# Body Dysmorphic Disorder

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**KEYWORDS**

• Body dysmorphic disorder • Obsessive-compulsive spectrum • Treatment
• Cognitive-behavioral therapy • Serotonin reuptake inhibitor

**KEY POINTS**

- Body dysmorphic disorder (BDD) has garnered much research attention in the past decade. Pharmacologic and nonpharmacologic treatment options are available but limited.
- The first-line pharmacotherapies for BDD are serotonin reuptake inhibitors (SRIs) which seem to require relatively high doses and long trial durations.
- The most empirically supported nonpharmacologic intervention for BDD is cognitive-behavioral therapy (CBT), which is a time-limited, symptom-focused treatment that involves psychoeducation, cognitive restructuring, perceptual/mirror retraining, exposure and response prevention, and relapse prevention.
- Available data from medication and CBT trials are limiting as far as generalizability and lack of well-controlled designs. It remains unclear which modality is more efficacious and whether combination therapies offer additional advantages over monotherapies.
- Highly delusional patients may be more likely to seek treatment from nonpsychiatric professionals, such as cosmetic surgeons, dermatologists, and dentists, for their BDD concerns.

## OVERVIEW: NATURE OF THE PROBLEM

Characterized as a disorder of imagined ugliness, BDD has long been described in the psychiatric literature. BDD was introduced only in 1980 to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)-III*[1] as an atypical somatoform disorder, called *dysmorphophobia*, and was given a separate diagnosis in *DSM* (Third Edition Revised)[2] in the somatoform disorders section. By the time the *DSM* (Fourth Edition,

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| Abbreviations | |
|---|---|
| AN | Anorexia nervosa |
| BDD | Body dysmorphic disorder |
| CBT | Cognitive-behavioral therapy |
| *DSM* | *Diagnostic and Statistical Manual of Mental Disorders* |
| OCD | Obsessive-compulsive disorder |
| SAD | Social anxiety disorder |
| SRI | Serotonin reuptake inhibitor |

Text Revision) was published,[3] the classification of BDD evolved to include a criterion that the disorder was not better accounted for by another mental disorder (such as anorexia nervosa [AN]); however, it was still classified as a somatoform disorder. Given the recent research attention on the strong relationship between BDD and obsessive-compulsive disorder (OCD),[4,5] the *DSM* (Fifth Edition) now includes BDD under a new section for OCD and related disorders.[6] Thus, the predominant view today is that BDD is an obsessive-compulsive spectrum disorder due to strong evidence of the overlap between BDD and OCD in terms of phenomenology, comorbidity, and treatment response.

Despite such revisions in the *DSM*, BDD has consistently been defined by an excessive preoccupation with imagined defects in physical appearance. BDD differs from normal appearance concerns because it is associated with significant distress and can lead to meaningful functional impairment in interpersonal relationships and occupational status. When real physical defects are present, BDD is marked by exaggerated concerns about the severity of the defect, as manifested by a strong frequency, duration, and intensity of preoccupation about the defect. Individuals with BDD exhibit ritualistic patterns of thoughts and behaviors associated with hiding, correcting, or fixing the perceived defect, such as intrusive thoughts about appearance, mirror checking, and camouflaging.[7–9] They may also engage in significant avoidance of people, places, or situations where they think that their appearance may be evaluated. An individual's preoccupation may become difficult for a person to control and could consume several hours of the day. Case studies have shown that individuals may become so preoccupied and distressed by their perceived defect or flaw that they may stop working or socializing and, in severe cases, may become housebound.[7]

In BDD, a person's focus of concern may center around 1 or many body parts, with the most common areas involving the skin, hair, and nose.[8,10] Preoccupation with several different aspects of appearance is not uncommon.[8,10] Individuals with BDD often experience low self-esteem as well as feelings of disgust or embarrassment. Due to the shame and secretive nature of the illness, BDD is often under-recognized or left untreated and represents an understudied research area in the literature.[7,9]

This review aims to provide an updated overview of BDD in terms of its psychopathology, etiology, epidemiology, and nosology, with an emphasis on current pharmacologic and nonpharmacologic treatment options for BDD. The authors also aim to integrate recent empirical data that inform these areas as well as identify areas of further research and provide suggestions for future directions.

## ASSOCIATED CLINICAL FEATURES

### *Delusionality*

Perhaps one of the most debilitating clinical characteristics of BDD is delusionality. Many individuals with BDD are completely convinced that their perceived defects are real, to the extent that others take special notice of their flaws.[11] In a study