Objectives

- Phenomenology and diagnosis of BDD
- Developmental factors in BDD
- Cognitive behavioural understanding of BDD
- Evidence for SSRI
- Evidence for and principles of CBT

Prevalence of BDD

- 2% adults in community
- 5% in private psychiatric in-patient unit
- 10% in cosmetic surgery / dermatology
  (nature of procedure may be important)

Almost never picked up without screening question

The failure to treat BDD

1. Low level of awareness in community
2. Present to dermatologist or cosmetic surgeon
3. Secretiveness and stigma - do not reveal real symptoms unless asked (present with depression, social anxiety, OCD)
4. Little research & treated inappropriately (e.g. antipsychotics & counselling) – NICE guidelines for OCD and BDD

Stigma & trivialization of BDD

"I wonder the value of devoting an editorial to BDD. While it may appear to be a debilitating condition...the 1 in 236 one legged Cambodian mine victims may disagree".

Cartes, BMJ Bulletin board after Editorial by Castle, D & Phillips, K 2001 i.e. real disfigurement worthy of attention.

Alternatively BDD often confused with body dissatisfaction
Preoccupation
- Preoccupation (>1 hour a day) with a perceived defect(s) or flaws that are not noticeable or appears only slight to others
- Extreme self-consciousness
- Ideas or delusions of self-reference

Location of “defect” in BDD
- Frequently multiple concerns – flaws; thinning hair/too much hair; acne; too greasy; open pores or cysts; wrinkles; scars; vascular markings; too pale or reddiness of complexion; asymmetrical or disproportionate; ugliness, not right; too masculine or feminine.
- Most common on face
- Nose, facial skin, hair, eyes, teeth, lips, chin or ugly in general
- Any part of the body may be the focus

Repetitive Behaviours in BDD
Function to verify, camouflage or reparation
- Mirror gazing
- Checking (touch), inspect or measuring
- Comparing self with others or old photos
- Ruminating
- Trying to convince others that defect exists
- Grooming, combing, smoothening, straightening, plucking or cutting hair
- Skin cleaning, picking, face peel/scrubs, bleaching
- Facial exercises
- Cosmetic procedures, dermatology

Interference in BDD
Avoidance of public and social activities
Single or discord in relationships
Unemployed or occupational/academic disadvantage/ school refusal
Debt from cosmetic procedures
Housebound or severe avoidance
Hospitalized

Screening questions for BDD
Especially depression, substance abuse, social phobia & OCD - stigma of BDD is worse and fear labelled vain or narcissistic or laughed at
If you don’t ask, you don’t get

"Some people are very bothered by the way they look. Is that a problem for you?"
If screen positive

- What concerns do you have about your appearance? (How noticeable do you think it is?) (Is there a discrepancy between their perceived defect and actual self)
- On a typical day, how many hours a day is your appearance at the forefront of your mind?
- Do you have to check your appearance a lot?
- Is it very distressing / shameful for you?
- Does it interfere with your ability to study/ work?
- Does it interfere in dating or your relationship?
- Does it interfere in your social life?

What observation suggest a diagnosis BDD?

- Is he/she wearing a hat, baseball cap, sunglasses, baggy clothes, scarf (inappropriately)?
- Is there visible body piercing or a tattoo?
- Is the person heavily made up?
- Is the person’s head shaven?
- Does the person have long hair to hide their face?
- Is the person sitting in particular way (to hide the worst side)?
- Does the person find it difficult to make eye contact?
- Are there are scars from skin-picking?

ICD-10

- ICD 10 is unhelpful for BDD – symptoms may be part of hypochondriacal disorder, schizotypal disorder, delusional disorder, or Other persistent delusional disorder.....so ICD11

Obsessive Compulsive and Related Disorders - ICD11

- Obsessive Compulsive Disorder
- Hoarding Disorder (new in ICD11 & DSM5)
- Body Dysmorphic Disorder (new in ICD11)
- Skin-picking Disorder (new in ICD11 & DSM5 )
- Trichotillomania
- Hypochondriasis (different section in DSM5)
- Olfactory Reference Disorder (new in ICD11 only)

How understand BDD?

- Phenomenology
- Identify cognitive processes and behaviours
- Motivation/ function of processes
- Experimental studies to determine whether they are maintaining factors
- Develop interventions and test them

How understand BDD?

- 18 BDD patients and 18 healthy controls
- Both BDD and controls experience imagery
- BDD patients more vivid, recurrent, distorted
- Viewed from an observer perspective
- Defined their “self” (an aesthetic object)
- Associated with early memories (e.g. teasing, changes in adolescence, sexual abuse)
"Self as an aesthetic Object"

Feature(s) defines the self or identity


Development of BDD
(Veale et al 1996, Neziroglu 2001)

- Memories of being teased about "being different" or abuse may not have been emotionally processed and have been conditioned to body image
- Helps in engagement in therapy

CBT model in BDD
- Self-focussed attention on constructed body image from an observer perspective which has fused with reality
- More accurate and sensitive perception of actual face ("lost rose tinted glasses")
- Attentional bias to "defects" compared to overall appearance and self as a person
- Idealised values about importance of appearance in defining the self ("aesthetic object")
- Motivated to avoid rejection and humiliation (and memories)
- Constant comparison with others and ruminating ("Why?, If only...")
- Avoidance & safety seeking behaviours
- Function to verify, camouflage or reparation of the perceived defect to keep safe even if unintended consequences
More Info

Steps 3–5 Treatment options for adults with BDD

Mild functional impairment
- Brief CBT (+ERP)
  - < 10 therapist hours (individual or group formats)
  - Patient cannot engage in CBT (+ERP) is inadequate

Moderate functional impairment
- Offer choice of:
  - More intensive CBT (+ERP)
    - >10 therapist hours or course of an SSRI

Severe functional impairment
- Offer combined treatment of CBT and an SSRI

Inadequate response after 12 weeks
- Multidisciplinary review

Please refer to QRG for full overview of treatment pathway

Steps 3–5

Treatment options for adults

Severe functional impairment:
- Offer combined treatment with CBT (including ERP) and an SSRI

Offer either:
- a different SSRI or clomipramine

Refer to multidisciplinary team with expertise in OCD/BDD

Consider:
- More intensive CBT (more frequent, experienced therapists)
- High doses sertraline or escitalopram with ECG monitoring

CBT for BDD

1. Develop a good understanding of the development of the problem.
Understand the associations made about your body image when you were younger – update memories
2. Focus on maintenance factors (avoidance, safety seeking behaviours, checking, ruminating, comparing, self-focused attention)

Step 6 - Intensive treatment and inpatient services

- People with severe/chronic problems should have continuing access to multidisciplinary teams with specialist expertise in BDD
- Inpatient/residential unit services are appropriate for a small proportion of people with BDD
- Local (CCG) or National funding for severe treatment refractory BDD in designated units

Efficacy of Cognitive Behaviour Therapy versus Anxiety Management for Body Dysmorphic Disorder: A Randomised Controlled Trial

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RCT CBT v Anxiety Management

- (Veale et al, 2014)
## Credibility and Expectancy of Treatment

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<thead>
<tr>
<th></th>
<th>CBT</th>
<th>Anxiety Management</th>
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<tr>
<td>CEQ Credibility</td>
<td>Median (IQR)</td>
<td>[Range 3–27]</td>
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<tr>
<td></td>
<td>6.0 (4.5)</td>
<td>5.2 (3.2)</td>
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<tr>
<td>CEQ Expectancy</td>
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<td></td>
<td>6.0 (6.1)</td>
<td>3.0 (2.1)</td>
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## Outcome long term follow up

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<th>Week 16</th>
<th>Follow up</th>
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<tbody>
<tr>
<td>BDD-YBOCS (&lt;30% decrease)</td>
<td>20 (51.3%)</td>
<td>18 (46.2%)</td>
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<tr>
<td>Full remission (YBOCS &lt;12/48)</td>
<td>9 (23.1%)</td>
<td>11 (28.2%)</td>
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<tr>
<td>Partial remission (YBOCS 12-24/48)</td>
<td>21 (53.8%)</td>
<td>22 (56.4%)</td>
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## Conclusions

- Difficult to treat group for 12 weeks
- Strengths active comparator 12 weeks
- Limitations small study, no control
- Optimize length of therapy (20–24 sessions) and maintenance follow up
- Optimize treatment depression
- Develop new treatment modules
Primary outcome: Significant time x group interaction at post-tr and at 2-m FU.

Fluoxetine or placebo for 12 weeks
50% responders (30% or > mod YBOCS)
33% reduction on YBOCS mod for BDD
Delusional = non-delusional
Effect of discontinuation not known

RCT pimozide augmentation

• BDD non-responders to fluoxetine for 12 weeks or more and up to 80mg/day
• 8-week double-blind parallel group study
• Pimozide + fluoxetine (n=11) vs. placebo + fluoxetine (n=17)
• Pimozide 1mg/day, after one week 2mg/day, increased by 2mg a week to a max. of 10mg/day if tolerated
• No difference – anti-psychotic not recommended
Cosmetic surgery in BDD
- Some procedures (mammaplasty, labiaplasty & pinnaplasty probably safe)
- Dermatology & rhinoplasty most common & worst satisfaction
- After surgery often transfer preoccupation to a different area
- Successive operations decreasing satisfaction
- A few might develop BDD after surgery

Prospective study (Tignol, 2007)
- Follow up minimal defect (10 BDD, 14 non-BDD)
- 7 BDD and 8 non-BDD had surgery
- Satisfaction with surgery high
- 6 of 7 BDD surgery still had BDD and higher levels of handicap than those without BDD. 3 non-BDD developed BDD after surgery
- Need to replicate in much larger study with specific procedure like rhinoplasty

“D.I.Y” Cosmetic Surgery
(Veale, 2000)
- Pinch and stapling skin (for rhytidectomy)
- Filing down teeth to alter jawline
- Superglue ears (for pinnaplasty)
- Sandpaper to skin (for dermabrasion)
- Ex-sanguiination to look paler
- Cutting self to release fat (for liposuction)
- Iron to face to remove wrinkles

I’m going to have surgery...
- Diagnosis of BDD makes satisfaction with surgery unpredictable
- At best, may be satisfied (e.g., when unambiguous) but for many procedures unlikely to alter symptoms of BDD or focus of the preoccupation changes
- More risky if type changes (rhinoplasty)
- At worst, may make preoccupation and handicap worse.
- Offer to discuss with the surgeon
- If determined to have surgery, usually delay therapy
- Good prospective studies required