unipolar major depression or social anxiety disorder may respond to the same medication used for BDD, other comorbid disorders (eg, bipolar disorder) require different medications. In addition, patients with comorbid substance use disorders are generally not treated with benzodiazepines or other controlled substances.

- Medication safety and adverse effects.
- Patient preferences.
- Pregnancy status.
- Age – For children, adolescents, and some older adults, lower initial and maximum medication doses may be efficacious and better tolerated than doses prescribed for the general population of adults with BDD. For children, we generally do not exceed FDA maximum medication doses. In addition, CBT that was developed for adults needs to be adapted for children and adolescents.

Involve family members if clinically appropriate — We suggest involving the family if it is appropriate and potentially helpful (parental/guardian involvement is required for minors) [2]. Family members often bring patients with BDD for treatment because patients manifest poor insight (and thus may resist psychiatric treatment), impaired functioning, and suicidal thoughts and behavior, and the family can support the patient and encourage adherence with the treatment plan. In addition, family members generally benefit from psychoeducation about the illness and its treatment.

Use motivational interviewing if needed — Motivational interviewing modified for BDD may be necessary to engage and retain patients in psychiatric treatment. Patients with BDD may be reluctant to accept psychiatric treatment due to poor BDD-related insight, a wish for cosmetic treatment rather than psychiatric treatment, the belief that psychiatric treatment will not be helpful, and discomfort being seen by other people. (See "Overview of psychotherapies", section on 'Motivational interviewing'.)

Monitoring — At the beginning of treatment, ill outpatients who are receiving medication are generally seen once every few weeks, and patients receiving CBT are seen weekly or more often. The visit frequency also depends upon clinical urgency. In patients who improve with medication, the frequency of visits can be tapered, with visits every one to two months. Stable remitted patients can eventually be seen once every three to six months. Patients who receive CBT are usually seen at least weekly for approximately six months; following improvement, as-needed “booster sessions” may be helpful to maintain gains.

We monitor BDD symptoms over time by asking the patient:

- What is the total time each day that you think about your appearance?
- How much distress is caused by these thoughts about your appearance?

- How much do the concerns about your appearance interfere with daily functioning (eg, work, school, and social)?

Clinicians can also ask about total time spent each day performing BDD repetitive behaviors (ie, rituals, compulsions).

In addition, clinician should monitor depressive symptoms and suicidal thinking and behavior, because depression and suicidality are common in patients with BDD. One option for monitoring depression and suicidality is the self-report Patient Health Questionnaire – Nine Item (PHQ-9) (table 2). Information about comorbid psychopathology in BDD and the use of the PHQ-9 to assess depression is discussed separately. (See "Body dysmorphic disorder: Clinical features", section on 'Comorbidity' and "Using scales to monitor symptoms and treat depression (measurement based care)", section on 'Patient Health Questionnaire - Nine Item'.)

Discourage cosmetic interventions — For patients with BDD, we suggest that clinicians not perform surgical, dermatological, dental, or other cosmetic treatments because these interventions usually do not help [2,9-11]. This approach is consistent with practice guidelines:

- American Academy of Otolaryngology – A 2017 guideline states that BDD is a contraindication to elective rhinoplasty and that patients seeking surgery should be screened for BDD [12,13].

- American College of Obstetricians and Gynecologists – A committee opinion states that individuals younger than age 18 who request breast or labia surgery should be screened for BDD and that if the obstetrician-gynecologist suspects an adolescent has BDD, referral to a mental health clinician is appropriate [14]. A subsequent opinion on elective female genital cosmetic surgery states before surgery is considered, patients should be referred and assessed for BDD if indicated (eg, they acknowledge sexual appearance concerns) [15].

However, we do not recommend avoiding cosmetic interventions in patients with skin damage due to BDD-related skin picking that requires dermatologic treatment.

Although most patients with BDD receive cosmetic treatment in an attempt to “fix” their perceived appearance flaws, BDD symptoms respond poorly to cosmetic procedures in the large majority of cases and may even worsen [9,12,13]. In addition, dissatisfaction with the outcome of cosmetic treatment may lead patients to become litigious, threatening, or violent toward clinicians who provide such treatment.

We suggest that patients presenting for cosmetic treatment be assessed for BDD (table 3) [9]. In addition to inquiring about BDD's diagnostic criteria (table 1), it can be helpful to assess patient motivations and expectations for cosmetic treatment; determine whether patients have had past cosmetic treatment with which they have been dissatisfied; ask whether surgeons, dermatologists, dentists, or other clinicians have recommended against cosmetic treatment; and observe the patient's behavior in the office (eg, making unusual requests for appointment times so as to avoid being seen by other people).

If BDD is suspected in patients presenting for cosmetic treatment, we suggest:

- Explaining to the patient that they may or do have BDD
- Educating patients about BDD
- Conveying concern that cosmetic treatment appears very unlikely to be helpful
- Discussing the potential for pharmacotherapy (eg, SSRIs) and CBT to improve BDD symptoms
- Referring the patient to a mental health clinician who is knowledgeable about BDD

If the patient insists upon receiving cosmetic treatment, clinicians can recommend delaying it until after the patient has tried psychiatric treatment, which may improve BDD symptoms to the point that the patient no longer desires a cosmetic intervention. However, some patients receive cosmetic treatment regardless of the clinician's recommendations, in which case efforts should be made to have the patient receive mental health treatment concurrently.

Additional information about the prognosis and course of illness of BDD following cosmetic procedures is discussed separately. (See "Body dysmorphic disorder: Clinical features", section on 'Cosmetic interventions'.)

Referral — Patients with BDD should be referred to mental health clinicians who preferably have experience treating the disorder. Although primary care clinicians may be able to treat mild BDD (eg, mild distress and no suicidal ideation or behavior), most patients are referred for management, especially those with moderate to severe symptoms and those who require psychotherapy or are suicidal.

CHOOSING TREATMENT

Choosing a specific treatment regimen for body dysmorphic disorder is discussed separately. (See "Body dysmorphic disorder: Choosing treatment and prognosis".)

INFORMATION FOR PATIENTS

Many patients can benefit from reading about their illness at websites such as those maintained by the International OCD Foundation and the author of this topic at her website.

SUMMARY

- Body dysmorphic disorder (BDD) is diagnosed according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria (table 1). (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Diagnosis'.)

- Before initiating treatment for BDD, it is important to engage patients and establish a therapeutic alliance by expressing empathy and providing hope that evidence-based treatment usually helps. Educate patients about BDD and effective psychiatric treatments for the disorder, focus on the patient's excessive preoccupation and impaired functioning, avoid focusing on how the patient looks, individualize treatment, and involve family members if clinically appropriate. (See 'Approach to the patient' above.)

- We monitor BDD symptoms over time by asking patients how much time each day that they think about their appearance and how much distress is caused by these thoughts. We also ask about daily functioning (eg, work) and rituals, and we monitor depressive symptoms and suicidal thinking and behavior. (See 'Monitoring' above.)

- For patients with BDD, clinicians should not perform surgical, dermatological, or other cosmetic treatments. In the large majority of cases, BDD symptoms respond poorly to cosmetic procedures and may even worsen. (See 'Discourage cosmetic interventions' above.)

- Patients with BDD are typically referred to mental health clinicians. (See 'Referral' above.)

- Several effective treatments are available for BDD. (See "Body dysmorphic disorder: Choosing treatment and prognosis".)

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