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A meta-analysis of psychological and pharmacological treatments for Body Dysmorphic Disorder

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Abstract

Although psychological and pharmacological treatment approaches for Body Dysmorphic Disorder have been evaluated, the relative effectiveness of these two types of interventions has not been examined. We conducted a meta-analysis of randomized clinical trials and case series studies involving psychological (i.e., behavioural, cognitive-behavioural, cognitive) or medication therapies. Our findings support the effectiveness of both types of therapy, but suggest that cognitive-behavioural treatment may be the most useful. These findings require cross-validation through large-scale clinical trials.
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Keywords: Body Dysmorphic Disorder; Meta-analysis; Cognitive-behaviour therapy; Treatment studies

Introduction

Body Dysmorphic Disorder (BDD) is characterized by a preoccupation with an imaginary defect in appearance or an excessive concern with a slight physical abnormality (American Psychiatric Association [APA], 2000) (Phillips, McElroy, Keck, Pope, & Hudson, 1993). This preoccupation causes significant distress for the person and/or is disruptive to his or her daily functioning (APA, 2000). Phillips et al. (1993) found that 97% of the 30 patients with BDD in their study avoided social or occupational activities. Fifty per cent of the patients had at least one

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psychiatric hospitalization due to BDD and 40% experienced suicidal ideation. Social isolation and, in severe cases, failure to leave one's home were also reported.

Psychological and pharmacological treatments for BDD have received increasing attention in the past 10 years. Pharmacotherapy studies have primarily focused on serotonin reuptake inhibitors (SRIs). In medication studies, clomipramine (Hollander et al., 1999), fluvoxamine (Perugi et al., 1996; Phillips, Dwight, & McElroy, 1998; Phillips, McElroy, Dwight, Eisen, & Rasmussen, 2001), fluoxetine (Phillips, Albertini, & Rasmussen, 2002) and citalopram (Phillips & Najjar, 2003) have been examined. Overall, investigators have concluded that SRIs are effective in improving insight as well as in reducing distress and the time occupied by defect-related compulsions (Phillips, 1998). However, the clinical significance of these findings (e.g., magnitude of their effect) has not been evaluated.

Psychological interventions have primarily involved behaviour therapy (BT) and cognitive-behaviour therapy (CBT) (e.g., McKay et al., 1997; Rosen, Reiter, & Orosan, 1995). One notable exception is the study of Geremia and Neziroglu (2001) that involved cognitive therapy in the absence of behavioural interventions.

Several researchers have focused on the efficacy of BT alone, in the absence of a cognitive component (Campisi, 1995; Gomez-Perez, Marks, & Gutierrez-Fisac, 1994; Khemlani-Patel, 2001; Marks & Mishan, 1988; McKay et al., 1997). BT often consists exclusively of exposure and response prevention (ERP; Khemlani-Patel, 2001). During ERP, patients are gradually exposed to anxiety-provoking stimuli (e.g., site of one's nose) and are prevented from engaging in behaviours aimed at reducing anxiety (e.g., hiding the perceived deficit during a conversation). The exposure continues until the anxiety diminishes to a manageable level (Neziroglu & Yaryura-Tobias, 1993). CBT also involves exposure and response prevention, but is augmented with cognitive techniques such as identification of appearance-related automatic thoughts, identification of cognitive distortions, and modification of such cognitions (e.g., Butters & Cash, 1987; Khemlani-Patel, 2001; Veale et al., 1996). Although ERP and CBT have generally been found to be effective in decreasing symptom severity (Looper & Kirmayer, 2002), the efficacy of these treatments compared to medication has not been evaluated.

Both individual (e.g., Campisi, 1995; Gomez-Perez et al., 1994; Khemlani-Patel, 2001; Marks & Mishan, 1988; McKay et al., 1997; Neziroglu, McKay, Todaro, & Yaryura-Tobias, 1996; Neziroglu & Yaryura-Tobias, 1993; Veale et al., 1996) and group therapies (e.g., Rosen et al., 1995; Wilhelm, Otto, Lohr, & Deckersbach, 1999) have been employed. Randomized control trials (RCTs) (Phillips et al., 2002; Veale et al., 1996), case series (Khemlani-Patel, 2001; McKay et al., 1997; Neziroglu et al., 1996; Perugi et al., 1996; Phillips et al., 1998; Phillips & Najjar, 2003), case studies (Campisi, 1995; Geremia & Neziroglu, 2001; Marks & Mishan, 1988; Neziroglu & Yaryura-Tobias, 1993) and a cross-over trial (Hollander et al., 1999) evaluating the effectiveness of treatments for BDD have been conducted. However, effect sizes are typically not discussed and psychotherapeutic and pharmacological treatments have not been compared to one another. To the best of our knowledge, this is the first meta-analytic investigation of this literature. We aimed to examine the efficacy of treatments for BDD and to compare the effectiveness of psychological and pharmacological therapies.

Method

BDD treatment studies were identified through searches of PsycLIT and MedLine databases using the keywords body dysmorphic disorder, dysmorphophobia, and imagined ugliness. Studies

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