Body Dysmorphic Disorder, More Than Vanity

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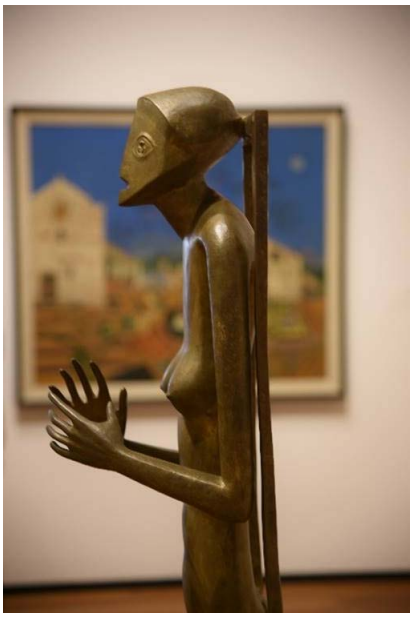


"I'm so fat." "I look disgusting." "Why couldn't I have been a good-looking person?" "My nose is too big." "I need to lose 5 more pounds." These are common phrases that we all have probably heard others speak or maybe even told ourselves. While it is not uncommon for people to dislike something about their appearance, such phrases could be overlooked or ignored, thus making it easy for body dysmorphic disorder to fall 'under the radar.'

Body dysmorphic disorder (BDD) is a syndrome which includes a preoccupation with a perceived deficit in the appearance of one or more body parts that leads to clinically significant stress, impairment and dysfunction (Hunt, Thienhaus, & Ellwood, 2008). Preoccupations with appearance can total to about 3-8 hours every day (Phillips, 2004). The perceived flaw, real or imagined, may be any part of the body. The most common areas are around the face, especially the nose, hair, eye, eyelids, lips, jaw, skin and chin. Other common complaints include asymmetry, body features that feel out of proportion, baldness, acne, wrinkles, vascular markings, scars, or extremes of complexion (Neziroglu & Lippman, 2015). What distinguishes BDD from other body related concerns is that individuals may engage in some form of body monitoring such as mirror checking, skin picking, or excessive grooming.

Estimating BDD's prevalence is somewhat difficult, but it is not entirely uncommon and found throughout the world (Phillips, 2004). Worldwide, the current estimated prevalence rate ranges from 0.7% to 2.4% (Neziroglu & Lippman, 2015), affecting both women and men equally (Tartakovsky, 2013). Risk factors for the development of BDD include history of childhood neglect and/or abuse and family history of OCD (American Psychiatric Association, 2013).

Emotional distress in disclosing their thoughts and feelings may cause many patients reluctance or avoidance in disclosing BDD symptoms or concerns to their providers.. They might feel too embarrassed or ashamed, they might feel that they will be negatively judged or have their concerns misunderstood (Phillips, 2004). BDD could be missed in clinical settings (Hunt et al., 2008) as providers may view individuals' concerns as normal appearance complaints, eating disorders, or obsessive-compulsive disorders.

Another factor of this clinical presentations is that patients with BDD may have additional presenting concerns such as have higher rates of anxiety, depression, substance use, and suicide given the features of this disorder (Hunt et al., 2008).

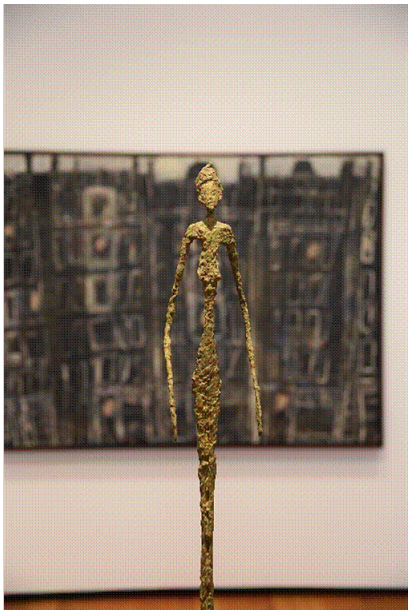
Comorbidity is defined as an individual having multiple coexisting diseases (Valderas, Starfield, Sibbald, Salisbury, & Roland, 2009). Phillips found that substance-use disorders, social phobia, obsessive compulsive disorder, and personality disorders also commonly co-occur with BDD. It is estimated that seventy-five percent of those with BDD will experience major depressive disorder in their lifetime. Anywhere from 45 - 71 percent of BDD patients experience suicidal

thoughts, and 24 - 28 percent have attempted suicide (Tartakovsky, 2013).

Many BDD patients seek out cosmetic solutions to quell their appearance-based anxiety. Results of one study found that 77 percent pursued cosmetic surgery and 50 percent sought dermatological treatments instead of looking for mental health services. Notably, 76 to 83 percent of those who sought cosmetic procedures did not see a change in symptoms while others felt worse and regretted the procedure (Tartakovsky, 2013). This has obvious implications for pre-surgical psychological screening for cosmetic surgery. Such screenings are already common for bariatric surgery, certain types of neurological surgery, or for implantation of nerve stimulators or pain devices.

Many patients experience social isolation due to the symptoms of BDD. Social interactions may be avoided as they intensify beliefs individuals' may hold about their perceived beliefs. Friends and family who try to tell individuals that "they look fine" or that the perceived flaw "is not real" may unintentionally make the condition worse. Patients may assume that people are aware of their flaw, causing them to withdraw from social situations and obsess even more over their appearance ("17 Scarey Body Dysmorphic Disorder," 2014).

There are specific criteria that need to be met in order to make a diagnosis of BDD. According to current DSM-V criteria (American Psychiatric Association, 2013), diagnosis requires preoccupation with one or more perceived defects or flaws in physical appearance that is not observable or appear slight to others. In addition, the preoccupation must clinically signify distress or impairment in social, occupational or other important areas of functioning. At some point the individual engages in repetitive behaviors or mental acts in response to appearance concerns. Such behaviors may include mirror checking, excessive grooming, skin picking or reassurance.



Exclusionary criteria for BDD include that the preoccupation cannot be better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder

Empirically validated treatments available for those diagnosed with BDD include pharmacotherapy with serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT) (Hartmann, Greenberg, & Wilhelm, 2014). Serotonin is known to affect mood, emotion, sleep, and appetite. SRIs are antidepressant medications that are widely used for a large range of disorders, such as major depressive disorder, social anxiety disorder, bulimia, etc. They have been found to decrease rumination and compulsions (Phillips, & Hollander, 2008).

CBT models of BDD incorporate an understanding of biological, psychological, and sociocultural factors in the development and maintenance of BDD. The therapy sessions would begin with assessment, psychoeducation, and then progress with techniques to aid the patient in recovery. CBT techniques include cognitive restructuring, learning to become aware of certain cognitions that are related to behavior, distress, and perceptions, training in methods to combat ruminations, and will sometimes involve techniques for exposure and ritual prevention.

While patient reluctance and patient embarrassment may contribute to difficulties in detecting BDD, clinician awareness and knowledge about symptoms, comorbid conditions, and available treatment is likely to reduce risk of missed diagnosis, and misdiagnosis.

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