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Body Dysmorphic Disorder: A Guide for Primary Care Physicians

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Body dysmorphic disorder (BDD), also known as dysmorphophobia, is a relatively common yet under-recognized psychiatric disorder that often presents to non-psychiatric physicians.[34, 35] Although the symptoms may sound trivial, in more severe cases individuals with this disorder may be unable to work, socialize, or leave their homes, and some commit suicide.[34, 35, 44] These patients, especially those with more severe BDD, can be challenging to treat. As one dermatologist stated, "I know of no more difficult patients to treat than those with body dysmorphic disorder."[7]

Although BDD remains under-recognized by mental health and other medical professionals, it has been described for more than a century and reported around the world.[34] BDD is included as a separate diagnosis in DSM-IV, psychiatry's diagnostic manual.[2] As defined in DSM-IV, BDD consists of a preoccupation with an imagined defect in appearance; if a slight physical anomaly is present, the person's concern is markedly excessive. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The dermatology literature contains many descriptions of patients with BDD, often under such rubrics as dysmorphophobia,[5, 6] dysmorphic syndrome,[24, 25] dermatologic hypochondriasis,[60] dermatological non-disease,[6] monosymptomatic hypochondriasis non-disease,[6] and monosymptomatic hypochondriasis (delusions of dysmorphosis).[5] Patients with BDD who compulsively pick their skin often are referred to as having "psychogenic excoriation."[15, 48]

The surgery literature, too, contains many descriptions of BDD, referring to these patients as having "minimal deformity,"[10] as "insatiable" surgery patients,[14] as "psychologically disturbed" patients,[11] and as "poly-surgery addicts."[13] (Because these studies generally did not use rigorous diagnostic criteria, it is likely that some, although not all, of the patients described by these terms have BDD.) Surgery and dermatology literature note that the treatment outcome of these patients is frequently poor, with patients often voicing dissatisfaction with an outcome that is objectively acceptable. In some cases, the patient is satisfied with the appearance of the treated body part but then focuses their dissatisfaction on another body area.[5, 6, 13, 16, 24, 34]

This clinically focused chapter provides an overview of BDD for primary care physicians. It describes BDD's clinical features and prevalence, its treatment response, and how to recognize and diagnose BDD. The authors also offer suggestions for primary care physicians who encounter these often difficult-to-treat, high-risk patients.

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CLINICAL FEATURES

Appearance Preoccupations

Individuals with BDD are preoccupied with the thought that some aspect of their appearance is unattractive, deformed, or *not right* in some way.[34, 35, 44] These preoccupations commonly involve the face or head, although any body part can be the focus of concern.[39, 44] The most common areas of concern are the skin, hair, and nose.[18, 39, 56] Patients often present with worries about acne, scarring, facial lines, marks, or pale skin; thinning head hair or excessive body hair; or a large or crooked nose. In reality, the body area appears normal or the flaw is minimal (e.g., not readily noticeable at conversational distance). These minimal or nonexistent appearance flaws are perceived by the patient to be unattractive, devastating, and the cause of much anxiety and distress. *Muscle dysmorphia* is a type of BDD in which individuals (usually men) worry that their body build is small and puny, when in reality they are typically large and muscular.[50]

BDD preoccupations are distressing, time consuming, and usually difficult to resist or control. Most patients have poor insight or are delusional, not recognizing that the flaw they perceive is actually minimal or nonexistent.[45] When the clinician reassures them that they look fine, or attempts to talk them out of their belief about the perceived deformity, most patients are not swayed from their view. A majority of individuals have ideas or delusions of reference[44, 45]; that is, they think that other people take special notice of the supposed defect and perhaps talk about it or mock it. For example, a woman with BDD thought that motorists who drove by her would get into car accidents because they would be so horrified by her supposed ugliness.

Repetitive Behaviors

Nearly all patients with BDD engage in one or more repetitive, often time-consuming, and compulsive behaviors.[35, 39, 44] The usual intent of such behaviors is to examine, improve, or hide the perceived defect. The behaviors include excessive checking of the perceived appearance flaw in mirrors and other reflecting surfaces. Many patients groom excessively (e.g., they comb, style, wash, or cut their hair for hours a day). A majority of sufferers camouflage the perceived deformity with hair, makeup, body positioning, or clothing (e.g., wearing a hat to hide “balding”). To avoid looking “pale,” some individuals tan excessively, even to the point of severely burning and damaging their skin. Other common behaviors include comparing their appearance with that of other people, seeking reassurance about how they look (usually without believing the reassurance provided), and compulsively and repeatedly requesting dermatologic treatment or cosmetic surgery.

Approximately one-third of patients compulsively pick at their skin, trying to remove minor blemishes or otherwise clear or perfect their skin.[48] A growing literature documents how time consuming and problematic this behavior can be. Some of the authors’ patients, for example, report that they spend 8 or 12 hours a day picking at their skin. They may use their fingers or implements such as pins, needles, staple removers, razor blades, or knives.[48] Such behavior can cause considerable skin damage; this is one subgroup of BDD patients who may not look normal. In more extreme cases, the behavior can be life threatening, as in the case of a woman who picked with tweezers at a pimple on her neck, exposing her carotid artery and requiring emergency surgery.[31]

COMPLICATIONS

BDD causes considerable distress and impairment in functioning.* Preoccupations and related behaviors can impair concentration and consume a great deal of time. Many individuals avoid work, relationships, and social situations because they worry that they look ugly or that others are laughing at them. BDD can cause severe depression and anxiety, and can lead to unemployment or dropping out of school. Being housebound and requiring psychiatric hospitalization is relatively common. Levels of functioning varies, however.[35] Individuals with milder symptoms may, with effort, function well despite their distress, although usually below their capacity. Those with severe BDD may be completely incapacitated by their symptoms. Patients with BDD also have unusually poor quality of life. One study found that they had poorer mental health-related quality of life than has been reported for patients with other severe illnesses, such as type 2 diabetes, a recent myocardial infarction, or depression.[36]

It should be emphasized that patients with BDD, especially those with more severe symptoms, are at risk of suicide. In the largest series of patients with DSM-IV-defined BDD, approximately one-quarter of patients had attempted suicide.[39] Suicide risk also is emphasized in the dermatology literature.[6] In a series of dermatology patients who committed suicide, most had acne or BDD.[8]

DEMOGRAPHIC FEATURES AND COURSE OF ILLNESS

The reported sex ratio of BDD has varied, with some studies reporting a preponderance of men[13, 18] and others a preponderance of women.[51, 56] In the largest published series, 51% were men.[39] Nearly three quarters of patients have never been married.[39] BDD usually begins during adolescence and can even occur in childhood.[1] The disorder appears to be chronic,[45] although patients who receive appropriate psychiatric treatment appear to have a generally favorable course.[42] Prospective studies are needed to confirm these retrospective findings.

ASSOCIATED PSYCHIATRIC DISORDERS

Most patients with BDD seen in psychiatric settings have other psychiatric disorders. Commonly co-occurring disorders are major depression, social phobia, substance abuse or dependence, and obsessive-compulsive disorder.[44, 45] In addition, a majority of patients with BDD also have a personality disorder.[29, 43, 56]

BODY DYSMORPHIC DISORDER IN WOMEN

BDD's clinical features generally appear similar in women and men, although women are more likely than men to be preoccupied with their hips and weight, pick their skin and camouflage with makeup, and have comorbid bulimia nervosa.[39] Virtually nothing is known about how the menstrual cycle, pregnancy, postpartum period, and menopause affect BDD symptoms. Our clinical impression is that many women experience increased BDD symptoms premenstrually, and that BDD symptoms tend to continue unchanged during pregnancy, although no systematic data are available to confirm or disconfirm these impressions.

Case Study

Ms. A. was a 27-year-old single white female who was referred to the first author by a dermatologist, who stated, "I'm referring you a patient with perfect skin." The patient presented with a chief complaint of "I see a lot of skin doctors." She had seen dozens of dermatologists,

*References [6, 16, 18, 24, 25, 34, 35, and 60].

as well as her primary care physician, to no avail. Ms. A. was convinced that she had severe acne, scars, and "veins" on her face. She frequently checked mirrors, applied makeup for hours a day, and picked at her skin. She also frequently asked other people, including her physicians, whether her skin looked okay. She stated that because she so incessantly sought reassurance from her doctors, most of the dermatologists in Boston were probably seeing therapists.

As a result of her BDD symptoms, Ms. A. had dropped out of school, was unemployed, and was completely socially isolated and housebound; she had also attempted suicide and had been psychiatrically hospitalized. Treatment with numerous antibiotics and isotretinoin had not diminished Ms. A.'s concerns with her appearance. An antipsychotic and a tricyclic antidepressant (desipramine) also were ineffective; however, she had a good response to fluoxetine (Prozac) 40 mg/day, with a significant decrease in her preoccupation, distress, picking behavior, and suicidality, as well as significant improvement in functioning.

PREVALENCE

The rate of BDD in primary care settings is unknown. Reported rates of current BDD in the general population are 0.7%,[12] 1.1%,[4] and 2.3%.[27] BDD is relatively common but underdiagnosed in psychiatric settings.[32, 47] In cosmetic surgery settings, rates of 6%,[53] 7%,[52] and 15%[22] have been reported. In the dermatology literature, BDD has been noted to be relatively common yet under-recognized.[5, 6, 16, 25, 60] In a study of 268 patients presenting for dermatologic treatment, 11.9% (95% confidence interval, 8.0% to 15.8%) of patients screened positive for BDD.[41] Most had concerns about the appearance of their skin, and a sizable percentage reported experiencing severe or extreme distress or functional impairment as a result of their appearance concerns.

TREATMENT RESPONSE

Surgical, Dermatologic, and Other Non-Psychiatric Medical Treatment

A majority of BDD patients seen in a psychiatric setting have sought and received non-psychiatric treatment,[18, 45, 56] mostly in the form of dermatologic treatment and surgery[39]; however, they may see any type of physician.

Prospective treatment outcome studies with non-psychiatric treatment have not been conducted. Based on clinical experience, however, BDD has been described in the dermatology literature as difficult to treat.[6, 7, 16, 24] This literature notes that such patients may consult numerous physicians and pressure them to prescribe unsuitable and ineffective treatments.[24, 25] Some sue or threaten to harm their physician.[7] These patients often are said to respond poorly to dermatologic treatment, with no improvement in BDD symptoms.[6, 7, 24]

In the surgery literature, the treatment outcome of BDD has generally been said to be poor.[34] While there are some suggestions that certain patients with minimal deformity are good surgical candidates if they are psychiatrically screened,[9, 10] it is unclear in these reports which patients had BDD. Many authors caution against performing surgery on BDD patients because of poor outcomes, including dissatisfaction with the procedure[14] or violence toward the surgeon.[26, 46, 55, 59]

Most patients with BDD who are seen in a psychiatric setting retrospectively report that non-psychiatric treatment was not beneficial.[45, 56] Some develop increased or new appearance preoccupations following such treatment.[35, 44] Patients may receive multiple procedures in their search for a cosmetic solution to this psychiatric problem.[13] Some patients perform their own surgery, as did one man who cut his nose open and tried to replace his nasal cartilage with

chicken cartilage.[35] Prospective studies are needed to confirm these clinical impressions and empirical findings.

Pharmacotherapy

Available data indicate that serotonin-reuptake inhibitors (SRIs, SSRIs) often are effective for BDD.[17, 20, 33, 40] These medications are antide-pressants that also, unlike other antidepressants, decrease obsessions and repetitive behaviors. Those currently available are fluvoxamine (Luvox), fluoxetine (Prozac), paroxetine (Paxil), citalopram (Celexa), sertraline (Zoloft), and clomipramine (Anafranil).

The best-studied SRIs in BDD are fluvoxamine and clomipramine. In an open-label study of fluvoxamine, 19 (63%) of 30 subjects responded.[40] In another open-label fluvoxamine study, two-thirds of 15 subjects responded.[33] The only published controlled pharmacotherapy trial of BDD, a double-blind cross-over study of 29 randomized patients, compared clomipramine (an SRI) to desipramine (a non-SRI tricyclic anti-depressant).[17] Clomipramine was superior to desipramine for BDD symptoms and functional disability. A recently completed study by the first author (n = 74) found that fluoxetine was more effective than placebo (Phillips KA, unpublished data).

Although fluvoxamine and clomipramine are the most thoroughly studied SRIs, clinical experience suggests that all of the SRIs may be effective for BDD.[35, 37, 38] A growing literature suggests that SRIs are also often effective for compulsive skin picking.[3, 23, 31, 48, 54] For an individual patient, one SRI may be more effective than another, although the SRI that is most effective for a given patient must be determined by trial and error and cannot be predicted. Non-SRI psychotropic medications have been less well studied in BDD; however, available data indicate that while some may be useful as adjunctive treatments with SRIs, they are generally ineffective for BDD when used as single agents.[17, 19, 37, 44, 45]

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) also appears to be effective against BDD. CBT is a here-and-now kind of treatment that focuses specifically on BDD symptoms. The therapist is quite active in the treatment, and often prescribes homework. CBT consists of elements known as exposure and response prevention. Exposure consists of having patients expose the perceived defect in social situations (for example, going to formerly avoided restaurants or stores without a hat or heavy makeup, or sitting in a crowded waiting room). Response prevention consists of helping patients avoid BDD behaviors, using techniques such as covering or removing mirrors, limiting grooming time, covering skin areas that are picked, and stopping makeup use and seeking reassurance. Cognitive restructuring, which helps patients change erroneous beliefs about their appearance and the importance attributed to appearance, is also often part of treatment.

Case series and studies using no-treatment wait-list controls have found that CBT is effective for a majority of patients with BDD. In a report of five patients with BDD, four improved using such approaches in 90-minute sessions one day or five days per week.[30] Another report of 13 patients found that BDD significantly improved in 12 90-minute group sessions.[58] In another study, exposure and response prevention plus cognitive techniques were effective in 77% of 27 women who received this treatment in eight weekly two-hour group sessions.[51] Subjects in the treatment group improved more than those in a no-treatment waiting-list control group. In a pilot study of 19 patients (primarily women) who were randomly assigned to a CBT group or a no-treatment waiting-list control group, there was significantly greater improvement in BDD symptoms in the group that received CBT.[51] One small study (n = 10) found that patients

who participated in an intensive behavioral therapy program, including a 6-month maintenance program, maintained their improvement at up to 2 years.[28]

Available evidence suggests that other types of psychotherapy or counseling generally are ineffective for BDD, although little research on their efficacy has been done.[44, 45]

RECOGNIZING AND DIAGNOSING BODY DYSMORPHIC DISORDER

Because of the morbidity that BDD so often causes, as well as the potential for a poor outcome with non-psychiatric treatment, it is important to identify BDD in primary care settings. BDD is diagnosed by asking questions whose answers determine whether the DSM-IV diagnostic criteria, presented above, are met. Questions that can be asked to determine this are listed below:

1. Have you ever been very worried about your appearance in any way?
   - If YES: What was your concern? Did you think (body part) was especially unattractive?
   - If YES: What about the appearance of your face, skin, hair, nose, or the shape or size or other aspect of any other part of your body?
1. Did this concern preoccupy you? That is, did you think about it a lot and wish you could worry about it less?
2. What effect did this concern have on your life? Did it cause you a lot of distress or interfere with your functioning in any way?

Clues to the presence of BDD are listed below:

- Excessive concern with, or distress over, minor or nonexistent appearance flaws
- Difficulty functioning (e.g., problems at work or social avoidance)
- Skin picking
- Camouflaging (e.g., wearing heavy makeup or a hat)
- Other BDD-related behaviors, such as reassurance seeking or excessive grooming
- Referential thinking (i.e., thinking that others are taking special notice of them because of how they look)
- Dissatisfaction with previous dermatologic, other medical, or surgical treatment
- Unusual or excessive requests for cosmetic procedures
- Belief that a cosmetic procedure will transform the individual's life or fix all their problems

Primary care physicians who encounter patients presenting with one or more of these clues should ask the diagnostic questions presented above to determine whether BDD is present.

PRACTICAL SUGGESTIONS FOR PRIMARY CARE PHYSICIANS

The following suggestions are based on available data and the authors' clinical experience. These recommendations may change over time, as more is learned about BDD.

Provide Psychoeducation About Body Dysmorphic Disorder

Psychoeducation is an important element of any treatment. The authors suggest approaching patients in the following way:

- Tell them that they appear to have a body image problem (or disorder) known as body dysmorphic disorder. Tell them that BDD is a known and treatable disorder that many people have.
- Recommend reading material on BDD, so patients can learn more about their condition. Several books and web sites contain information on BDD for the layperson.[21, 35, 49, 50]
- For patients who repeatedly seek reassurance about how they look, explain that providing them with reassurance generally isn't helpful and that a more effective approach is to obtain appropriate treatment for their body image concerns.
- Don't discount or disparage patients' appearance concerns. Doing so can be devastating to them. Keep in mind that these patients suffer tremendously. Explain that rather than having a significant medical or surgical problem, they have a body image problem consisting of being overly concerned about and affected by how they think they look.
- If clinically appropriate for a particular patient, it may be helpful to educate family members and significant others about BDD.

It is Generally Ineffective to Try to Talk Patients Out of Their Concern or to Tell Them to Stop Picking Their Skin

- Because most patients with BDD think that their view of their appearance is accurate, it usually is fruitless to try to convince them that their beliefs are irrational, that their defect is *imagined*, or that they look normal. You might tell them that your view of how they look differs from theirs, but trying to convince them that you are right and they are wrong is likely to be unsuccessful and frustrating. An exception to this pertains to the minority of patients who recognize that they are blowing their deformity out of proportion and who acknowledge that they really don't look as bad as they think. With these patients, it is helpful to reinforce that this view is correct. It usually is more fruitful to focus on the distress and impairment that the appearance concerns cause the patient rather than on how they look. Such a focus may facilitate referral to a mental health professional.
- It usually is useless and frustrating for patients to simply advise them to stop picking their skin. The picking behavior is a compulsive activity over which patients have little or no control.[48] Educating them that the picking is a symptom of BDD and is treatable can be helpful.

It is Probably Best to Avoid Cosmetic Procedures

- Although definitive data on the treatment outcome of surgery and non-psychiatric medical treatment for BDD are lacking and no one can predict how a given patient will respond to such treatment, the data presented above suggest that these treatments are unlikely to be successful and may even make the patient worse. In some cases, such treatment precipitates psychosis, suicidal behavior, or violence. We suggest telling patients that because they have BDD, you are concerned that they will be unhappy with the treatment—that as best we know, surgery and other non-psychiatric medical treatment is unlikely to be successful and can even worsen their concern.
- It is probably also best to avoid doing *a little something* to appease the patient, as this approach, too, can be unsuccessful–even disastrous. The authors saw one case, for example, in which a surgeon refused to do the extensive surgery requested by the patient but did give him facial creams. In the patient's view, the creams created huge,

dark spots on his skin. As a result, he went on a rampage with a hammer, destroying his parents' furniture and threatening to harm his family.

Attempt to Refer the Patient to a Psychiatrist for Treatment

- Rather than referring the patient to another primary care physician, or to a dermatologist or cosmetic surgeon, the authors recommend attempting to refer the patient to a psychiatrist for treatment with an SRI. This can be facilitated by using the psychoeducational approach discussed above, telling patients that they have a body image problem that is best treated by someone with expertise in the condition. It is of course best to refer to a psychiatrist familiar with BDD and its treatment.
- If patients resist referral because they continue to believe the problem is physical, not psychological, focus on the large amount of time they spend obsessing about how they look, the amount of distress it is causing them, and how it is affecting—even ruining—their life.[35] Focusing on psychiatric treatment's potential to decrease suffering and improve functioning may facilitate the referral.
- If the patient wants to try therapy instead of medication, keep in mind that most mental health professionals are not trained in CBT. It is important to refer to a therapist (a physician, psychologist, or social worker) who is trained in CBT and familiar with BDD.
- If a patient is severely depressed or suicidal, an SRI is needed. In this case, we recommend not referring the patient for CBT alone.

For Skin Pickers, a Combination of Psychiatric and Dermatologic Treatment May be Best

One group of BDD patients who may require dermatologic treatment are those who pick their skin. Because they can significantly damage their skin, dermatologic treatment may be necessary. Dermatologic treatment will not stop the picking, however, and should be combined with the psychiatric treatment described above.

For Low-Risk Patients who Refuse Referral to a Psychiatrist or a Mental Health Professional Trained in Cognitive-Behavioral Therapy, Consider Treating the Patient Yourself with an Serotonin-Reuptake Inhibitors

- SRIs are relatively straightforward to use, although drug interactions must be considered. For patients who refuse referral to a mental health professional, it is probably better to attempt treatment with an SRI yourself rather than forgo treatment. If this route is chosen, suicidality must be monitored frequently. If patients are or become suicidal or severely depressed, they should be referred to a psychiatrist familiar with BDD.
- To determine whether an SRI will work, patients should receive an SRI trial of 12 to 16 weeks in duration, and the highest SRI dose recommended by the manufacturer or tolerated by the patient should be reached if a lower dose is ineffective.[37] If this fails, another SRI should be tried.[37] If several SRIs fail, referral to a psychiatrist should again be considered. It appears that most patients who respond to an SRI will require longer-term treatment, as the risk of relapse appears high with SRI discontinuation.[38, 40] More detailed recommendations on the pharmacotherapy of BDD are provided elsewhere.[37]

SUMMARY

In recent years, BDD has gone from being a neglected psychiatric disorder to one that is becoming better recognized and understood. Nonetheless, research on this disorder is still in

its early stages, and much more investigation of BDD is needed, especially in non-psychiatric medical settings. Available data indicate that the disorder is fairly common, frequently presents to non-psychiatric physicians, often responds poorly to non-psychiatric medical and surgical treatment, and often responds well to SRIs and CBT. Treatment recommendations will be modified as more research is done. In the meantime, it is important that primary care physicians screen patients for BDD and accurately diagnose this condition, as available psychiatric treatments are very promising for patients who suffer from this distressing and sometimes disabling disorder.

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