Body Dysmorphic Disorder

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The GP's role

GPs have a role in identifying body dysmorphic disorder (BDD) in patients, organising referrals to psychologists or other medical specialists and assisting patients to understand and manage the disorder.

Overview

- BDD is characterised by a debilitating preoccupation with a perceived defect in one's own physical appearance. The physical attribute of concern may be non-existent or so minor as to be unnoticeable by others. Behavioural characteristics of BDD — such as constantly checking one's appearance, repeated attempts at correcting the perceived defect, or excessive exercising — can limit daily function.
- Muscle dysmorphia is a form of BDD characterised by a perceived lack of muscularity. Excessive exercise and specific dietary patterns are common behavioural consequences of muscle dysmorphia[1]. Misuse or abuse of androgenic steroids appears commonly in males with muscle dysmorphia[2].
- Males are more likely than females to have genital manifestations of BDD[3].
- BDD is distinct from gender dysphoria, although both may occur in individuals.

Prevalence

- Approximately 1 in 50 (2%) adults have BDD. The disorder most commonly manifests in adolescence, with subclinical symptoms occurring for years before diagnosis[4]. There is no gender difference in the prevalence of BDD[5] but muscle dysmorphia occurs much more often in males[6].

Etiology

- BDD is likely due to genetic, psychosocial and cultural factors[7].
- BDD is more likely than usual to occur in people who:
  - Have a first-degree relative with BDD
  - Experience childhood trauma
  - Are from sexual or racial minority groups.

Use of social media, especially image sharing services (e.g. Snapchat, Instagram), is associated with concern about body image[8] but there is no high-quality evidence linking social media use and formal diagnosis of BDD.

Comorbidities

- BDD is a chronic condition. It can persist throughout adulthood and its influence on adolescent social and emotional development may have long-term functional consequences[5]. However, treatment can lessen the symptom severity and the negative functional impact of BDD[3].
- In males, BDD often accompanies depression, social and generalised anxiety, emotional and behavioural difficulties, problems with peer relationships, hyperactivity, drive for masculinity and a reduced quality of life[5]. Occurrence of these common comorbidities during adolescence can have lasting harmful effects on social functioning, romantic relationships and educational and vocational achievements[5].
- People with BDD are more likely to have suicidal thoughts or behaviours than people without the disorder, with increasing severity and presence of comorbidities related to increasing risk[9].

Screening and diagnosis

- People with BDD may lack insight into their disorder, making them unlikely to seek direct help for the condition[4]. Some behaviours that accompany muscle dysmorphia, such as adherence to exercise routines and avoidance of unhealthy foods, can be misinterpreted as beneficial and positively reinforced.
- Only a minority of people with BDD are diagnosed[10].

Common repetitive behaviours of people with BDD

- Grooming.
- Picking at skin.
- Checking appearance in mirror.
- Mirror avoidance.
- Seeking reassurance.
- Camouflaging (covering perceived defect with makeup, hair and/or clothing).
- Touching perceived defect.
- Excessive exercise.
- Comparing appearance with others.
- Seeking correction of perceived defect (e.g. cosmetic surgery).

Useful screening questions for BDD

- Are you concerned about some aspect of your appearance?
- Do you spend a lot of time worrying about some aspect of your appearance?
- Do you spend a lot of time trying to hide physical defects?
- Do you think you are malformed, misshapen or disfigured in some way?
- Do you think your body functions in an offensive way (e.g. bad body odour, flatulence, sweating)?
- Has anyone told you that you look normal, even though you know something is wrong about your appearance?
- Have you felt like you need to see a medical specialist (e.g. cosmetic surgeon, dermatologist) to correct a problem with your appearance?
- Do you feel the need to change your appearance in photos by using apps (like Facetune) or filters (like in Snapchat)?

Diagnostic criteria for BDD[3]

- Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- Performance of repetitive physical or mental behaviours (e.g. skin picking, comparing one's physical appearance with others) in response to appearance concerns.
- Significant distress or impairment in important functions (e.g. social, occupational).
- Preoccupation with appearance is not better explained by concerns about body fat or weight in the presence of an eating disorder.
- Body dysmorphic disorder occurs with muscle dysmorphia if there is a belief of insufficient muscularity or small build (with or without preoccupations about other body regions)[3].

- Insight into BDD[3] is considered absent for people who are convinced their body dysmorphia beliefs are true, or poor for people who think the beliefs might be true. Good or fair insight into BDD is attributed to people who consider their body dysmorphic beliefs to be definitely or probably false, or may or may not be true.

Treatment

- Psychological and psychopharmacological treatment of BDD can moderate symptoms and improve functionality, but only a minority of people with the disorder receive therapy[10].
- Barriers to treatment include shame and stigma, a perception that psychological and psychiatric treatments are ineffective and denial of the disorder (and, hence, failure to seek treatment)[10].
- Many people with BDD seek cosmetic treatments to fix the perceived physical defect, but such procedures generally have poor outcomes[11] and should be discouraged[4].
- People with BDD should be counselled about the likely futility of pursuing cosmetic outcomes and the associated distress and cost that can arise[4]. People with BDD who seek referral for cosmetic procedures would likely be better served by discussion aimed at providing an understanding of the underlying psychological problem and highlighting the benefit of appropriate treatment.
- Cognitive behavioural therapy for BDD commonly consists of exposure with response prevention, over a period of 3-6 months and seems effective at reducing symptom severity for some time; however, longer-term monitoring is recommended to detect symptom severity and relapse[12]. Telehealth and internet-based therapy show promise in treating BDD[13].
- Selective serotonin reuptake inhibitors (SSRIs) may take weeks to months to be effective for BDD and are usually needed in a higher dose than for treatment of depression[4]. In cases where SSRIs are ineffective, the tricyclic antidepressant clomipramine may be used, or alternatively, off-label use of some antipsychotics may be considered[4].

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Date reviewed: July 2022
Clinical review by Dr Scott Griffiths (University of Melbourne); Healthy Male Nursing and Allied Health Advisory Group; Healthy Male General Practice Advisory Group.

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