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Beyond the mirror: Treating body dysmorphic disorder

A multimodal approach appears most effective for this distressing disorder of imagined ugliness

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Identifying which came first—body dysmorphic disorder (BDD) or comorbid anxiety or depressive disorders—can be as complex as treating the disorder's delusional thinking and high suicide risk. To help you when working alone or with a psychotherapist, we offer strategies we have found useful for:

- diagnosing BDD
- educating patients and families about it
- choosing and dosing medications
- addressing inaccurate perceptions with targeted cognitive-behavioral therapies.

continued

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Box

What is body dysmorphic disorder?

Body dysmorphic disorder (BDD) is preoccupation with an imagined defect in physical appearance or excessive concern about a slight physical anomaly that causes significant distress or impairs social, occupational, or other functioning.[1] BDD patients have obsessive thoughts about their "flaws" and engage in compulsive behaviors and avoidances related to how they perceive their appearance, similar to behavior seen in obsessive-compulsive disorder. BDD causes great distress and disability, often accompanied by depression and suicidality.[2]

BDD occurs in an estimated 0.7% of the general population[3] and in 6 to 14% of persons receiving treatment for anxiety or depressive disorders.[4,5] These estimates may be low, however, as persons with BDD often do not seek treatment. Men and women are equally affected.[6] Average age of onset is 16, although diagnosis often doesn't occur for another 10 to 15 years.[7]

Though many recommendations are based on published data, we also draw on our clinical experience because research on effective BDD treatments is limited.

ASSESSMENT

BDD causes patients great distress and disability—often accompanied by major depression—but is easy to miss or misdiagnose *(Box)*.[1-7] Even when suicidal, BDD patients often do not reveal their symptoms to clinicians,[2] probably because of poor insight or shame about their appearance. When a patient describes being unable to stop thinking about specific aspects of his or her appearance, assess further for BDD.

BDD patients' conviction that their appearance is defective ranges from good insight to mildly overvalued ideation to frankly delusional.[8] They often have ideas of reference (such as thinking others may be looking at their "defective" body part) and delusions of reference (such as being convinced others are talking about their "defective" body part). Asking a patient the questions in *Table 1* can help establish the diagnosis. BDD also is included in the Structured Clinical Interview for DSM-IV (SCID). Useful assessment tools include:

- Body Dysmorphic Disorder Questionnaire,[9] a 5-minute, patient-rated scale for screening
- Body Dysmorphic Disorder Examination,[10] to diagnose BDD, survey BDD symptoms, and measure severity
- Yale-Brown Obsessive-Compulsive Scale modified for Body Dysmorphic Disorder (BDD-YBOCS),[11] for measuring symptom severity and changes over time.

Comorbidity. Psychiatric comorbidity is common in BDD *(Table 2)*,[6,7,12-14] and deciding which disorder to address first can be difficult. If there is acute mania or non-BDD psychosis, we suggest that you stabilize these before treating BDD. Suicidality or severe substance dependence or abuse may result from BDD and therefore needs to be treated in conjunction with BDD.

If comorbid obsessive-compulsive disorder (OCD) or social phobia symptoms are interconnected with the patient's BDD, treat concurrently; if not, address sequentially, starting with the more-severe symptoms. For example, symptoms that suggest social phobia (such as fear of public speaking) may be related to BDD, and treatment should focus on BDD. A patient with obsessive fears about how "contaminants" will affect her skin's appearance may need to have the OCD and BDD addressed concurrently.

For other comorbidities, the treatment hierarchy is less clear. Major depression, for example, may be caused by severe BDD and might not improve until BDD improves. Even when a patient has several concurrent Axis I disorders, don't overlook treating BDD; otherwise, the patient may remain quite impaired.

Assess suicide risk, as ≥ 25% of BDD patients may attempt suicide in their lifetimes.[2] Safety measures include frequent monitoring, medication, family involvement, and—if necessary—hospitalization.

PATIENT EDUCATION

Improving insight. Educate patients that BDD is a brain disorder that creates faulty, inaccurate thoughts and perceptions about appearance. Many patients initially resist a BDD diagnosis; delusional thinking and poor insight lead them to assume the "flaw" they see is an accurate perception. They may need to hear about other persons with similar concerns to realize that a psychiatric disorder is causing their distress.

Other helpful resources for improving insight include:

- group therapy
- *The Broken Mirror*, by Katharine A. Phillips, MD,[15] which contains case examples to which BDD sufferers may relate
- Web sites and online forums (see *Related resources*).

Explaining BDD. Discuss possible causes of BDD, giving patients alternate explanations for the physical defects they perceive. Contributing factors may include:

- neurobiological abnormalities and genetic factors[16]
- a history since childhood of shyness, perfectionism, or anxious temperament
- being teased, abused, or in poor family and peer relationships.[17]

Emphasize that multiple, different, converging factors cause BDD for each individual.

Table 1

Patient interview: Questions to help diagnose BDD

Are you concerned about specific parts of your appearance that you believe are ugly or defective?
Do you find it difficult to stop thinking about parts of your appearance?
Do you avoid certain situations, places, or being seen in general because of your appearance?
Do you feel anxious, ashamed, disgusted, or depressed by specific aspects of your appearance?
Are any of your behaviors influenced by your appearance, such as trying to hide parts of your appearance or taking a long time getting ready to leave your residence?
Does your preoccupation cause you a lot of distress, anxiety, disgust, and/or shame?
Is preoccupation with your appearance interfering with your social life, ability to work, job performance, or other important areas of your life?
Do you tend to use mirrors very often or avoid them?
Does what you see in the mirror determine your mood that day?
How important do you think appearance is in life?
Do you use any oral or topical medications for dermatologic reasons or to prevent hair loss?
Have you ever had cosmetic surgery? If so, how satisfied were you with the outcome? Did you have any revisions?

The obsessive-compulsive cycle. Explain that thoughts create distressing emotions, and that persons with BDD try to relieve or prevent these emotions by performing compulsive behaviors. Compulsions then strengthen the association between intrusive thoughts about appearance "defects" and negative feelings about appearance.

Review a list of common compulsions *(Table 3)* with BDD patients, as many have engaged in

Table 2

Lifetime prevalence (%) of comorbid Axis I disorders in BDD

Study	N	Major depression	Social phobia	OCD	Substance use disorders
Gunstad and Phillips (2003)*[12]	175	75	37	30	30
Zimmerman and Mattia (1998)[14]	16	69	69	38	6
Perugi et al (1997)[13]	58	41	12	41	†
Veale et al (1996)[7]	50	8	16	6	2
Hollander et al (1993)[6]	50	68	12	78	22

N: number of study subjects
OCD: obsessive-compulsive disorder
* Phenomenology group
† not reported

Source: Adapted and reprinted with permission from reference 12.

these behaviors for years without realizing they are compulsions.

PHARMACOTHERAPY

BDD is a severe and complex disorder that often requires multimodal treatment using cognitive-behavioral therapy (CBT) and medication (*Algorithm*).[18] In our experience, most BDD patients need medication for the disorder and for common comorbidities. We recommend starting medications before or when beginning CBT for patients with moderate to severe BDD (BDD YBOCs ≥ 20).

Serotonin reuptake inhibitors (SRIs) have reduced BDD symptoms in open-label[19,20] and controlled trials.[21,22] As first-line treatments, SRIs decrease distress, compulsions, and frequency and intensity of obsessions about perceived defects; they also can improve insight.[21-24] SRIs appear equally effective for delusional and nondelusional patients;[21,23] whether CBT is similarly effective is unclear.

Relatively high dosages are usually necessary, according to published flexible-dosing trials in BDD,[19-23] a retrospective chart review[24] and our experience. Try dosages similar to those used for OCD *(Table 4)* as tolerated, and monitor for side effects. Twelve to 16 weeks of treatment are often needed for a full therapeutic effect.[20-21]

Augmentation. Consider adding another agent if a full SRI trial achieves partial symptom relief. One open-label trial of 13 BDD patients found that 6 (46%) improved when buspirone (mean dosage 48.3 mg/d) was added to SRI therapy.[25] In a chart review, Phillips et al[24] reported variable response rates of BDD patients treated with augmentation trials of clomipramine (4/9), buspirone (12/36), lithium (1/5), methylphenidate (1/6), and antipsychotics (2/13).

Few studies have examined antipsychotic use in BDD. Placebo-controlled data are available only for pimozide.[27] Conventional antipsychotics are unlikely to be effective, either as monotherapy[26] or augmentation.[27] As for the atypicals, olanzapine augmentation showed little to no efficacy in one small trial, although the average dosage used was low (4.6 mg/d).[28] In our experience, atypicals—such as aripiprazole, 5 to 30 mg/d; quetiapine 100 to 300 mg/d; olanzapine, 7.5 to 15 mg/d; or risperidone, 1 to 3 mg/d—can improve BDD core symptoms and improve insight.

Algorithm

Strategy for treating body dysmorphic disorder

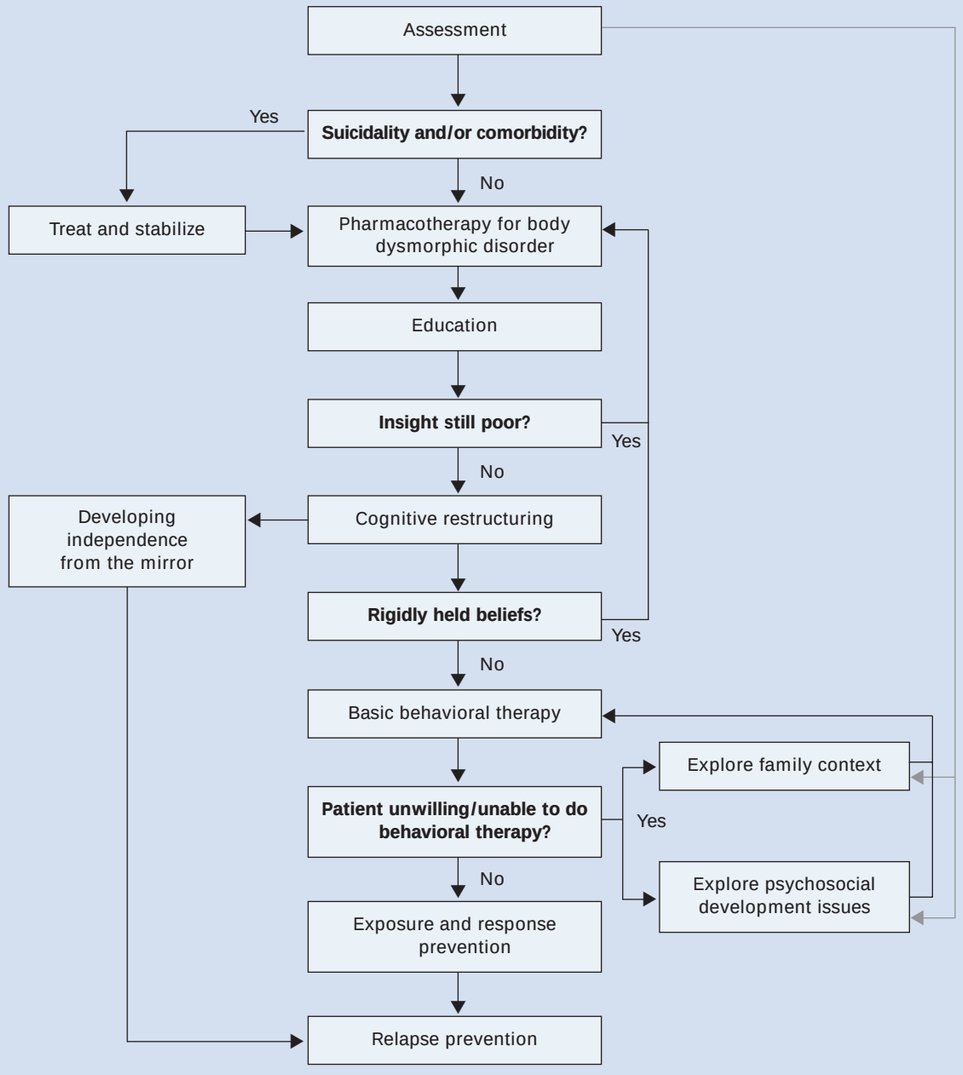

Table 3
Common BDD compulsions and avoidances

Excessive grooming
Excessive checking or avoidance of mirrors and other reflective surfaces
Asking for reassurance about appearance
"Camouflaging" (hiding or covering up) supposed defects
Scrutinizing the appearance of other people and comparing to oneself
Avoiding social interactions
Avoidance of certain lighting conditions
Skin-picking to "fix" perceived flaws
Having repeated cosmetic or dermatological procedures, such as dermabrasion, cosmetic surgery, etc.

Benzodiazepines can be useful for acute anxiety or agitation. Carefully monitor benzodiazepine use, however, as substance abuse is relatively common in BDD patients.[29]

SPECIALIZED CBT TECHNIQUES

Cognitive restructuring. Trying to convince BDD patients there is nothing wrong with their appearance will not be successful. Instead, we use cognitive restructuring to challenge the rationality of their thoughts and beliefs and to find alternate, more rational ones:

Therapist: "I know I cannot convince you that your (body area) is not defective, but can you give me evidence of how this 'defect' has affected your life?"

BDD patient: "Well, I haven't had a date for a long time. I think this is evidence that my (body part) must be ugly, and that no one wants to date me because of it."

Therapist: "What are some other possible reasons why you haven't had a date in a long time? You admitted that you have barely left your house for many months. Is it possible that you have not had a date for a long time because you rarely go outside?"

With cognitive restructuring, patients learn to:

- identify automatic thoughts and beliefs that provoke distress
- examine evidence supporting or refuting these beliefs
- de-catastrophize (such as "What is the worst thing that could happen if you left the house today without checking your [body part]? Do you think you would eventually be able to cope with that?")
- learn to more accurately assess the probability of feared negative consequences
- arrive at rational responses.

In our experience—which is supported by OCD literature—participating in CBT is very hard for patients with frank delusions, and insight determines how effective cognitive restructuring can be.[30] If a patient is convinced a body part is defective, she is unlikely to stay in treatment—much less be open to restructuring her thoughts. Even unsuccessful attempts can help you gauge the intensity of patients' beliefs, however.

During cognitive restructuring, it is important to uncover patients' core beliefs (underlying, organizing principles they hold about themselves, others, and the world). BDD patients commonly believe that appearance is of utmost importance and that no one could love them because of their "defect." The therapist can then help the patient challenge the rationality of those core beliefs.

Behavioral therapy. Basic behavioral therapy attempts to normalize excessive response to appearance concerns and to prepare patients for

continued on page 81

continued from page 74

Table 4
Recommended SRI dosages for treating BDD*†

Drug	Dosage range (mg/d)
Citalopram	40 to 100
Clomipramine	150 to 250
Escitalopram	20 to 50
Fluoxetine	40 to 100
Fluvoxamine	200 to 400
Paroxetine	40 to 100
Sertraline	150 to 400

* Off-label use.
† May exceed FDA-recommended maximum dosages.

exposure and response prevention therapy (ERP). Having identified their compulsions, the next step is to guide patients in changing these behaviors, such as by:

- decreasing reassurance-seeking
- reducing avoidance of social situations
- decreasing opportunities to use the mirror
- reducing time spent on the Internet seeking cosmetic solutions
- increasing eye contact in social situations
- decreasing scanning of others' physical features.

For example, suggest that BDD patients stand at least an arm's length away when using a mirror for normal grooming. Then, instead of focusing on their body part, they will view it within the context of their entire face and body.

EXPOSURE AND RESPONSE PREVENTION

ERP exposes the patient to situations that evoke negative emotions—primarily shame and anxiety in BDD—so that they gradually habituate to these feelings. Individualize exposure exercises, targeting the body parts each person believes are defective. Because these exercises are intended to induce the discomfort patients usually experience, do not attempt ERP until the patient has had extensive education, developed insight, and has consented to treatment.

Create a hierarchy of ERP tasks *(Table 5)*, ranking situations from low- to high-distress. Address items lower on the hierarchy first, and progress to higher items as the lower ones become easier to perform. Do not attempt the highest-distress items until the patient has improved insight and is not severely ill and suicidal.

During exposures, patients must remain in distress-provoking situations—without performing compulsive behaviors—until their negative feelings decrease by at least 50% of the initial subjective, self-rated distress level. Leaving the situation before stress diminishes may reinforce shame and discomfort. Performing compulsive behaviors during or after an exposure will negate the exposure's effect.

Mirrors and ERP. Some therapists use mirrors for exposure exercises, but this is a complex issue. Mirror-checking is a common BDD compulsion that provides temporary relief but ultimately reinforces negative, intrusive thoughts about the disliked body area. How BDD patients perceive themselves changes from moment to moment; they may stare at and analyze any reflective surface in hopes that their "defect" will not appear as deformed or ugly that day. Thus, one cannot predict whether looking in the mirror at any one time is an exposure or a compulsion.

ERP exercises for BDD need to emphasize behaviors that involve interactions with the outside world, rather than reinforcing the importance of appearance. Using the mirror for ERP could promote checking compulsions and may send the message that appearance is the focal

Current PSYCHIATRY

Table 5

Exposure and response therapy: a BDD patient's sample hierarchy

	Subjective distress rating (scale of 0 to 100)
High-distress tasks	
1. Purposely creating the appearance of acne/skin defects	100
2. Intentionally messing up my hair before going in public	100
3. Standing under bright or fluorescent lighting in public	90
4. Sitting in a position where others can directly see my face for an extended period	85
5. Highlighting my face with a flashlight or bright light, while sitting in front of my therapist or another person.	80
Lower-distress tasks	
6. Intentionally going outside in daylight hours, instead of only after dark	70
7. Not turning away from others in an attempt to prevent them from seeing my face	65
8. Standing close to people when talking to them, rather than standing at a distance	50
9. Going out in public without camouflaging my hair with hats or scarves	40

point of treatment. On the other hand, for patients with persistent mirror avoidance, gradual mirror exposures may be useful. A technique called mirror retraining helps patients objectively view their appearance and has been used with success in some individuals.

Body dysmorphic disorder often requires multimodal treatment using cognitive-behavioral therapy (CBT) and medication. Begin by addressing psychiatric comorbidities, suicide risk, insight, and psychosocial or family issues that may thwart CBT.

Bottom Line

PSYCHOSOCIAL DEVELOPMENT

BDD therapy challenges the disorder's core theme—that appearance is one's only important attribute—and helps patients identify and develop qualities not related to appearance. Through social interactions, the BDD patient can:

- develop a multidimensional sense of self
- receive nonappearance-related positive feedback from the outside world.

Explore psychosocial development during the assessment phase and when a patient shows little progress in CBT. In some patients, for example, BDD onset in childhood or adolescence interferes with developmental transition to adulthood.

In our experience, some patients may resist treatment because of conscious and unconscious fears of adult responsibilities and relationships. We focus therapy on making them aware of these phenomena, exploring fears of development, and encouraging them to seek new relationships and responsibilities.

Because a BDD patient's symptoms often create conflict and distress at home, offer the family support and education about the disorder. Occasionally, forces within the family seem to be working against the individual's recovery and/or independence.

In some families, an individual with BDD may become the "identified patient," diverting attention from other dysfunctional family members or relationships. During therapy, the BDD patient's goal to develop a sense of self that is not appearance-based may run counter to the family's need to keep him or her in the "sick" role.

If therapy is to succeed, talk to the patient about these dynamics. Consider family therapy if resistance to change is strong. When a patient is not progressing well with CBT, we find understanding the family system can be useful to com-

Related resources

FOR CLINICIANS:

- Phillips KA. "I'm as ugly as the elephant man:" How to recognize and treat body dysmorphic disorder. *Current Psychiatry* 2002;1(1):58-65.
- Cororve MB, Gleaves DH. Body dysmorphic disorder: a review of conceptualizations, assessment, and treatment strategies. *Clin Psychol Rev* 2001;21(6):949-70.

FOR PATIENTS AND FAMILIES:

- Phillips KA. *The broken mirror.* New York: Oxford University Press; 2005.
- BDD and body image program, Butler Hospital, Providence, RI. BDD education and support. www.BDDcentral.com.
- Winograd A. Director, Accurate Reflections, Los Angeles, CA. Support group and information on BDD and obsessive compulsive spectrum disorders. www.AccurateReflections.com

DRUG BRAND NAMES

Alprazolam • Xanax
Aripiprazole • Abilify
Buspirone • BuSpar
Citalopram • Celexa
Clomipramine • Anafranil
Desipramine • Norpramin
Escitalopram • Lexapro
Fluoxetine • Prozac
Fluvoxamine • Luvox
Lithium • Lithobid, others
Methylphenidate • Ritalin, Concerta
Olanzapine • Zyprexa
Paroxetine • Paxil
Pimozide • Orap
Quetiapine • Seroquel
Risperidone • Risperdal
Sertraline • Zoloft

DISCLOSURES

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

prehensive BDD treatment, although this observation remains to be validated.

PREVENTING AND TREATING RELAPSE

Educate patients that BDD is usually chronic, even when treated with psychotherapy and medication.[31] Relapse often occurs, especially when patients discontinue medications on their own[24] or drop out of therapy early. No guidelines exist, but based on our experience:

- we continue medication for at least 1 year after a patient improves
- psychotherapy is more variable but may need to last 6 to 12 months or more.

When therapy ends, we encourage patients to practice and reinforce everything they learned during treatment. Casting BDD resurgence as normal—and not as failure—will help patients who relapse to resist the downward spiral of low self-esteem, shame, and turning to the mirror for reassurance. Identifying BDD symptom triggers and developing plans to cope with them may also prevent relapse. CBT "booster sessions" scheduled monthly for 3 to 6 months may help patients who have completed therapy.

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