

Review article

Treating body dysmorphic disorder with medication: Evidence, misconceptions, and a suggested approach

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Abstract

Body dysmorphic disorder (BDD) is a relatively common and often disabling disorder with high morbidity and mortality. Both psychotropic medication and cognitive behavioral therapy (CBT) are considered first-line treatments for BDD, and medication treatment is often essential for more severely ill and suicidal patients. In this practical overview of the pharmacotherapy of BDD, we briefly describe BDD's clinical features, associated morbidity, and how to recognize and diagnose BDD. We describe the importance of forming a therapeutic alliance with the patient, the need for psychoeducation, and other essential groundwork for successful treatment of BDD. We review available pharmacotherapy research, with a focus on serotonin-reuptake inhibitors (SSRIs, or SRIs), which are currently considered the medication of choice for BDD. Many patients have substantial improvement in core BDD symptoms, psychosocial functioning, quality of life, suicidality, and other aspects of BDD when treated with appropriate pharmacotherapy that targets BDD symptoms. We also discuss practical issues such as dosing, length of treatment, and potential side effects associated with the use of SRIs. In addition, we discuss pharmacotherapy approaches that can be tried if SRI treatment alone is not adequately helpful. Finally, some misconceptions about pharmacotherapy, gaps in knowledge about BDD's treatment, and the need for additional research are discussed.

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Why treat BDD with medication?

Body dysmorphic disorder (BDD), a distressing or impairing preoccupation with an imagined or slight defect in one's physical appearance, is a relatively common disorder. An estimated 0.7–1.7% of the general population has BDD (Bienvenu et al., 2000; Faravelli et al., 1997; Otto, Wilhelm, Cohen, & Harlow, 2001; Rief, Buhlmann, Wilhelm, Borkenhagen, &

Brahler, 2006). BDD appears far more common than this in inpatient and outpatient settings (Phillips, 2005a). Currently, psychotropic medication and cognitive behavioral therapy (CBT) are considered the first-line treatments for BDD. Medication treatment is appropriate for individuals who meet full DSM-IV criteria for BDD, and, in our view, medication is essential for more severely ill and suicidal patients (Phillips, 2005a). Available data indicate that appropriate pharmacotherapy substantially improves core BDD symptoms, psychosocial functioning, suicidality, and other aspects of BDD in a majority of patients (Phillips, 2005a).

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Several lines of reasoning support the use of medication to treat BDD. First and foremost, available evidence, reviewed in this paper, indicates that certain medications are often efficacious for BDD. In addition, BDD's pathogenesis likely involves genetic/neurobiologic factors (Phillips, 2005a). BDD also has similarities to obsessive compulsive disorder (OCD), social phobia, and major depressive disorder—disorders for which the efficacy of pharmacotherapy is well established (Phillips, 2005a).

In our clinical experience, a major impediment to successful treatment is BDD's under-recognition and underdiagnosis. Indeed, BDD appears to usually go undiagnosed in clinical settings (Grant, Kim, & Crow, 2001; Phillips, McElroy, Keck, Pope, & Hudson, 1993; Phillips, Nierenberg, Brendel, & Fava, 1996; Zimmerman & Mattia, 1998). Therefore, we first present a brief overview of BDD's clinical features, associated morbidity, and how to recognize and diagnose BDD. After briefly discussing essential groundwork for treatment, we review available pharmacotherapy research, with a focus on serotonin-reuptake inhibitors (SSRIs or SRIs), which are currently considered the medication of choice for BDD. We suggest strategies for successfully treating BDD with medication, and we discuss misconceptions about medication. Finally, we note some of the research needed to advance and improve the pharmacologic treatment of patients with this severe illness.

Clinical features of BDD

Appearance preoccupations, poor insight, and compulsive behaviors

Appearance preoccupations

People with BDD are preoccupied with the idea that some aspect(s) of their appearance is ugly, unattractive, deformed, defective, or flawed in some way (Hollander, Cohen, & Simeon, 1993; Phillips, 1991; Phillips et al., 1993; Veale et al., 1996). Concerns may focus on any body area, with multiple areas of concern common. The face or head are frequently disliked, most often the skin (for example, acne, scars, wrinkles, or pale skin), hair (for example, hair thinning or excessive body or facial hair), and nose (for example, size or shape). The preoccupation usually focuses on specific areas but may involve overall appearance, as in muscle dysmorphia (a preoccupation with the idea that one's body is too small or is insufficiently lean or muscular) (Pope, Gruber, Choi, Olivardia, & Phillips, 1997).

BDD preoccupations are time consuming (occurring an average of 3–8 hours a day) and usually difficult to resist or control (Phillips, 2005a). They are distressing and associated with low self-esteem, shame, rejection sensitivity, and high levels of neuroticism, introversion, depressed mood, anxiety, anger–hostility, and perceived stress (Phillips, 2005a). Patients often believe that they are inadequate and unacceptable—e.g., worthless, inadequate, unlovable, and an object of ridicule and rejection (Veale et al., 1996).

Insight/delusional and referential thinking

Most individuals with BDD are largely or completely convinced that their view of their appearance defects is accurate and undistorted. Studies have found that 27–39% of patients are currently delusional (Phillips, 2004; Phillips, Menard, Pagano, Fay, & Stout, 2006). Most do not recognize that their belief is due to a mental illness or has a psychological/psychiatric cause (Phillips, 2004). Several studies have found that insight is poorer in BDD than in OCD (Eisen, Phillips, Coles, & Rasmussen, 2004; McKay, Neziroglu, & Yaryura-Tobias, 1997; Phillips et al., 2007)

In addition, a majority have ideas or delusions of reference, believing that other people take special notice of the supposed defects—for example, stare at them, laugh at them, or recoil in horror because they look so bad (Phillips, 2004).

Compulsive and safety behaviors

Nearly all individuals perform BDD-related compulsive or safety behaviors, which aim to diminish the distress caused by thoughts about the perceived flaws (Phillips, Menard, Fay, & Weisberg, 2005). Common behaviors include compulsively comparing the disliked body areas with the same areas on other people, camouflaging the disliked areas (for example, with a hat, hair, sunglasses, posture, makeup), compulsive checking of mirrors and other reflective surfaces, excessive grooming (for example, makeup application, hair styling, shaving, hair plucking), skin picking, reassurance seeking, and excessive exercise or weightlifting. These behaviors are time consuming (usually occurring for many hours a day) and are difficult to resist or control. More recently identified behaviors include tanning (for example, to darken “pale” skin or cover perceived scars or acne), excessive clothes changing, and compulsive shopping (for example, for beauty products, acne or hair-loss remedies, or clothes), which can cause substantial debt (Phillips, 2005a).

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