

Recognizing Body Dysmorphic Disorder (Dysmorphophobia)

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ABSTRACT

Dysmorphophobia is a psychiatric condition which frequently presents in the clinics of dermatologists and plastic surgeons. This disorder (also called body dysmorphic disorder) is troublesome to the patient whilst being confusing for the doctor. This commonly undiagnosed condition can be detected by a few simple steps. Timely referral to a psychiatrist benefits most patients suffering from it. This article describes with a case vignette, how to recognize body dysmorphic disorder presenting in the dermatological or aesthetic surgery set up. Diagnostic criteria, etiology, approach to patient, management strategy and when to refer are important learning points. The importance of recognizing this disorder timely and referring the patient to the psychiatrist for appropriate treatment is crucial. This article covers all aspects of body dysmorphic disorder relevant to dermatologists and plastic surgeons and hopes to be useful in a better understanding of this disorder.

KEYWORDS: Body dysmorphic disorder, dysmorphophobia, psychiatrist referral

Case vignette: A 20-year-old student of XII standard was brought to a dermatologist by her parents for the treatment of acne and a scar on her forehead, neither which were clearly visible to her parents or the doctors. On more careful examination, a minor, nearly invisible scar was seen on her forehead and what she called acne was a very mild skin blemish on her cheeks. Her parents informed that even though her skin problems were negligible, her concern regarding them was not. She kept on worrying the entire day regarding how ugly they made her look and could not be reassured by anyone that these scars and acne were hardly visible. She checked her face repeatedly in the mirror all day and constantly asked for her parents "honest opinion" on her looks. She used to buy and apply different kinds of makeup to cover up her defects and grew her hair so long as to practically cover her forehead and cheeks with it. She used to wear very dull colored clothes so as to avoid being noticed by anyone as she believed everyone looks at her and makes fun of her facial appearance. She was a

good student had recently dropped out of school as she felt kids were making fun of her ugliness. Her ritualistic mirror checking was drowning her study time, and she could not cope. She did not like to go anywhere, except to clinics of skin specialists or plastic surgeons who, she hoped eagerly, could "cure her ugliness." She had read about every possible scar removal technique and acne treatment on the internet and was unusually well versed in this regard. Her parents informed that the moment a dermatologist said that she does not need any treatment, she asked to go to another one, and that they have been doctor-shopping on her persistence since last year. She was finally referred to a psychiatrist where she continued regular treatment. She responded to fluoxetine (40 mg) and cognitive behavior therapy. Response to treatment came after 2 months of regular therapy and her overall distress and dysfunction diminished even though the

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feeling of being ugly got only attenuated. Despite the persisting mild thoughts of having skin problems, her preoccupation with it and repeated mirror checking got significantly reduced. She resumed her studies and got back to a more social life after the treatment.

INTRODUCTION

It is not uncommon to see young girls and boys being excessively worried about their appearance. It is, however, very common to have missed diagnosable cases of dysmorphophobia [or body dysmorphic disorder (BDD)] coming to the dermatologist/cosmetologist for correction of their “self-perceived” defects.

BDD is a psychiatric disorder that is more common between the ages of 15 years and 30 years and more prevalent in women than in men.^[1] It is a relatively common disorder with point prevalence of 0.7-4% in the US alone. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), reports that 7-8% of patients who seek plastic surgeries have BDD but this may very well be just the tip of the iceberg as far as the prevalence of BDD is concerned. BDD is common among the dermatological patients.^[2] Clinical features may have some gender differences.^[3,4]

How to recognize a case of BDD?

Typically, the patients suffering from this disorder are the ones who present with unusually overwhelming concerns with the self-perceived defects in their face or other body parts at the clinics of dermatologists or plastic surgeons. However, these defects are usually not recognized by the onlookers or are ignorable or slight. Also, peculiar is their preoccupation with these defects that are evident in their narrations or information by their family members. These patients are so centered on their facial or body defects that they ignore other more important aspects of life such as work or family or even their health and well-being. The worry associated with the “imagined” or “slight” defects is so deep-rooted and troublesome for these patients that they spend nearly all their time distressing over it or making unsatisfying attempts to hide it with make up or hair. They indulge in fruitless behaviors such as repeated mirror checking or asking others “how bad do I look?”. Such patients are frequently found comparing their appearance to others and almost always feel that they are at the losing end. The constant belief of being “ugly” or “unattractive” or even “repulsive” surmounts their entire thought process and no amount of reassurance or negation of the defect can convince or appease them. They usually avoid public gatherings, and when they are forced to go to any they feel everyone is staring at their defects and are ridiculing them. Many such patients of BDD are housebound and prefer to avoid the imagined scrutiny of their appearance

even if it costs them their jobs or studies. More than 20% patients are unemployed^[5] and 55% are unmarried.^[6] The overall distress and dysfunction is very significant in these patients. But the real plight of their negative emotional state is best understood by the realization of the fact that one fifth of patients of dysmorphophobia attempt suicide, and some succeed! BDD increases the likelihood of suicide.^[5,7]

So much pain for just a slight or even nonexistent bodily defect seems so trivial a cause for disturbing one’s life so much, let alone for ending it! This brings one to the pertinent question – why is physical appearance most important for these patients? Psychoanalysts argue that “it is not actually” and that the body part perceived as defective is only a symbol of underlying emotional conflict that is complexly referred and reflected to a random body part. Other theorists with psychosocial understanding explain that our concepts of what is beautiful and what is ugly are conditioned by our families and culture and may be stringent or stereotypical. Individuals with low self-esteem or poor development of a stable sense of self, get anxious when they find themselves not meeting descriptions of beauty accurately. They confuse beauty with acceptability and feel that unattractive people are hated by all. Biological sciences and the current diagnostic criteria given in the DSM-5 consider BDD to be a part of the obsessive compulsive disorder (OCD) spectrum, wherein the neurotransmitter serotonin is specifically implicated and response to drugs used in OCD, which are selective serotonin reuptake inhibitors (SSRIs), is significant. Functional neuroimaging studies (fMRIs) in a recent study suggest that the fault lies in the visual processing of images in the patients of BDD.^[8,9]

However, it must be understood that dysmorphophobia or BDD is a rather poorly studied condition. A significant reason is also because very few patients suffering from BDD actually reach the psychiatrist. Most are only frequent visitors and treatment seekers coming to dermatologists, cosmetologists, and plastic surgeons. And because of the relatively sparse understanding of this disorder among these doctors, it prevents an objective recognition and thereafter psychiatric referrals of patients of BDD.

In more ways than one, the onus lies on the doctors of these specialties (that the patient seeks for the correction of aesthetic defects), to timely identify and refer patients of dysmorphophobia for psychiatric intervention. As much as a medical concern, dermatologists and plastic surgeons are also ethically obligated to refer these patients to psychiatrists before indulging in costly and usually multiple procedures for these patients.

The diagnostic criteria in the DSM-5^[10] for BDD by the American Psychiatric Association are given in Table 1.

Apart from being a major diagnostic criteria, DSM-5 criteria also help to understand the concern with the defect especially a specific facial feature (usually the nose), or more than one feature (such as a crooked nose and a short forehead), or a vague and incomprehensive feature (such as a scrunchy chin or a feeble smile). The patient's complaint may be a general, nonspecific "ugliness" of the face or may include "defects" of other body parts such as breasts, calves, bottoms, skin, and genitalia. The body part with defect may remain constant or may change over a period of time. Males may be obsessed with an "unmuscular" body with a need to "bulk up."^[11] Another peculiar feature is the unusually dramatic expectation that these patients have from the corrective procedures/surgeries, which is usually unmet after the surgery as a result many patients may request for repetitive corrective procedures. Literature is abundant with cases in which patients opt for multiple surgeries, repeated number of times, to attain the "perfect look" that they can never attain as satisfaction with one's appearance is essentially absent in such cases. Such patients take the risk of surgical complications multiple times and continue to remain unsatisfied no matter what the real outcome of the procedure is. Repetitive procedures make their appearance suffer further but that does not limit their obsession with their imagined facial defect. No one can convince these patients that their concerns about their appearance are baseless or unnecessary not even doctors or plastic surgeons. The only hope and response rests in psychiatric intervention.

Table 1: DSM-5 criteria for body dysmorphic disorder

- a. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- b. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
- c. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- d. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Specify if:

With muscle dysmorphia

Specify if:

Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed").

With good or fair insight

With poor insight

With absent insight/delusional beliefs

Note: The above data (diagnostic criteria and specifiers) are adopted from the DSM-5 (American Psychiatric Association, 2013).

BDD is not very difficult to diagnose but there are a few important considerations in doing that. One has to make sure that it is not confused with a genuine concern regarding a genuinely significant defect in appearance for which patient wants correction. As per the diagnostic criteria, the defect in appearance should be either "imagined" or only "slight" and not prominent. Also the concerns with excessive weight point toward eating disorders and not BDD. One must try and make sure that the negative self-image is not a function of depression alone from which the patient is suffering (depression could be a result of BDD but should not be the cause essentially). Also the patient must not be suffering from psychosis that alters his judgment and perception.

The focus of BDD patients is by definition on physical appearance. Data exist on patients with BDD having obsessional concerns about odor. Given the significant overlap between halitosis and BDD, one can postulate that halitosis is a variant of BDD and the diagnostic criteria of BDD should be extended to include the concerns about odor.^[12] Whether halitosis or olfactory reference syndrome is a truly unique disorder, or merely a part of symptomatology of other psychiatric conditions, remain controversial.^[13]

Patients suffering from dysmorphophobia may have other comorbidities such as depression, social phobia, and OCD and delusional disorder.^[14]

The course of BDD may be protracted and undulating. The asymptomatic period may be sparse.^[15]

How to approach a case of BDD?

While approaching such patients, one needs to be cautious so as to not scare them away by labeling their concerns with their appearance as "baseless" and their complaints as purely psychological. One has to first try and develop a rapport with the patient and his family, which is possible only after patiently listening to their complaints, in an understanding and empathetic manner. After reassuring and answering all queries of the patient, one must make an earnest attempt of bringing the focus of the discussion from the physical defect to the distress and dysfunction the patient has been actually suffering. Thereafter, the patient and his family should be explained about the disorder, BDD, and the suggestion to meet a psychiatrist should be made so that their condition can improve properly after that.

Management of BDD

Management of BDD is essentially done by a psychiatrist and his team. There is a role of medications as well as psychotherapy in the treatment of BDD. SSRIs are a group of antidepressants that are known to reduce symptoms in at least 50% of patients of BDD.^[1] Augmentation with antipsychotics may improve response in more resistant cases.^[16] There are studies that report of a positive

response to psychotherapies such as cognitive behavior therapy.^[17-19] Some studies recommend the combination of medications and psychotherapy.

Why to refer to psychiatrist?

Let us now come to why is it important for dermatologists to recognize and diagnose and refer BDD? It is because first, such patients will never be satisfied with any procedure. Second, because the defect is not physical but essentially psychological in nature, and treatment of the disorder and response are expected with psychiatric interventions only. Also, it is ethically incorrect to take advantage of a person's mental illness and charge him for procedures that he does not need. And importantly, to prevent malpractice suits as unsatisfied patients are more likely to sue. Finally referring BDD patients to a psychiatrist will contribute to a better understanding and research about this disorder.

When to refer a case of BDD to a psychiatrist?

1. In case of a diagnostic dilemma.
2. When the presentation convincingly meets the diagnostic criteria mentioned earlier in this article.
3. When a patient is persistently unsatisfied after repeated treatments or cannot be reassured.
4. When a patient's life seems to revolve around his slight defect.
5. Ideally a psychiatrist's opinion should be sought before treating the dermatological defect of any such patient whose defect is slight and his concern is out of proportion.

As it is often said that "beauty lies in the eyes of the beholder" in this case it is the invisible ugliness that lies in the eyes of such persons when they look at the mirror. The mirror reflects not what is present in appearance, but what is missing in the soul.

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