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StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-.

# Body Dysmorphic Disorder

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Last Update: November 20, 2020.

## Introduction

Body dysmorphic disorder, or BDD, formally known as dysmorphophobia, is a psychiatric condition defined in the DSM 5 as a preoccupation with a perceived defect or flaw in one's physical appearance that is either not noticeable or only slightly observable by others. The preoccupation is severe enough to cause marked impairment in social, academic, occupational, or other areas of functioning. In order to meet diagnostic criteria, an individual at some point during the illness must engage in repetitive behaviors, such as excessive mirror checking, camouflaging (i.e., covering up the defect with makeup, clothing, etc.), skin picking, excessive grooming, excessive weight lifting or pervasive mental acts such as comparing one's appearance to others. These behaviors are typically time-consuming, difficult to control, and are distressing to the individual. On average, these acts will last around 3 to 8 hours per day. The perceived physical flaws most commonly occur on the skin, hair, or nose, but any body part can be involved. Individuals with this disorder, on average, experience preoccupations with 5 to 7 different body parts throughout his or her life. A subcategory of BDD is muscle dysmorphia, where an individual perceives his or her muscles to be too small or insufficient. Another form of this disorder is BDD by proxy, which involves an individual's preoccupation with a perceived physical defect in another person.[1]

In 1891, Enrico Morselli, an Italian psychiatrist, coined the term dysmorphophobia to describe the condition of people who perceive themselves as flawed but with no apparent physical deformities. This term was derived from the Greek word "dysmorfia," which means "ugliness." Cases of this condition have been discussed by Pierre Janet, a French psychologist, who labeled it as "l'obsession de la honte du corps," which translates to "obsessions of shame of the body." Sigmund Freud also detailed a case known as "Wolf Man," a man with an obsession with his nose, which caused him significant social distress. This condition was first recognized in the DSM in 1980 as an atypical somatoform disorder. In 1987, it was classified as a distinct somatoform disorder. DSM 5 now classifies BDD under obsessive-compulsive and related disorders.[2]

## Etiology

The etiology of BDD appears to develop from biological, cultural, psychosocial, and neuropsychological factors.[3] Research suggests that a history of parental neglect or emotional, physical, or sexual abuse during childhood is related to BDD.[3][4] One study demonstrated that individuals with BDD reported experiencing more traumatic events in early childhood in comparison to healthy controls.[4] BDD might have a genetic component, as studies have shown that individuals with a first-degree relative with the condition experience BDD three to eight times higher than the general population.[3]

## Epidemiology

Body dysmorphic disorder has been estimated to have a prevalence of 1.9% in the community, around 5.9% in adult outpatient psychiatric settings, and 7.4% in adult inpatient psychiatric settings.[1] BDD is estimated to occur in 2.2% of adolescent populations and 3.3% of student populations.[5] BDD is more commonly seen in cosmetic-related settings, such as in cosmetic surgery (13.2%), dermatology (11.3%), rhinoplasty surgery (20.1%), and orthognathic surgery (11.2%).[1] Research demonstrates variability with gender ratios with an estimated range between 1 to 1 and 3 to 2 of females to males.[6] In the psychiatric setting, the ratio of females to males is approximately equal. In community settings, females appear to be affected at higher rates.[7] BDD most commonly starts during

adolescence.[3]

## Pathophysiology

Research indicates abnormalities in frontostriatal and temporoparietaloccipital circuits involving visual-spatial processing.[7] Greater left hemisphere activity, specifically in the lateral prefrontal cortex and lateral temporal lobes was observed in individuals with BDD in comparison to controls, indicating more detail-oriented visual facial processing as opposed to more global holistic processing.[3] Research has also shown possible differences in brain morphology, with a smaller orbital frontal cortex and anterior cingulate volume and increased total white matter compared to healthy control subjects.[8]

## History and Physical

On examination, the provider must distinguish between a perceived flaw versus a true physical defect. Skin lesions secondary to skin picking are common with body dysmorphic disorder and can be observed during the examination of the patient. Obtaining a thorough history of cosmetic procedures and surgical interventions is essential, along with past psychiatric history, prior suicide attempts, suicidal ideations, and previous treatments.[7]

## Evaluation

Body dysmorphic disorder can be difficult to identify because individuals often have limited insight into the condition or carry feelings of shame and embarrassment regarding the preoccupations.[9]

Assessment questions include:

- Do you feel concerned about your appearance?
- How much time do you spend worrying about this or trying to change it?
- How have you been affected by this in terms of quality of life?

When determining the severity of distress and impairment, it is essential to look at social, occupational, and academic functioning. Assess for obsessive thoughts and repetitive behaviors, including the amount of time, level of impairment, and distress these thoughts and behaviors cause. These behaviors can include camouflaging, comparisons to others, seeking reassurance from others, skin picking, frequent mirror checking, and excessive grooming.[6] Providers should also screen for suicidal ideations, delusions, and mood disorder symptoms.

BDD can be specified with the degree of insight, which includes good, fair, poor, absent, and delusional.

The current standard of assessment for BDD is the Yale-Brown Obsessive-Compulsive Scale (modified for BDD), which is a 12-item measurement conducted by the provider.[10] Self-administered questionnaires, including the Body Dysmorphic Disorder Questionnaire, can be used as a quick screening tool.

## Treatment / Management

Treatment of body dysmorphic disorder includes psychological and pharmacological interventions. Research suggests the benefits of psychotherapy, including cognitive-behavioral therapy (CBT) and metacognitive therapy. SSRIs such as fluoxetine have been shown to be beneficial.[11][12] Studies have suggested that clomipramine is helpful for BDD in comparison to desipramine.[11] However, not a large amount of randomized controlled trials (RCTs) exist regarding the efficacy of other pharmacological interventions.[12] Currently, there are no RCTs directly comparing the efficacy of therapy alone versus treatment with medications alone.[1] Attempting to correct the perceived flaw with cosmetic or surgical interventions has been shown not to improve outcomes and has the potential to make the disorder worse.[7]

## Differential Diagnosis

Differential diagnoses include eating disorders, other obsessive-compulsive disorders, illness anxiety disorders, depressive disorders, anxiety disorders, and psychotic disorders. Body dysmorphic disorder symptoms should not be better explained by any of these conditions, although these can co-occur with BDD.[1]

## Prognosis

Although body dysmorphic disorder is thought to be a chronic disorder, studies suggest likely response to evidence-based treatments. RCTs have shown a response rate of 50% to 80% with pharmacological treatment. Response rates can be monitored over time with BDD rating assessments mentioned above. Relapse rates were shown to decrease with long-term pharmacologic treatment.[13]

## Complications

Comorbid psychiatric disorders are common with body dysmorphic disorder and result in greater functional impairment. MDD is the most prevalent comorbid condition. Anxiety disorders, substance abuse, and OCD are also common.[14] BDD results in marked dysfunction in social, academic, occupational, or other areas of functioning. Individuals with BDD often avoid social activities, intimate relationships, or engaging in work or school.[1] Individuals with BDD have been found to be 2.6 times more likely to attempt suicide and four times more likely to experience suicidal ideation than someone without the condition. Studies have shown that around one-third of individuals with BDD are delusional, which leads to greater severity of symptoms and a higher impairment of functioning.[1]

## Deterrence and Patient Education

Psychoeducation regarding body dysmorphic disorder is important, as many patients lack insight into the condition. Patients should be discouraged from seeking cosmetic procedures, as this has not been shown to improve outcomes.[6]

## Enhancing Healthcare Team Outcomes

Individuals are more likely to first present to other medical providers, including cosmetic surgeons and dermatologists, before being evaluated by mental health professionals. Body dysmorphic disorder is usually not identified in individuals until 10 to 15 years after the onset of the condition.[7] Studies have shown that cosmetic professionals have some degree of awareness of BDD. However, the number of patients who are identified to have this disorder is far less than the estimated prevalence of BDD in these clinical settings. Screening tools, such as the Yale-Brown Obsessive-Compulsive Scale (modified for BDD) and the Body Dysmorphic Disorder Questionnaire, can be used as a quick assessment. It is important for providers, such as dermatologists, plastic surgeons, primary care physicians, etc., to be able to screen and identify for BDD and to make appropriate referrals and collaborate with psychiatrists and psychologists.[15]

## Continuing Education / Review Questions

- Access free multiple choice questions on this topic.
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Bookshelf ID: NBK555901 PMID: 32310361