Body Dysmorphic Disorder (DSM-IV-TR #300.7)

In body dysmorphic disorder (BDD) patients become overly concerned, or at times convinced, that in some fashion or other they are misshapen or deformed, despite all evidence to the contrary. Given these concerns, patients rarely seek treatment from psychiatrists, preferring to visit dermatologists or cosmetic surgeons. Although the lifetime prevalence of this disorder is not known, anywhere from 2 to 6% of patients seen in dermatology or cosmetic surgery clinics are affected.

Historically, and still in the United Kingdom and Europe, this disorder has been known as dysmorphophobia; whether or not the cumbersome phrase "body dysmorphic disorder," as used in the DSM-IV, is preferable to the mellifluous "dysmorphophobia" is a matter of debate.

ONSET

The morbid concern that one has a defect typically has an insidious onset in midteenage to late teenage years.

CLINICAL FEATURES

Patients are generally concerned about some aspect of their appearance or with the possibility that they have some deformity. Different patients express different concerns, and most have more than one; in most cases the concerns focus on the face or the head. Facial and scalp hair are not right; the nose is misshapen or too large; the skin is scarred or pimpled or deformed by wrinkles; the eyes may be too far apart. The breasts are too large or too small; they are unequal in size or asymmetric. Blemishes are seen on the hands or the face; the hips are too large.

On examination the physician finds either no abnormality at all or, if one is present, it is trivial and would pass unnoticed by almost anyone else.

Reassurance from the physician, however, that "there is nothing wrong" or "nothing to be concerned about" has little lasting effect on these patients. Only a small minority recognize the groundlessness of their concerns; the vast majority are more or less convinced, and in a significant proportion the conviction becomes a delusion. Patients are often in torment over their "defect," and the majority repeatedly check themselves in mirrors: in some cases such "mirror-checkers" may be so distressed by what they see that they may avoid mirrors, or cover them up. Most patients avoid contact with others, and a minority become housebound; ideas or delusions of reference may appear. A majority of patients eventually seek treatment from plastic surgeons or dermatologists, with uniformly disappointing results and a tendency to seek legal redress.

Most patients have concurrent disorders, such as major depression or obsessive-compulsive disorder.

COURSE

Dysmorphophobia pursues a chronic, waxing and waning course in most patients; although over long periods of time, the "focus" of concern may change, nevertheless the concern with appearance, *per se*, remains constant.

COMPLICATIONS

As noted, social withdrawal is common, and patients may be unable to work or to sustain relationships with others. Suicidal ideation is common, and completed suicide may occur.

ETIOLOGY

Although the etiology is not known, the response to SSRIs and the similarity of an "obsession" with a defective appearance with the obsessions seen in obsessive-compulsive disorder suggest that dysmorphophobia may be one of the "obsessive-compulsive spectrum" disorders.

DIFFERENTIAL DIAGNOSIS

A heightened concern about appearance is normal during adolescence; the fact that it passes with time or a change in circumstances differentiates it from dysmorphophobia.

In narcissistic personality disorder, one may see an excessive concern with maintaining a perfect facial appearance; however, this interest in appearance is only part of a more pervasive drive to perfection that affects almost every aspect of the patient's life. By contrast, patients with dysmorphophobia are content with being "merely normal" in other aspects of their lives.

In those cases where the concern is delusional, a diagnosis of delusional disorder, somatic subtype, may be considered. Here, however, the typical nonpsychotic symptomatology preceding the development of the delusion enables the correct diagnosis. The fact that these patients with psychotic dysmorphophobia are in every way similar to nondelusional patients, including response to treatment, further argues against making a diagnosis of delusional disorder.

Patients with transsexualism are convinced of the defective nature of their sexual characteristics; however, here the concern is secondary to the patient's conviction either that he is actually a female and that his penis is a mistake or, conversely, that she is actually a male and that her breasts are a mistake.

Anorexia nervosa is characterized by a pervasive concern with shape and size, that at times may be quite focal: the hips are too big; the cheeks are too chubby. However, the anorexic's goal is not to become normal in appearance, but rather to succeed in the pursuit of thinness.

In hypochondriasis patients may be overly concerned about blemishes and the like. Their concern is not so much with

being unattractive as it is with the possibility that the blemish indicates the presence of a severe underlying disease.

In the midst of a depressive episode, patients may become concerned or convinced that they are deformed. This conviction, however, is intimately connected with the patient's notion of sin and guilt, notions that are not part of dysmorphophobia.

Patients with schizophrenia may have all manner of concerns about their appearance; however, these tend to be bizarre and unusual and are accompanied by the other symptoms typical of the disease not found in dysmorphophobia.

TREATMENT

As patients with dysmorphophobia are loath to consider their pathologic concerns per se, they rarely stay in treatment.

Both fluoxetine and clomipramine are effective in reducing the intensity of the patients' concerns, and there is some preliminary evidence for the effectiveness of behavior therapy. Importantly, both clomipramine and fluoxetine are as effective in the psychotic subtype of dysmorphophobia as they are in the non-psychotic subtype.

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