

International Journal of Advanced Psychiatric Nursing

E-ISSN: 2664-1356
P-ISSN: 2664-1348
IJAPN 2019; 1(2): 29-32
Received: 25-05-2019
Accepted: 27-06-2019

Vibha Bansriar
Demonstrator, Psychiatric
Nursing, PT. Deendayal
Upadhyay and Ayush
University Raipur
Chhattisgarh, Govt. College of
Nursing Bilaspur,
Chhattisgarh, India

Body dysmorphic disorder

Vibha Bansriar

Abstract

Body dysmorphic disorder is one of the most difficult conditions to manage but a significant proportion of patients do respond to selective serotonin reuptake inhibitors. Body dysmorphic disorder (BDD) is defined as a preoccupation with an “imagined” defect in one’s appearance. Alternatively, where there is a slight physical anomaly, then the person’s concern is markedly excessive. The preoccupation is associated with many time-consuming rituals such as mirror gazing or constant comparing. BDD patients have a distorted body image, which may be associated with bullying or abuse during childhood or adolescence. Such patients have a poor quality of life, are socially isolated, depressed, and at high risk of committing suicide. This group of drugs has helped to revolutionize the treatment of this common but disabling disorder of perceived body ugliness. Patients often show obsessional features, and depression is common. Ever present is a risk of suicide in these patients.

Keywords: Body dysmorphic disorder; dysmorphophobia, delusional disorder, somatoform disorder, obsessive-compulsive spectrum, clinical feature and treatment

Introduction

Body dysmorphic disorder (BDD) is characterised by excessive and persistent preoccupation with perceived defects or flaws in appearance. These perceived flaws are unobservable or appear only slight to others, but nevertheless give rise to significant distress and impairment in the sufferer. BDD sufferers can become preoccupied with any aspect of appearance, but the most common concerns relate to facial features, including nose, eyes, skin and hair. To meet diagnostic criteria for BDD, the appearance preoccupation cannot be better explained by concerns with body fat or weight in an individual who fulfils diagnostic criteria for an eating disorder. Diagnostic criteria for BDD also specify that at some point during the course of illness, the individual will have performed repetitive behaviours (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 their appearance concerns.

Cause

As with most mental disorders, BDD's cause is likely intricate, altogether biopsychosocial, through an interaction of multiple factors, including genetic, physical (e.g. disabilities), developmental, psychological, social, and cultural. BDD usually develops during early adolescence, although many patients note earlier trauma, abuse, neglect, teasing, or bullying.^[11] In many cases, social anxiety earlier in life precedes the development of BDD. Family influence has also been linked to the development of BDD. Though twin studies on BDD are few, one estimated its heritability at 43%. There have been studies done that show a link between mother and daughter, as well. Yet BDD's cause may also involve introversion, negative body image, perfectionism, heightened aesthetic sensitivity, and childhood abuse and neglect. A study done by the Osnabrück University and Ruhr-University Bochum found a connection between BDD in mothers and their daughters. In the study, they tracked mother's and daughter's eye movements and found that there were significant similarities in attention distribution. It was found that the participants paid more attention to the negative body areas of themselves and peers than the positive body areas. The study concluded that there was a strong correlation between mother's viewing patterns and body image and their daughter's.

Sign and Symptoms

Whereas vanity involves a quest to aggrandize the appearance, BDD is experienced as a quest to merely normalize the appearance. Although delusional in about one of three cases, the appearance concern is usually non delusional, an overvalued idea.

Corresponding Author:
Vibha Bansriar
Demonstrator, Psychiatric
Nursing, PT. Deendayal
Upadhyay and Ayush
University Raipur
Chhattisgarh, Govt. College of
Nursing Bilaspur,
Chhattisgarh, India

The bodily area of focus can be nearly any, yet is commonly face, hair, stomach, thighs, or hips. Some half dozen areas can be a roughly simultaneous focus. Many seek dermatological treatment or cosmetic surgery, which typically do not resolve the distress. On the other hand, attempts at self-treatment, as by skin picking, can create lesions where none previously existed.

BDD shares features with obsessive-compulsive disorder, but involves more depression and social avoidance. BDD often associates with social anxiety disorder. Some experience delusions that others are covertly pointing out their flaws. Cognitive testing and neuroimaging suggest both a bias toward detailed visual analysis and a tendency toward emotional hyper-arousal.

Most generally, one experiencing BDD ruminates over the perceived bodily defect several hours daily or longer, uses either social avoidance or camouflaging with cosmetics or apparel, repetitively checks the appearance, compares it to that of other people, and might often seek verbal reassurances. One might sometimes avoid mirrors, repetitively change outfits, groom excessively, or restrict eating.

BDD's severity can wax and wane, and flare ups tend to yield absences from school, work, or socializing, sometimes leading to protracted social isolation, with some becoming housebound for extended periods. Social impairment is usually greatest, sometimes approaching avoidance of all social activities. Poor concentration and motivation impair academic and occupational performance. The distress of BDD tends to exceed that of either major depressive disorder or type-2 diabetes, and rates of suicidal ideation and attempts are especially high.

Evidence-based treatments are available for BDD

In line with the extant evidence base, clinical guidelines recommend cognitive behavioural therapy (CBT) and serotonin reuptake inhibitors (SRIs) in the treatment of BDD. In clinical trials, CBT for BDD typically involves 12-22 weekly sessions, with a key therapeutic strategy being exposure with response prevention (E/RP). E/RP involves the gradually confronting of feared situations (e.g., bright lights, mirrors, social situations) and resisting the urge to perform safety-seeking behaviours (e.g., camouflaging, applying excessive make-up, focusing attention internally) to neutralise distress, with the goal of achieving anxiety habituation. Additional strategies that have been used in CBT for BDD include psychoeducation, motivational enhancement techniques, cognitive restructuring, mirror retraining and attention training.

In adult populations, six randomised controlled trials (RCTs) have demonstrated CBT to be efficacious in reducing BDD severity compared with no treatment or waitlist control conditions, supportive therapy and anxiety management. Furthermore, the first RCT of CBT for BDD in adolescents was recently published, showing developmentally tailored CBT to be efficacious compared with a control condition. A meta-analysis of the seven RCTs conducted to date concluded that CBT as an efficacious treatment for BDD symptoms (effect size (ES) = 1.22) and associated features, such as depression (ES=0.49) and insight/delusionality (ES=0.56). While these outcomes are encouraging, 46%-60% of BDD trial participants do not respond sufficiently to CBT, and remission rates are low. Outcomes may be even less favourable in routine clinical

practice, where patients are unselected and clinicians may be less experienced in the treatment of BDD. There is a clear need to evaluate the long-term effects of CBT for BDD since few studies have addressed this question to date. A recent 12-month follow-up study of adolescents who had received CBT for BDD indicated that overall gains are maintained but that a significant proportion continue to experience clinically significant symptoms and remain vulnerable to a range of potential risks and negative outcomes (e.g., cosmetic surgery, suicidal behaviour, risky sexual behaviours). For this reason, longer term monitoring of patients with BDD following CBT is recommended.

Although CBT is an efficacious treatment for BDD, many patients continue to experience significant symptoms and there is a pressing need to improve existing CBT packages for BDD to enhance outcomes. Such efforts can be informed by better understanding the mechanism underlying the development and maintenance of BDD and its recovery. In parallel, empirical attention should also be given to developing evidence-based methods for disseminating CBT for BDD, given that the treatment is not widely available. For example, therapist-guided internet-based CBT has the potential to greater increase availability and access. A recent RCT found that 56% of patients with BDD responded to a 12-week internet-based CBT package with just 13 min of therapist support per week on average. Further trials comparing the efficacy or non-inferiority of low-intensity remote interventions like internet-based BDD for mild to moderately severe (non-suicidal) BDD against gold standard face-to-face CBT are needed. Such low intensity interventions could represent a first treatment option in a stepped care model, which could potentially increase availability of CBT and optimise the limited available resources.

A range of SRIs have been used in the treatment of BDD, including fluoxetine, fluvoxamine, citalopram, escitalopram and clomipramine. Most evidence for the efficacy of pharmacotherapies in BDD comes from open trials, and only four RCTs of pharmacotherapy have been conducted to date, which have found response rates ranging from 53%-70%. The most recent RCT conducted was a two-phase trial. Phase 1 was a 14-week open trial in which patients with BDD were treated with escitalopram. In phase 2, treatment responders were randomised to escitalopram continuation or placebo for a further 6 months, in a double-blind design. Results showed that 40% of placebo group relapsed compared with only 18% of the escitalopram-continuation group, and overall the escitalopram-continuation group made further gains. The key implications of this study are that patients with BDD should remain on SRI medication for relatively long periods to reduce the likelihood of relapse occurring. While dose-finding studies have not been conducted in BDD, available data and clinical experience indicate that BDD often requires SRI doses that are higher than those required to treat depression and similar to those required to treat OCD. Of note, clinical experts in the field have suggested that doses required to treat BDD often exceed the regulatory limit. In addition, tailoring SRI titration is recommended, based on factors such as severity of illness, risk, how well the medication is tolerated and patient preference.

Further research is needed to establish the relative efficacy of different SRIs and to compare pharmacotherapy to CBT in RCTs and meta-analytic studies. There is also a need to

further evaluate potential augmentation strategies for BDD patients who do not respond to SRIs. To date, research on augmentation strategies in BDD is limited to one small open trial and one RCT which evaluated pimozide and olanzapine augmentation of fluoxetine, respectively. These studies did not find beneficial effects of augmentation, but this warrants investigation as clinical experience and guidelines suggest that SRI augmentation with an atypical antipsychotic can be beneficial.

Conclusions

In summary, BDD is a relatively common and potentially debilitating disorder, but research on BDD is still in its infancy compared with other psychiatric disorders. There is a pressing need to increase awareness of this serious condition and to promote detection, diagnosis and treatment. Current research and clinical guidelines indicate that CBT and SRI medication are the treatments of choice for BDD. Expert clinical experience suggests that longer courses of CBT (i.e., more sessions) and higher doses of SRI medication are often required to treat BDD compared with other common psychiatric disorders such as depression. Severe BDD cases may be best managed in specialist settings given the high levels of morbidity, risk and complexity of treatment. While many patients respond well to existing evidence-based treatment, a significant proportion experience enduring symptom. Ongoing research into the aetiology of BDD and factors predicting treatment response may shed light on the mechanisms underlying the development and maintenance of the disorder, ultimately leading to new and improved treatment possibilities.

References

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed VA: Arlington American Psychiatric Publishing, 2013.
- Phillips KA, Didier ER, Menard W *et al.* Clinical features of body dysmorphic disorder in adolescents and adults. *Psychiatry Res.* 2006; 141:305-14.10.1016/j.psychres.2005.09.014
- Phillips KA, Menard W, Quinn E, *et al.* A 4-year prospective observational follow-up study of course and predictors of course in body dysmorphic disorder. *Psychology Med.* 2013; 43:1109-17.10.1017/S0033291712001730
- Matrix-Cols D, Fernández De La Cruz L, Isomura K *et al.* A pilot randomized controlled trial of cognitive-behavioural therapy for adolescents with body dysmorphic disorder. *J Am Child Adolescence Psychiatry.* 2015; 54:895-904.10.1016/j.jaac.2015.08.011
- Angelakis I, Gooding PA, Panagiotis M. Suicidality in body dysmorphic disorder (BDD): a systematic review with meta-analysis. *Clinical Psychology Rev.* 2016; 49:55-66.10.1016/j.cpr.2016.08.002
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Washington, 2000.
- Phillips KA, Stein DJ, Rauch SL *et al.* Should an obsessive-compulsive spectrum grouping of disorders be included in DSM-V? *Depress Anxiety.* 2010; 27:528-55.10.1002/da.20705
- Veale D, Matsunaga H. Body dysmorphic disorder and olfactory reference disorder: proposals for ICD-11. *Rev Bras Psiquiatr.* 2014; 36(1):14-20.10.1590/1516-4446-2013-1238
- Phillips KA, Wilhelm S, Koran LM *et al.* Body dysmorphic disorder: some key issues for DSM-V. *Depress Anxiety.* 2010; 27:573-91.10.1002/da.20709
- World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders: clinical descriptions and diagnostic guidelines. Geneva: WHO, 1992.
- Stein DJ, Kogan CS, Atmaca M *et al.* The classification of obsessive-compulsive and related disorders in the ICD-11. *J Affect Disord.* 2016; 190:663-74.10.1016/j.jad.2015.10.061
- Veale D, Gledhill LJ, Christodoulou P *et al.* Body dysmorphic disorder in different settings: a systematic review and estimated weighted prevalence. *Body Image* 2016; 18:168-86.10.1016/j.bodyim.2016.07.003
- Schneider SC, Turner CM, Mond J *et al.* Prevalence and correlates of body dysmorphic disorder in a community sample of adolescents. *Aust N Z J Psychiatry* 2017; 51:595-603.10.1177/0004867416665483
- Bjornsson AS, Didier ER, Grant JE *et al.* Age at onset and clinical correlates in body dysmorphic disorder. *Compressor Psychiatry.* 2013; 54:893-903.10.1016/j.comppsych.2013.03.019
- Marques L, Weingarden HM, Leblanc NJ *et al.* Treatment utilization and barriers to treatment engagement among people with body dysmorphic symptoms. *J Psychosomatic Res.* 2011; 70:286-93.10.1016/j.jpsychores.2010.10.002
- Brohede S, Wingren G, Wijma B *et al.* Validation of the Body Dysmorphic Disorder Questionnaire in a community sample of Swedish women. *Psychiatry Res.* 2013; 210:647-52.10.1016/j.psychres.2013.07.019
- Phillips KA, Atala KD, Pope HG. Diagnostic instruments for body dysmorphic disorder. American Psychiatric Association: American Psychiatric Association 148th annual meeting Miami, 1995.
- Phillips KA, Hollander E, Rasmussen SA *et al.* A severity rating scale for body dysmorphic disorder: development, reliability, and validity of a modified version of the Yale-Brown Obsessive-Compulsive Scale. *Psychopharmacology Bull.* 1997; 33:17-22.
- Phillips KA, Hart AS, Menard W. Psychometric evaluation of the Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS). *J Obsessive Compel Relat Disord.* 2014; 3:205-8.10.1016/j.jocrd.2014.04.004
- Bowyer L, Krebs G, Mataix-Cols D *et al.* A critical review of cosmetic treatment outcomes in body dysmorphic disorder. *Body Image.* 2016; 19:1-8.10.1016/j.bodyim.2016.07.001
- Monzani B, Rijssdijk F, Anson M *et al.* A twin study of body dysmorphic concerns. *Psychology Med* 2012; 42:1949-55.10.1017/S0033291711002741
- Lopez-Sola C, Fontenelle LF, Alonso P *et al.* Prevalence and heritability of obsessive-compulsive spectrum and anxiety disorder symptoms: a survey of the Australian Twin Registry. *American Journal of Medical Genetics Part B, Neuropsychiatric genetics: the official publication of the International Society of Psychiatric Genetics.* 2014; 165b:314-25.

23. Didie ER, Tortolani CC, Pope CG *et al.* Childhood abuse and neglect in body dysmorphic disorder. *Child Abuse Negl.* 2006; 30:1105-15.10.1016/j.chabu.2006.03.007
24. Buhlmann U, Marques LM, Wilhelm S. Traumatic experiences in individuals with body dysmorphic disorder. *J Nerv Ment Dis.* 2012; 200:95-8.10.1097/NMD.0b013e31823f6775
25. Neziroglu F, Khemlani-Patel S, Yaryura-Tobias JA. Rates of abuse in body dysmorphic disorder and obsessive-compulsive disorder. *Body Image.* 2006; 3:189-93.10.1016/j.bodyim.2006.03.001
26. Weingarden H, Curley EE, Renshaw KD *et al.* Patient-identified events implicated in the development of body dysmorphic disorder. *Body Image.* 2017; 21:19-25.10.1016/j.bodyim.2017.02.003
27. Webb HJ, Zimmer-Gembeck MJ, Mastro S *et al.* Young adolescents' body dysmorphic symptoms: associations with same-and cross-sex peer teasing via appearance-based rejection sensitivity. *J Abnormal Child Psychology.* 2015; 43:1161-73.10.1007/s10802-014-9971-9
28. Weingarden H, Renshaw KD. Body dysmorphic symptoms, functional impairment, and depression: the role of appearance-based teasing. *J Psychology.* 2016; 150:119-31.
29. Buhlmann U, Wilhelm S, Glaesmer H *et al.* Perceived appearance-related teasing in body dysmorphic disorder: a population-based survey. *Int J Cogn Ther.* 2011; 4:342-8.10.1521/ijct.2011.4.4.342
30. Webb HJ, Zimmer-Gembeck MJ, Maestro S. Stress exposure and generation: a conjoint longitudinal model of body dysmorphic symptoms, peer acceptance, popularity, and victimization. *Body Image.* 2016; 18:14-18.10.1016/j.bodyim.2016.04.010