


Body Dysmorphic Disorder in the Substance Abuse Treatment Setting



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Historical Perspective

- *Dysmorphophobia* Morselli 1891
 - Subjective feeling of ugliness or physical defect
 - Obsession or shame with the body
 - Kraepelin attributed it to Obsessive Neurosis (OCD)
 - DSM III-R changed diagnosis to Body Dysmorphic Disorder

Diagnostic Criteria for BDD

- A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
- B. The preoccupation causes clinically significant distress or impairment in social , occupational or other important areas of functioning
- c. The preoccupation is not better accounted for by another mental disorder

Joe B.



Joe B.

- ❑ 28 y.o. Single Caucasian Male
- ❑ Referred to treatment for ETOH, benzodiazepines and prescription Opiates
- ❑ 10 year history of BDD focused on a receding hairline that was NOT receding
- ❑ Camouflaging (hats, combing forward)
- ❑ Grooming (2+ hours per day)
- ❑ Mirror checking
- ❑ S/P hair grafts X2

Social History

- ❑ Never married; had a 'serious' GF in college but broke up before graduation
- ❑ Attended an Ivy League law school for one semester but dropped out because he could not tolerate being in the lecture hall
- ❑ Moved to LA where he worked intermittently as a paralegal; usually fired for excessive absences and lateness

Substance Use History

□ Alcohol

- Drank socially in College but began to drink regularly during the day to try to control anxiety while in Law School. Currently drinking between a pint and a fifth of vodka per day

□ Benzodiazepines

- Alprazolam 0.5 mg QID first prescribed for Social Anxiety Disorder
- Currently prescribed Alprazolam 1 mg QID but is taking 2-3 mg QID with Rx's from multiple MDs

Substance Use History (cont.)

- Hydrocodone
 - First prescribed for sprained ankle
 - Currently taking 20-30 per **day**
- Current treatment
 - Venlafaxine 150 mg/day
 - CBT twice weekly

Psychiatric History

- ❑ First diagnosed with Social Anxiety Disorder after dropping out of Law School
- ❑ Diagnosed with Major Depression six months later due to decreased sleep, decreased appetite, decreased energy, feelings of worthlessness and SI
- ❑ Diagnosed with OCD based on grooming rituals
- ❑ Diagnosed with BDD after referral by his dermatologist after 2 hair graft procedures
- ❑ Suicidal ideation but no previous attempts

Location of Perceived Defects

Body Part	Percent (%) with Concern
Skin	73
Hair	56
Nose	37
Eyes	20
Teeth	20
Ugly face	14
Lips	12
Chin	11
Eyebrows	11
Ears	9

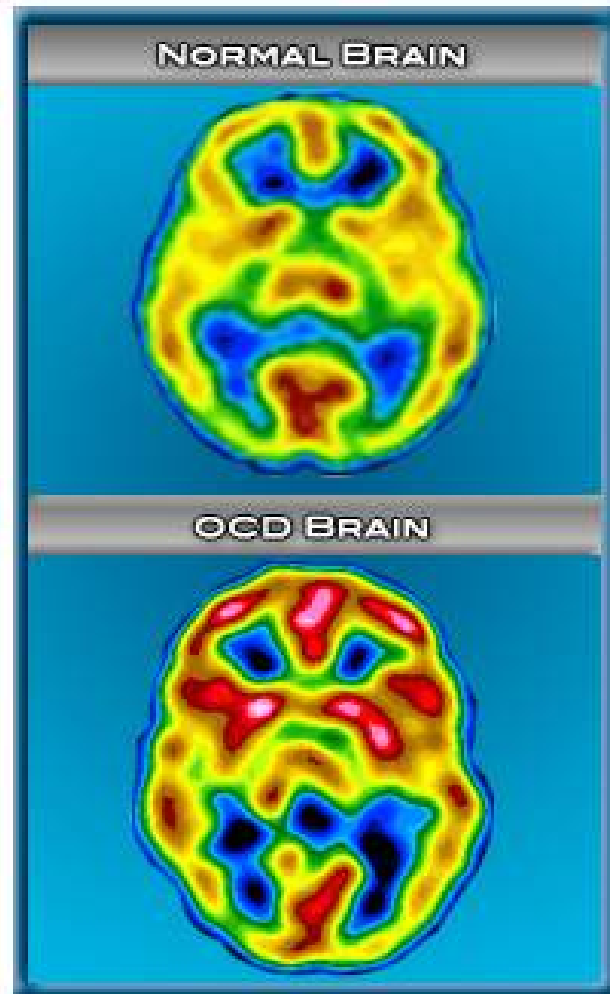
Muscle Dysmorphia

- BDD Subtype with preoccupation with muscularity
 - Extreme fear that their bodies are too small
- Behaviors include:
 - Compulsive weight lifting, 5-6 hours/day
 - Dietary restrictions – obsession with precise ratios of fat/protein/carbohydrates
- Occurs in both men and women

BDD and OCD

	OCD	BDD
Obsessions	contamination, doubt, order/symmetry, sexual thoughts	perceived body defect, causes shame, notice by others, inferiority
Repetitive Behaviors	checking, washing, counting	camouflaging, mirror checking, skin picking
Age of Onset	early adolescence	adolescence
Prevalence	1.6%	1.7%
Genetics	familial risk (4-5X controls)	familial risk (3X controls)
SSRI response	Yes	Yes
Neuroimaging	increased activity in cortico-striatal-thalamo-cortical circuit	caudate asymmetry, left hemisphere differences

SPECT Scan: Normal vs. OCD Brain



BDD Repetitive Behaviors

Table 2: Common behaviors of patients who have body dysmorphic disorder

Behavior	Percentage of people with behavior
Camouflaging	91
With posture	65
With clothing	63
With hand	49
With hair	49
With hat	29
Comparing body part with others	88
Checking appearance in mirrors and other reflecting surfaces	87
Seeking surgery, dermatologist	72
Excessive grooming	59
Seeking reassurance, attempt to convince others that defect is unattractive	54
Touching defect	53
Clothes changing	46
Dieting	39
Skin picking	38
Mirror avoidance	24
Excessive tanning	22
Excessive exercise	21
Excessive weight lifting	18

Data from Phillips KA. The broken mirror: understanding and treating body dysmorphic disorder. New York: Oxford University Press; 2005.

Social Impairment in BDD

- Never married = 70%
- Work related difficulties
 - Unemployment
 - Inadequate education
- Social isolation
- <6% achieve social remission in a 3 yr f/u

The pervasive belief, at times delusional, that others take extraordinary notice of their 'defect'

Developmental Factors

- Nearly 80% report childhood maltreatment
 - Emotional neglect 68%
 - Emotional abuse 56%
 - Physical abuse 35%
 - Physical neglect 33%
 - Sexual abuse 28%
- 40% report maltreatment was 'severe'
- Severity of sexual abuse correlated with current BDD severity but not when other factors controlled
- Attempted suicide was related to emotional, sexual and physical abuse

Suicide

- ❑ 80% report a history of suicidal ***ideation***
- ❑ One in four has attempted suicide
- ❑ Annual rate of completed suicide = 0.3%
- ❑ During 4 year f/u BDD, 3% attempted suicide
- ❑ Treatment with SSRI does not increase suicide risk
- ❑ 29% of subjects in the 12 weeks trial experienced emergent suicidal symptoms

Phillips, KA and Kelly, MM. *Int Clin Psychopharmacol.* 24(1): 26-28, 2009.

Suicide in Adolescents and Adults

Suicidality Lifetime	Adolescents	Adults	<i>P</i>
Ideation	81%	77%	NS
Ideation Due to BDD	47%	57%	NS
Suicide Attempt	44%	24%	0.012
Suicide Attempt Due to BDD	14%	12%	NS

Substance Abuse in BDD



Patterns of Drug Use in BDD

Substance Use Disorder	Total	Abuse	Dependence
Any substance – Lifetime	49%	29%	36%
Any substance – Current	17%	9%	10%
Alcohol – Lifetime	43%	14%	29%
Cannabis – Lifetime	30%	12%	18%
Cocaine – Lifetime	9%	3%	6%
Hallucinogens	9%	7%	2%
Sedative/hypnotics	8%	3%	5%
Opiates	6%	3%	3%
Stimulants	6%	3%	3%
Steroids	2%	0.5%	1.5%

BDD + SUD - Clinical Aspects

- Males:Females = 2:1
- Younger
- Order of onset
 - BDD first = 60%
 - BDD + SUD same year = 21%
 - SUD first = 19%
- 68% report that BDD contributed to SUD
- 30% report BDD as main reason for SUD
- Higher rates of suicide attempts (38% vs 19%)
- Trend to more delusional BDD symptoms

Factors Contributing to SUD

- ❑ High levels of perceived stress
- ❑ Poor quality of life
- ❑ Self-medication for anxiety symptoms

Treatment



SRI and BDD

- Community treatment usually inadequate
 - Dose too low (< 40mg Fluoxetine or equiv)
 - Duration too short (less than 10 weeks)
- 40% Do NOT report BDD sx to their psychiatrist
- Fluoxetine significantly better than placebo
 - 35% decrease in severity vs. 14% on placebo

SRI and BDD (cont.)

- 40% much improved, 15% very much improved
- Mean Fluoxetine dose = 78 mg
- Mean time to response = 7.7 weeks
- Delusional patients responded equally well
- Nearly half are essentially unchanged

Pharmacology (cont.)

- ❑ SRI (Selective Serotonin Reuptake Inhibitors)
 - Fluoxetine, Fluvoxamine, Citalopram appear effective
- ❑ SNRI (Serotonin-Norepinephrine Reuptake Inhibitors)
 - Clomipramine, Venlafaxine
- ❑ Behavioral symptoms may improve less on medications than distress measures
- ❑ Symptoms continue to improve with maintenance treatment up to several years
- ❑ Non-responders should be switched to another SRI, or augmented with Buspirone

Psychotherapy for BDD

- CBT
 - Identification of appearance related automatic thoughts
 - Identification of cognitive distortions
- BT
 - Exposure and Response Prevention

Cognitive Interventions

- Weekly – twice weekly
- Cognitive distortion
 - Others react negatively due to appearance
 - Results in rituals, social avoidance
- Identification of self-defeating thoughts
- Rehearsing/journaling adaptive responses to thoughts
- Replacing critical self-talk with more descriptive/objective remarks

Exposure and Response Prevention

- Engaging in social setting without engaging in preferred compulsion (e.g. camouflaging)
- Refraining from mirror checking
- Setting limits on grooming time

Joe B. - Course of Treatment

- Successful detox with Phenobarbital for benzodiazepine dependence and Suboxone, Clonidine and Trazadone for opiate dependence
- Venlafaxine increased to 225 mg/day
- Quetiapine added for anxiety, insomnia, obsessions

Clinical Course (cont.)

- ❑ Patient left AMA at the end of detox
 - Initially C/O discomfort sitting in groups
 - Later reported that shared bathrooms interfered with his grooming (2-3 hrs/day)
- ❑ Continued in IOP where he completed an additional 10 weeks of treatment
- ❑ Found a sponsor but had difficulty with small meetings. Attending speaker meetings
- ❑ Drug tests consistently negative
- ❑ After 6 months reported little improvement in BDD but NO substance misuse, NO suicidal ideation

Clinical Course of BDD and SUD

- SUD remission .29 over 3 years
- BDD full remission .17 over 3 years
- Participation in 12 step programs makes a difference in both SUD and BDD
- Benefits due to helping behaviors (service)
 - More than twice the rate of remission
- Significance of linkage between the helping behaviors and outcome

Pagano ME et al., *J. Stud. Alcohol and Drugs*
68:291-295. 2007

Substance Abuse and Suicide



Suicide and Substance Abuse

- ❑ Suicide is a leading cause of death in patients who abuse alcohol and drugs
- ❑ Patients with Alcohol Abuse or Dependence have 10X risk of suicide
- ❑ Intravenous drug users have 14X risk of suicide
- ❑ Clients entering treatment are especially high risk due to a myriad of stressors

Factors Related to Suicide

Cross sectional studies show that in ETOH dependence, attempted suicides are associated with:

- More severe course of dependence
- Higher rates of psychiatric co-morbidity
- Higher rates of other SUD's
- Higher rates of current unemployment
- Separation and divorce
- Fewer years of education

Protective Factors

- Reasons for living
- Clean and sober
- Attending support groups
- Religious beliefs against suicide
- Childrearing responsibilities
- Intact marriage
- Trusting relationship with clinician, MD or other care provider
- Employment
- Looking at the bright side of life

VA Longitudinal Study

- ❑ Prospective study of patients entering SUD Rx
- ❑ 8,807 patients studied at baseline and 1 year after entering treatment
- ❑ No subjects excluded
- ❑ Measures:
 - Psych and Substance abuse severity: ASI
 - Medical hospitalizations, days missed from work
 - Legal: treatment court remanded; probation/parole; awaiting trial
 - Employment/Social functioning: years of education, profession, driver's license, own a car, 3 paid days for work in previous 30 days
 - Demographics Illgen et al. 2007 *Predictors of Suicide Attempt One Year After Entry Into SUD Treatment*

Baseline Results

- 1 of 25 patients reported a suicide ATTEMPT within 30 days of their 1yr follow-up
- Psych predictors included: depression, anxiety, hallucinations, cognitive processing, controlling violent behavior, suicidal thoughts, and suicide attempt in past 30 days
- ***BUT*** all were proxies for lifetime suicide attempt

Other Baseline Findings

- ❑ Other risk factors: psychiatric problem 30d before baseline, number of prior inpatient Rx episodes, taking psychotropic meds at time of admission
- ❑ Years of cocaine use (age adjusted) was predictive
- ❑ # days of ETOH problems in 30d prior to admit was also predictive
- ❑ *Any baseline legal involvement conferred a LOWER risk of suicide*

Treatment Factors

- Number of days of SUD treatment but NOT Psych Rx was associated with lower risk of suicide attempt
- No overlap between baseline predictors and SUD treatment days (suicide severity/psych symptoms, alcohol problems, cocaine yrs, criminal justice involvement)
- High treatment participation lowers suicide risk in high risk clients by 50%

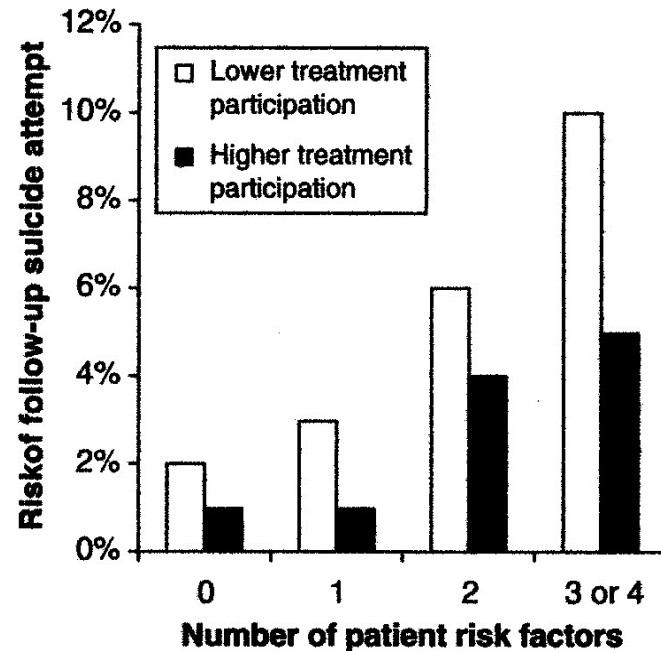


Fig. 1. Role of treatment participation in predicting future suicide attempt in patients with differing levels of baseline risk.

Assessment of Suicidal Alcoholics

- ❑ Suicide needs to be assessed in all ETOH patients at the beginning of treatment
- ❑ 77% of Alcoholics who commit suicide communicate suicidal ideation before they killed themselves
- ❑ Periodic reassessment is necessary since suicidal behavior is stigmatizing and information may not be volunteered
- ❑ Thoughts of death/wishes to be dead; suicidal thoughts; specific suicidal plan with means to implement
- ❑ Clients should be evaluated for other psychiatric disorders

Warning Signs for Suicide

- Suicidal communication
 - Threatening to hurt-kill him/herself
 - Talking about wanting to hurt-kill him/herself
- Seeking access to a method
 - Firearms, pills, hanging
- Making preparations
 - Writing or talking about death, dying, suicide
 - Giving away possessions, housing

Managing Suicidal BDD/ETOH clients

- ❑ Imminent suicidal plan or intent warrants psychiatric hospitalization
- ❑ Suicidal ideation may be short-lived when associated with alcoholic binge or withdrawal
- ❑ Removal of dangers at home pre-discharge (firearms, poisons, potentially lethal medications)
- ❑ SSRI's significantly decreased depressive sx (including suicidal ideation) in alcoholics; no increase SI in BDD
- ❑ Lithium decreases suicidal risk in non-alcoholic BP patients 7-fold but has not been studied in alcoholic patients, OCD, BDD.

Conclusions

- ❑ Suicide rates are markedly elevated in both BDD and SUD
- ❑ Clinicians need to evaluate for suicide risk in each client and at every visit
- ❑ Prior history of a suicide attempt and severity of BDD increase risk
- ❑ Protective factors cannot be relied upon in patients with suicidal ideation
- ❑ Retention in SUD treatment but not psych treatment lowers risks in co-morbid clients
- ❑ Unclear if medication or psych hosp decrease risk

Summary

- ❑ Despite extensive psychiatric treatment BDD was not revealed to treating psychiatrists
- ❑ Unsuccessful cosmetic procedure (from patient perspective) led to referral
- ❑ Substance dependence not revealed until patient was in psychotherapy
- ❑ Treatment of Substance Dependency - Mixed was successful despite limited improvement in other symptoms
- ❑ AA provided a context for progressive exposure, response prevention and altruistic activity

Thank You.

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