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Body dysmorphic disorder in the dermatology patient

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Abstract Body dysmorphic disorder is primarily a psychiatric disorder, in which the patient believes that some normal or very near normal aspect of his or her physical appearance is distorted or ugly. Should there be a minor abnormality, it is grossly exaggerated in the mind of the patient, causing feelings of shame and embarrassment and leading daily to spending hours at the mirror, or any reflecting surface, as the patient tries to conceal or remove the perceived abnormality through the development of ritualistic behavior. Although other organs can be involved—for example, the shape of the nose or a portion of an ear— the skin, hair, and nails are most commonly involved, while the patient constantly seeks reassurance about appearance from friends and family. There is a broad spectrum of severity in body dysmorphic disorder, ranging from obsessional worry to frank delusion, and the psychiatric comorbidities—anxiety, depression, and personality disorder—are prominent parts of the picture.

Unfortunately, the psychiatric comorbidities and the negative impact on every aspect of the patient's life may not be recognized by dermatologists and other non-psychiatric physicians, so that effective treatment is often not instituted or appropriate referrals made. This paper describes the incidence, possible etiologies, and clinical picture of body dysmorphic disorder in dermatology patients and discusses interpersonal approaches that may permit appropriate treatment or referral to take place. Specific treatments and prognosis are also discussed.
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Clinical picture

The patient with body dysmorphic disorder (BDD) has a firm belief that some aspect of his or her appearance is ugly, abnormal, or deformed.[1–5] This may be an obsessional worry or a frank delusion. Should there be an abnormality, it will be essentially imperceptible to the observer, yet it will virtually take over the patient's life.[2] The patient is consumed by feelings of shame and guilt, constantly worrying as to whether or not the problem is visible, whether everyone is looking at the patient, and what negative thoughts they may be having or, even worse, what they may be saying, behind the patient's back.[3] Due to this, the patient constantly bombards family, friends, or colleagues for reassurance and support. As many as 8 hours each day may be spent at the mirror, or indeed any reflecting surface—even shiny furniture or a shop window—and rituals are evolved,[4] as the patient, consumed by feelings of shame, attempts to find ways to conceal the problem area or frankly to remove it by picking it off. Picking is most common in patients whose skin is not inherently smooth—for example, in patients who have acne, keratosis

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pilaris, or even facial hairs. There are also patients in whom the skin is quite normal, but who, nevertheless, believe that something is amiss and pick incessantly, with fingernails, tweezers, needles, or even pen knives, leaving numerous scars, scratch marks, and ulcerations.[5]

At the time, it seems to the patient that picking will improve the appearance, although at the same time he or she knows full well that this is not the case and that picking can only make things worse; thus feelings of guilt and shame are greatly intensified by the action.[3,6,7]

The gender incidence of BDD is approximately equal, though men are less likely to seek help and tend to be older. In women, concerns are primarily about the skin of the face or the shape of the eyes, ears, or nose, whereas men more commonly worry about their hair, body build, and genitalia.[5] Social isolation, loss of work, or absence from school are often a part of the picture. Shame, even "disgust," and fear of negative criticism can prevent patients from leaving the home. One young woman reported that she had been confined to the house for 2 years. Confinement as long as 20 years has occurred in older patients. Extreme anxiety is more common than depression in this disorder.[3,7]

Because the skin, hair, and nails are so readily visible, patients with BDD not infrequently consult dermatologists, as well as plastic or dermatologic surgeons—indeed, dermatologists are the doctors most commonly consulted by patients with BDD.[4,7] If the consultant is not familiar with the condition or not empathically in touch with the patient, the patient may feel misunderstood, insulted, deeply frustrated, and angry. The patient will then seek another and yet another opinion, undergoing test upon test, and thus causing enormous and unnecessary expense to the health care system.[3] Occasionally, as many as nine different specialists have already been consulted (personal experience), and sometimes so great is the frustration and anger of the patient that violence against or even murder of a consultant reportedly takes place.[6,7] Because the patient's initial concern is wholly unrealistic, it is unlikely that any surgical procedure could satisfy those unrealistic wishes.[6–8]

Epidemiology

Although it may occur in childhood, the onset of BDD is most common in adolescence, a time when the patient is coming to terms with body changes and when the opinion of coevals is crucial to the sense of well-being.[3,8] Though present, the concern may not be acknowledged by the patient for a decade or more due to embarrassment and shame. Studies suggest that the gender incidence is equal, but clinical experience would suggest that there is a second peak in postmenopausal women.

Many studies have been carried out to determine the incidence of BDD in different populations.[3,6] In the general population, this is reportedly 0.7-2.4%, and in a general dermatology clinic 9-12%, whereas in a cosmetic dermatology clinic, the incidence is reportedly as high as 8-37%. Pathologic skin picking is noted in 26-45% of BDD patients, and in 36% of patients, the perception of abnormality is truly delusional. Eighty percent of patients are found to have entertained suicidal thoughts at some point in their lives, and successful suicides are reported.[7,9]

Etiology

What we know of the underlying causes of BDD can be viewed from two perspectives— developmentally and neuropsychiatrically. Developmentally, the way that one feels about oneself —one's body image and one's level of self-esteem—are generated very early in life, and for these to be realistic, the sense of touch is crucial.[10] The love and caring of parents is transmitted to the infant primarily through parental touch. The infant, to whom parental love and caring are transmitted throughout infancy and childhood, will develop a realistic body image, and positive self-esteem[11]—that is, appropriate positive feelings about the structure and function of the self—whereas the infant who experiences abuse or neglect and is deprived of loving touch will be more at risk for the development of severe anxiety, depression, dislike of the self, and feelings of shame. These children are at risk for developing BDD, and, in fact, in one study, more than 75% of patients with BDD reported recollections of childhood maltreatment, particularly emotional neglect, although physical and sexual abuse were also reported.[12,13]

From a neuropsychiatric perspective, there is evidence of abnormalities in visual processing,[14] and studies have found that there are morphologic changes in the brain in patients with BDD.[15] The mean volume of the orbitofrontal cortex was found to be smaller, and the volume of white matter greater than in control participants, and network abnormalities were noted. There is evidence of some overlap neurologically between BDD and the obsessive-compulsive spectrum disorders, and with the eating disorders, in both of which the body image is of some importance.[16]

Evaluation and diagnosis

It is important to remember that, were the patient able to accept the possibility of a psychiatric problem, the patient would not be in the dermatology office but rather that of the psychiatrist.

Appropriate questionnaires have been developed that patients can answer independently.[17] These are clearly essential for large studies, but in the office, if one takes a careful history, if one is empathic, and if one asks open-ended questions, one can learn a great deal of diagnostic information from the patient directly, while permitting a therapeutic relationship to develop. For example, is the patient initially defensive, having felt "brushed off" by prior consultants? Is the patient clearly anxious—fidgety, repeating questions over and over again,

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