

Body dysmorphic disorder and cosmetic dermatology: more than skin deep

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Summary

Body dysmorphic disorder (BDD) is relatively common in cosmetic practise, yet it remains under-recognized.

BDD patients are unnaturally concerned with minimal or non-existent flaws, most commonly in the skin (e.g. facial acne or scarring) and hair (e.g. hair loss). Many patients develop social avoidance and suffer occupational or academic impairment. More severely ill patients may become housebound or even attempt suicide. Despite the minimal or non-existent nature of the perceived appearance flaws, patients with BDD may request dermatological treatments such as isotretinoin or dermabrasion. Although treatment outcome has received little investigation, it appears that most patients are dissatisfied with dermatological treatment and, even if the outcome is objectively acceptable, they do not worry any the less about their appearance afterwards.

In contrast, a majority of patients respond to serotonin reuptake inhibitors or cognitive behavioural therapy. Treatment of these patients is best given by an experienced health professional. This may be a mental health professional or a dermatologist with an interest in psychological medicine.

Keywords: body dysmorphic disorder, cosmetic dermatology, dysmorphophobia

Introduction

Cosmetic concerns are increasingly pervading Western societies,¹ perhaps no concern more so than in the search for perfect skin. Cosmetic dermatology is a rapidly growing specialty and cosmetic dermatologists are frequently consulted to evaluate and treat various cosmetic defects. While many such problems are easily treated and have a good treatment outcome, practitioners need to be alert to patients with body dysmorphic disorder (BDD). Individuals with this under-recognized and severe psychiatric disorder often present to cosmetic dermatologists.² In

fact, dermatologists appear to be the physicians most likely to be seen by patients with BDD.³ Even if the treatment outcome is objectively acceptable, it appears that most BDD patients are dissatisfied and continue to obsess about their perceived flaws.³ Occasionally, this results in litigation or even violence toward the treating physician.⁴⁻⁶ As one dermatologist stated: 'The author knows of no more difficult patients to treat than those with body dysmorphic disorder'.⁴

Thus, there are compelling reasons for dermatologists and psychiatrists to work together to identify patients with BDD and provide effective psychiatric treatment. In this article the authors provide an overview of BDD, including its definition and clinical features (including compulsive skin picking), its presentation and how to screen for BDD in a dermatology setting, and management approaches.

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Body dysmorphic disorder: definition and clinical characteristics

Individuals with BDD, also known as dysmorphophobia, are preoccupied with an imagined or slight defect in appearance; if a slight physical anomaly is present, the appearance concerns are excessive. In other words, these patients consider themselves ugly or deformed despite an objectively normal appearance. To differentiate BDD from normal appearance concerns, which are common in the general population¹ the preoccupation must cause clinically significant distress or impairment by functioning (for example, social or occupational interference).⁷ BDD is classified as a somatoform disorder by the official psychiatric classification system, the Diagnostic and Statistical Manual of Mental Disorders (DSM).⁷

BDD has been described for well over a century under such rubrics as 'dermatological hypochondriasis', 'beauty hypochondria', 'Hässlichkeitskümmerer' (one who is worried about being ugly), and 'dermatological nondisease'.⁸ Additional terms used in the dermatology literature are dysmorphophobia,^{5,9} dysmorphic syndrome^{10,11} and monosymptomatic hypochondriasis (delusions of dysmorphism)⁹ (Monosymptomatic hypochondriasis and delusions of dysmorphism are equivalent to the delusional form of BDD, in which patients are completely convinced that their view of the 'defect' is accurate and undistorted, rather than having some insight into the fact that their view is distorted).

BDD's clinical features have been well described.¹²⁻¹⁷ At the disorder's core is the belief of being misshapen, deformed, ugly, or unattractive in some way. This cognitive distortion becomes an obsession, and the thoughts cause considerable distress and are difficult to suppress. Patients worry about their perceived appearance flaws for an average of 3–8 h a day. Approximately 50% of patients who come to psychiatric attention hold on to their belief so tenaciously and unshakably that it is considered delusional.¹⁴

In a series of 188 individuals with DSM-defined BDD who presented to a psychiatrist,¹⁵ the skin and hair were the most common areas of concern. Skin concerns usually involve the facial skin but may focus on other areas as well (e.g. back, legs, or arms). Skin complaints commonly include acne, scarring, wrinkles, colour (usually the belief that the skin is too red or too white), or marks (e.g. red marks, white marks, veins, or moles). Hair concerns most commonly focus on perceived balding or excessive facial or body hair, although patients may present with virtually any hair-related complaint (e.g. the hair being too curly, too straight, or uneven). Most other clinical series have similarly found that skin and hair are among the most common concerns.^{16,17}

To try to ameliorate the distress caused by their beliefs, patients resort to a number of strategies, which are usually unsuccessful or only minimally successful.¹²⁻¹⁷ These include camouflaging with make-up or clothing (e.g. wearing scarves to cover a perceived scar on the neck); use of skin lighteners or tanning creams; excessive tanning; repeated mirror-checking (some instead avoid mirrors because of the distress associated with viewing themselves); and asking other people (including their dermatologist) for reassurance about how they look.

Studies from psychiatric settings have found that nearly all patients experience social interference as a result of their concern, thinking they are too ugly and feeling too embarrassed and self-conscious to be around other people.¹²⁻¹⁷ Academic and occupational interference (e.g. being late for work, decreased ability to focus and decreased productivity, or inability to work) are also present in a majority of cases. In one series of patients seen in a psychiatric setting ($n = 188$), approximately one third had been completely housebound for at least one week because of BDD symptoms.¹⁵ And in a study that used the SF-36 (MOS-36; $n = 62$), BDD subjects' scores on all domains of mental health related quality of life were notably worse than norms for the general US population and for patients with depression, diabetes, or a recent myocardial infarction.¹⁸ Clinical observations in the dermatology literature consistently note the distress and morbidity associated with BDD.^{5,10,11,19,20}

Of particular concern, studies from the US ($n = 188$)¹⁵ and England ($n = 50$)¹⁶ found that approximately one quarter of patients with BDD have attempted suicide. A study from England of dermatology patients who committed suicide reported that most had acne or BDD.²¹

Compulsive skin picking: a particularly problematic BDD symptom

Skin picking has been recognized for many years in the dermatology literature, with labels such as 'dermatillomania' and 'neurotic excoriation'.²²⁻²⁴ This behaviour has been reported in a high percentage of patients with BDD (27% of 123 patients in one series).²² BDD patients who pick their skin are more likely than BDD patients who do not pick to consult a dermatologist.²²

Patients typically describe skin picking as compulsive—something they feel driven to do and are unable to resist.²² This behaviour can consume many hours a day and may involve the use of pins, knives, staple removers, tweezers, and razor blades.^{22,23} Skin picking can be dangerous; for example, when the picking is so deep as to threaten or expose underlying vessels, which occasionally requires emergency surgical intervention.^{22,25}

Ironically, the picking can be time consuming and extensive enough to result in considerable disfigurement (e.g. notable lesions, sometimes with secondary infection, or deep scarring), even to the extent that dermatological or surgical intervention is required. In such cases, although the skin lesions may be obvious, the patient still qualifies for the BDD diagnosis because the lesions are self-inflicted and the person's appearance was within normal limits prior to initiation of picking. It should be emphasised that although this behaviour is self-injurious, these patients do not intend to harm themselves; they do so only as an unfortunate by-product of attempts to improve the appearance of their skin.

Although skin picking commonly occurs as a symptom of BDD (in one third of skin pickers in two series)^{22,26} this behaviour is heterogeneous and can occur as a symptom of a variety of underlying disorders.²³ In one series ($n = 31$), skin picking was considered the result of obsessive–compulsive disorder in 52% of cases.²³ In other cases, picking appears to be a habit that is not triggered by an obsessional thought. While it is sometimes difficult to determine the cause of the picking, if the patient indicates that it is driven by appearance concerns and is intended to make the skin look better, it is likely the result of BDD. For example, patients who pick in order to remove blemishes for the purpose of 'smoothing out' or clearing their skin are candidates for a diagnosis of BDD, whereas those who pick to 'cleanse' their skin may have obsessive–compulsive disorder.

Hair concerns in patients with BDD

As previously noted, hair concerns are also common in BDD patients, compelling some to seek dermatologic treatment. The most common hair-related concern is hair loss and a fear of going bald (especially in men).¹⁵ Some patients evidence slight hair loss, whereas others have unusually full hair. This concern can drive them to cover their hair with caps, hats, scarves, hairpieces, and wigs, and to apply various tonics and hair sprays. Some undergo hair transplantation and other cosmetic procedures; others use medications such as finasteride and minoxidil.

BDD preoccupations may also focus on excessive facial hair or too much or too little body hair. Patients may go to great lengths to cover these body areas, and may shave, wax, or pluck body hair excessively. Hair plucking can be very time consuming and may have a ritualised quality. As is the case for skin picking, hair plucking can result in disfigurement, infection, and scarring. The hair plucking that occurs in BDD should be differentiated from that

of trichotillomania: BDD patients pluck their hair to improve their appearance – for example, by removing 'excessive' facial hair or making eyebrows more 'even'; in contrast, hair plucking in trichotillomania is not motivated by specific beliefs or thoughts.

BDD in patients seeking dermatological treatment

To the best of the present authors' knowledge, only two studies have systematically screened for BDD in patients presenting to a dermatologist. One study from the US² found that 11.9% (95% confidence interval [CI], 8.0–15.8%) of 268 patients screened positive for BDD. Rates were similar in a university cosmetic surgery setting (10.0% [95% CI, 6.1–13.9%]) and a community general dermatology setting (14.4% [95% CI, 8.5–20.3%]). Eight (25%) of the 32 subjects who screened positive for BDD were male (9.9% of all male subjects), and 24 (75%) were female (12.8% of all female subjects). Patients who screened positive for BDD received a variety of dermatologic diagnoses. The most common diagnoses were problems such as acne, rosacea, benign vascular lesions such as haemangiomas and telangiectasias, scarring, and pores.² The other study, performed in Turkey, found that 8.8% of 159 patients with mild acne presenting to a dermatologist had BDD.²⁷ Eight were male, and six were female. All patients had additional preoccupations involving other body areas.

Little research has been performed on the outcome of dermatologic treatment in patients with BDD. The dermatology literature, on the basis of clinical observations, notes that these patients can be difficult to treat^{4,5,10,20} and are often dissatisfied with and have a poor response to dermatologic treatment.¹⁰ In addition, they may request extensive work-ups, consult numerous physicians, and pressure dermatologists to prescribe unsuitable and ineffective treatments.^{10,11}

Studies from a psychiatric setting confirm these observations. In the largest published series of individuals with DSM-defined BDD ($n = 250$), nonpsychiatric medical/surgical treatment was sought by 76.4% and received by 66.0% of adults.³ Dermatologic treatment was the type of treatment most often received, by 45.2% of adults, with 2.4 ± 2.6 (range = 1–20) courses of treatment per adult who received dermatologic treatment. Antibiotics were most commonly prescribed, but treatments included minoxidil, isotretinoin, and dermabrasion. Across all types of treatment, 35.6% ($n = 267$) of requested treatments were not received, including 25.4% of all requested dermatologic treatments. The most common reason for not receiving requested treatment was the physician's considering the treatment unnecessary and not providing

it (76.2%; $n = 170$). In this study, the most common outcome of dermatologic treatment was no change in preoccupation with the perceived appearance flaw and no overall improvement in BDD symptoms. Such treatment led to the worsening of overall BDD symptoms in 8% and improvement in 10% of treatments. In another study, 81% of 50 BDD patients seen in a psychiatric setting were either dissatisfied or very dissatisfied with the outcome of non-psychiatric medical consultation or operation.¹⁶ Prospective studies from both psychiatric and dermatology settings are needed to further investigate this important topic.

Screening for BDD in a dermatology setting

It is important that dermatologists screen for BDD by asking patients with non-existent or minimal appearance flaws how much time they spend thinking about their perceived flaws each day and the extent to which such concerns cause distress or interfere with their functioning. Patients who are preoccupied with the perceived flaws (who think about them for at least an hour a day, for example) and whose concerns cause clinically significant distress or impairment in functioning should be diagnosed with BDD. A simple and reliable set of questions that dermatologists can ask to diagnose BDD has been published.²⁸

Clinical experience suggests that once BDD is diagnosed, it is best to tell patients that they have a body image problem known as BDD; a number of resources are available for patients.^{13,29} Simply dismissing the concern, reassuring patients that they look fine, or telling them to stop picking their skin is usually ineffective. In contrast to dermatologic treatment, serotonin-reuptake inhibitors (citalopram, escitalopram, fluoxetine, sertraline, paroxetine, fluvoxamine, and clomipramine)^{13,30,31} as well as cognitive-behavioural approaches^{13,32,33} often appear to be effective. Focusing on the distress and disability caused by their concerns, rather than on how they actually look, may be helpful in persuading patients to accept psychiatric referral. For those who resist such referral, the dermatologist might consult with a psychiatric colleague and treat the patient himself or herself with a serotonin-reuptake inhibitor (for a suggested approach, see References 13,31).^{13,31} However, suicidality should always be assessed, with referral of suicidal and more severely ill patients to a psychiatrist experienced in treating BDD. More detailed suggestions for how dermatologists might approach BDD patients are discussed in other studies.^{4,5,34}

Conclusions

BDD is a relatively common psychiatric condition that is often very distressing and disabling. Many sufferers

are too embarrassed or ashamed to seek help from psychiatrists and, seeing their problem as a cosmetic one, seek treatment from cosmetic specialists, including cosmetic dermatologists. It is important for dermatologists to be aware of this disorder, as dermatological interventions appear generally unhelpful. Treatment is best given by a health professional experienced in treating these patients, who may be a mental health professional or dermatologist with an interest in psychological medicine.

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