

02 - 10.2 Body Dysmorphic Disorder

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10.2 Body Dysmorphic Disorder

Body dysmorphic disorder is characterized by a preoccupation with an imagined defect in appearance that causes clinically significant distress or impairment in important areas of functioning. If a slight physical anomaly is actually present, the person's concern with the anomaly is excessive and bothersome. The disorder was recognized and named dysmorphophobia more than 100 years ago by Emil Kraepelin, who considered it a compulsive neurosis; Pierre Janet called it *obsession de la honte du corps* (obsession with shame of the body). Freud wrote about the condition in his description of the Wolf-Man, who was excessively concerned about his nose. Although dysmorphophobia was widely recognized and studied in Europe, it was not until the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 that dysmorphophobia, as an example of a typical somatoform disorder, was specifically mentioned in the US diagnostic criteria. In the fourth text revision of DSM (DSMIV-TR), the condition was known as body dysmorphic disorder, because the DSM editors believed that the term dysmorphophobia inaccurately implied the presence of a behavioral pattern of phobic avoidance. In the fifth edition of DSM (DSM-5), body dysmorphic disorder is included in the obsessive-compulsive spectrum disorders due to its similarities to obsessive-compulsive disorder (OCD).

EPIDEMIOLOGY

Body dysmorphic disorder is a poorly studied condition, partly because patients are more likely to go to dermatologists, internists, or plastic surgeons than to psychiatrists for this condition. One study of a group of college students found that more than 50 percent had at least some preoccupation with a particular aspect of their appearance, and in about 25 percent of the students, the concern had at least some significant effect on their feelings and functioning. DSM-5 reports a point prevalence in the United States of 2.4 percent. Available data indicate that the most common age of onset is between 15 and 30 years and that women are affected somewhat more often than men. Affected patients are also likely to be unmarried. Body dysmorphic disorder commonly coexists with other

mental disorders. One study found that more than 90 percent of patients with body dysmorphic disorder had experienced a major depressive episode in their lifetimes; about 70 percent had experienced an anxiety disorder; and about 30 percent had experienced a psychotic disorder.

ETIOLOGY The cause of body dysmorphic disorder is unknown. The high comorbidity with

depressive disorders, a higher-than-expected family history of mood disorders and OCD, and the reported responsiveness of the condition to serotonin-specific drugs indicate that, in at least some patients, the pathophysiology of the disorder may involve serotonin and may be related to other mental disorders. Stereotyped concepts of beauty emphasized in certain families and within the culture at large may significantly affect patients with body dysmorphic disorder. In psychodynamic models, body dysmorphic disorder is seen as reflecting the displacement of a sexual or emotional conflict onto a nonrelated body part. Such an association occurs through the defense mechanisms of repression, dissociation, distortion, symbolization, and projection.

DIAGNOSIS The DSM-5 diagnostic criteria for body dysmorphic disorder stipulate preoccupation with a perceived defect in appearance or overemphasis of a slight defect. It also stipulates that at some point during the course of the disorder, the patient performs compulsive behaviors (i.e., mirror checking, excessive grooming) or mental acts (e.g., comparing their appearance to that of others). The preoccupation causes patients significant emotional distress or markedly impairs their ability to function in important areas.

CLINICAL FEATURES The most common concerns (Table 10.2-1) involve facial flaws, particularly those involving specific parts (e.g., the nose). Sometimes the concern is vague and difficult to understand, such as extreme concern over a “scrunchy” chin. One study found that, on average, patients had concerns about four body regions during the course of the disorder. Other body parts of concern are hair, breasts, and genitalia. A proposed variant of dysmorphic disorder among men is the desire to “bulk up” and develop large muscle mass, which can interfere with ordinary living, holding a job, or staying healthy. The specific body part may change during the time a patient is affected with the disorder. Common associated symptoms include ideas or frank delusions of reference (usually about persons’ noticing the alleged body flaw), either excessive mirror checking or avoidance of reflective surfaces, and attempts to hide the presumed deformity (with makeup or clothing). The effects on a person’s life can be significant; almost all affected patients avoid social and occupational exposure. As many as one-third of patients may be housebound because of worry about being ridiculed for the alleged deformities; and approximately one-fifth of patients attempt suicide. As discussed, comorbid diagnoses of depressive disorders and anxiety disorders are common, and patients may also have traits of OCD, schizoid, and narcissistic personality disorders.

Table 10.2-1 Location of Imagined Defects in 30 Patients with Body Dysmorphic Disorders

Ms. R, a 28-year-old single woman, presented with the complaint that she is “ugly” and that she feels others are laughing at her because of her ugliness. In reality, Ms. R was an attractive woman. She first became preoccupied with her appearance when she was 13, when she became obsessed with her “facial defects” (e.g., her nose was too fat, her eyes were too far apart). Up until this point, Ms. R was confident, a good student, and socially active. However, her fixation on her face caused her to socially withdraw and have difficulty concentrating in school, which in turn had a negative effect on her grades. Ms. R dropped out of high school and went for her GED due to her preoccupation. She began to frequently pick at “blemishes” and hairs on her face. She frequently checked herself in mirrors and other reflectively surfaces (e.g., spoons, windows). She

found herself thinking about her defects almost all day every day. Despite reassuring comments from family and others, Ms. R could not be convinced that there was nothing wrong with her appearance.

DIFFERENTIAL DIAGNOSIS The diagnosis of body dysmorphic disorder should not be made if the excessive bodily preoccupation is better accounted for by another psychiatric disorder. Excessive bodily preoccupation is generally restricted to concerns about being fat in anorexia nervosa; to discomfort with, or a sense of wrongness about, his or her primary and secondary sex characteristics occurring in gender identity disorder; and to mood-congruent cognitions involving appearance that occur exclusively during a major depressive episode. Individuals with avoidant personality disorder or social phobia may worry about being embarrassed by imagined or real defects in appearance, but this concern is usually not prominent, persistent, distressing, or impairing. Taijin kyofusho, a diagnosis in Japan, is similar to social phobia but has some features that are more consistent with body dysmorphic disorder, such as the belief that the person has an offensive odor or body parts that are offensive to others. Although individuals with body dysmorphic disorder have obsessional preoccupations about their appearance and may have associated compulsive behaviors (e.g., mirror checking), a separate or additional diagnosis of OCD is made only when the obsessions or compulsions are not restricted to concerns about appearance and are ego-dystonic. An additional diagnosis of delusional disorder, somatic type, can be made in people with body dysmorphic disorder only if their preoccupation with the imagined defect in appearance is held with a delusional intensity. Unlike normal concerns about appearance, the preoccupation with appearance and specific imagined defects in body dysmorphic disorder and the changed behavior because of the preoccupation are excessively time-consuming and are associated with significant distress or impairment.

COURSE AND PROGNOSIS Body dysmorphic disorder usually begins during adolescence, although it may begin later after a protracted dissatisfaction with the body. Age of onset is not well understood because variably a long delay occurs between symptom onset and treatment seeking. The onset can be gradual or abrupt. The disorder usually has a long and undulating course with few symptom-free intervals. The part of the body on which concern is focused may remain the same or may change over time.

TREATMENT Treatment of patients with body dysmorphic disorder with surgical, dermatological, dental, and other medical procedures to address the alleged defects is almost invariably unsuccessful. Although tricyclic drugs, monoamine oxidase inhibitors (MAOIs), and

pimozide (Orap) have reportedly been useful in individual cases, other data indicate that serotonin-specific drugs—for example, clomipramine (Anafranil) and fluoxetine (Prozac)—reduce symptoms in at least 50 percent of patients. In any patient with a coexisting mental disorder, such as a depressive disorder or an anxiety disorder, the coexisting disorder should be treated with the appropriate pharmacotherapy and psychotherapy. How long treatment should be continued after the symptoms of body dysmorphic disorder have remitted is unknown. Augmentation of the selective serotonin reuptake inhibitor (SSRI) with clomipramine (Anafranil), buspirone (BuSpar), lithium (Eskalith), methylphenidate (Ritalin), or antipsychotics may improve the response rate.

RELATION TO PLASTIC SURGERY Few data exist about the number of patients seeking plastic surgery who have body dysmorphic disorder. One study found that only 2 percent of the patients in a plastic surgery clinic had the diagnosis, but DSM-5 reports the figure to be 7 to 8 percent. The overall percentage may be much higher, however. Surgical requests are varied: removal of facial sag, jowls, wrinkles, or puffiness; rhinoplasty; breast reduction or enhancement; and penile enlargement. Men who request penile enlargements and women who request cosmetic surgery of the labia of the vagina or the lips of the mouth often are suffering from this disorder. Commonly associated with the belief about appearance is an unrealistic expectation of how much surgery will

correct the defect. As reality sets in, the person realizes that life's problems are not solved by altering the perceived cosmetic defect. Ideally, such patients will seek out psychotherapy to understand the true nature of their neurotic feelings of inadequacy. Absent that, patients may take out their unfulfilled expectations and anger by suing their plastic surgeons— who have one of highest malpractice-suit rates of any specialty—or by developing a clinical depression.

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