

ARTICLE

Body dysmorphic disorder

Jennifer Ross & Simon Gowers

Jennifer Ross is an assistant psychologist and **Simon Gowers** is a Professor of Adolescent Psychiatry in the Section of Adolescent Psychiatry, University of Liverpool, UK. **Correspondence** Professor Simon Gowers, FRCPsych, University of Liverpool, Section of Adolescent Psychiatry, Academic Unit, 79 Liverpool Road, Chester CH2 1AW, UK. Email: simon.gowers@cwpl.nhs.uk

SUMMARY

Body dysmorphic disorder is a distressing and often disabling condition characterised by a preoccupation with imagined or slight physical defects in appearance. It has been recognised as a mental disorder for many years (and named body dysmorphic disorder since 1980), but epidemiological studies and clinical trials have been few. To a large extent, the disorder has been ignored by the mental health community, who often fail to elicit the diagnosis. This article reviews the diagnostic criteria for the disorder, its validity and its relationship to other disorders such as obsessive–compulsive disorder, anorexia nervosa, social phobia and somatisation disorders. The course of the illness, its aetiology and treatment approaches are discussed. As research is growing alongside an increase in patient presentations, body dysmorphic disorder requires a coherent response from healthcare services.

DECLARATION OF INTEREST

None.

Body dysmorphic disorder centres on an excessive concern and preoccupation with an imagined or minor defect in one's physical features. It is often disabling, but is underrecognised and often misunderstood by the general public and clinicians. Individuals with the disorder display a wide variety of symptoms, generally involving obsessive thoughts and compulsive behaviours relating to physical appearance. Facial features are most commonly the object of dissatisfaction. Body dysmorphic disorder is generally viewed as an obsessive–compulsive spectrum disorder, although some see it as an anxiety disorder, and it is classified in DSM-IV as a somatoform disorder (American Psychiatric Association 1994). It is sometimes confused with social anxiety disorder (with which it is commonly comorbid) as individuals with body dysmorphic disorder tend to be shy and socially avoidant.

History of the concept

Although body dysmorphic disorder has only recently been included in diagnostic systems, recognisable descriptions date to the 19th century. The characteristic features of 'dysmorphophobia' were first described in 1886 by Morselli. Subsequently, Kraepelin also described patients

with the disorder and Freud's description of 'the Wolf Man' can be seen as a probable case of body dysmorphic disorder (Brunswick 1928).

Eventually, dysmorphophobia was renamed body dysmorphic disorder, to distinguish it from primary phobic conditions, and listed as an atypical somatoform disorder in the American Psychiatric Association's DSM-III in 1980. No diagnostic criteria were included until the 1987 revision (DSM-III-R), in which it was classified as a separate disorder, with delusional and non-delusional subtypes.

With the publication of DSM-IV (American Psychiatric Association 1994), the criteria for body dysmorphic disorder were altered so that beliefs of a delusional nature were removed and coded separately on Axis I as delusional disorder, somatic type. Body dysmorphic disorder is included in the ICD-10 under 'hypochondriacal disorder' (F45.2), alongside hypochondriasis (World Health Organization 2007), which seems a less satisfactory classification. Furthermore, ICD-10 suggests a diagnosis of 'Other persistent delusional disorder' (F22.8) as an alternative in those whose beliefs are delusional, rather than this being an additional disorder as in DSM-IV. A DSM-5 working group is currently considering whether body dysmorphic disorder should be included within the category of obsessive–compulsive spectrum disorders (Phillips 2009). The key points of the DSM-IV and ICD-10 criteria are compared in Box 1.

BOX 1 Diagnostic criteria for body dysmorphic disorder

Both DSM-IV (American Psychiatric Association 1994) and ICD-10 (World Health Organization 2007) refer to preoccupation with appearance – in DSM (300.7) this is described as preoccupation with an imagined defect, whereas ICD (which includes body dysmorphic disorder within F45.2 hypochondriacal disorder) refers to persistent preoccupation with physical appearance.

Both systems now exclude delusional forms of dysmorphophobia.

DSM requires impairment of social or occupational functioning for the diagnosis, whereas ICD draws attention to the frequent occurrence of psychiatric comorbidity (especially depression and anxiety).

Reliability and validity of the diagnosis

Concern about appearance is very common and the boundary between mild body dysmorphic disorder and normal concern is often unclear. However, as with mood and anxiety disorders, the threshold for 'caseness' rests on the extent of impairment and preoccupation (often proposed as an hour a day at the forefront of one's mind). The perceived defect(s) or flaw(s) in physical appearance should not be observable or should appear slight to others. Cultural variables may play a significant part in the subjectivity behind determining which physical appearances are considered to be within the normal range, but any preoccupation should be considered abnormal.

Symptoms of body dysmorphic disorder overlap with those of other psychiatric disorders, such as major depressive disorder, obsessive–compulsive disorder (OCD), social phobia and eating disorders. In one study comparing body dysmorphic disorder with social phobia, 39.3% of 178 individuals with current body dysmorphic disorder had comorbid lifetime social phobia (34.3% had current social phobia) (Coles 2006). Social phobia onset was typically before that of body dysmorphic disorder and unrelated to appearance concerns. Individuals with body dysmorphic disorder, with and without lifetime social phobia, were similar in many characteristics such as age at body dysmorphic disorder onset, gender distribution, body dysmorphic disorder severity and overall functional disability (Coles 2006).

Although body dysmorphic disorder is categorised as a somatoform disorder in DSM-IV, many now view it as more closely related to OCD, due to its obsessive–compulsive symptoms and positive response to similar therapy and drug treatments. It appears to differ in several important respects however. Only 30% of people with OCD have an additional diagnosis of depression, compared with 80–90% of people with body dysmorphic disorder (Phillips 2007). Although in this series there was considerable overlap between the disorders, differences also emerged over the degree of insight, suicidal ideology and depressive comorbidity (all higher in body dysmorphic disorder). In contrast to OCD, individuals with body dysmorphic disorder do not normally find relief of anxiety by performing rituals such as mirror checking or grooming rituals – instead these may increase feelings of despair. Unlike other anxiety disorders, body dysmorphic disorder is much more likely to be accompanied by feelings of shame, guilt, disgust, self-hatred and depression.

The distinction between delusional and non-delusional forms of body dysmorphic disorder has

been questioned. Phillips *et al* (1994) compared 48 patients with non-delusional body dysmorphic disorder with 52 patients with delusional body dysmorphic disorder and found that they did not significantly differ in terms of sociodemographics, phenomenology, course of illness, associated features, comorbidity or treatment response. Patients with delusions had higher total scores on the modified Yale–Brown Obsessive Compulsive Scale questionnaire, suggesting that the delusional variant of body dysmorphic disorder may be a more severe form of the disorder.

Epidemiology

The incidence of body dysmorphic disorder is uncertain as population-based studies are lacking. Most individuals are first aware of symptoms during adolescence or early adulthood but in some, symptoms begin to appear in middle childhood and in others, quite late in life, often after a traumatic event. Reported rates vary depending on the gender ratio, the diagnostic threshold and instrument used to measure body dysmorphic disorder, the culture and the survey method used. For example, a German population study (Rief 2006) involving 2552 individuals aged 14 and above gave a prevalence of 1.7% (95% CI 1.2–2.1).

Unlike eating disorders, which are much more prevalent in women, body dysmorphic disorder appears to be as common in men as in women (at least in Western societies), although fewer men seek help for the disorder than women (Phillips 2005a). Surveys of body dysmorphic disorder in cosmetic surgery settings and dermatology clinics suggest that the disorder is relatively common in these populations, with a prevalence of between 3 and 10%. In psychiatric settings the diagnosis (although relatively easy to make) is often missed, as clinicians do not routinely ask about it. Thus in a study of consecutive adult psychiatric in-patients (Grant 2001), 16 of 122 individuals (13.1%) were diagnosed as having body dysmorphic disorder, although none had been diagnosed as such by their treating psychiatrist. All 16 patients reported that they would not raise the issue with their doctor unless specifically asked because of feelings of shame.

Conroy *et al* (2008) found a similar rate of 16% among psychiatric in-patients. A high proportion of patients reported that body dysmorphic disorder symptoms contributed to their suicidality, but only 1 out of the 16 (6.3%) had reported symptoms to the in-patient psychiatrist; the other 15 were too embarrassed to do so.

Both of these studies underline the importance of routinely asking a screening question for body

dysmorphic disorder in psychiatric service users, particularly in-patients and those presenting with depression, social phobia, OCD, alcohol or substance misuse or suicidal ideation.

Because patients do not readily volunteer their symptoms, the National Institute for Health and Clinical Excellence (NICE) guidelines for body dysmorphic disorder (National Collaborating Centre for Mental Health 2005) suggest that a simple open question should be used in a psychiatric assessment interview. An example is: ‘Some people worry a lot about their appearance. Do you worry a lot about the way you look and wish that you could think about it less?’ When answered positively, this should be followed up with further questions to clarify the extent and nature of bodily concerns and, for example, to distinguish body dysmorphic disorder from a possible eating disorder.

Clinical features

‘I didn’t go to college yesterday. I got up early and started to get ready to go today but I couldn’t. I put my makeup on but nothing would go right. I look at my reflection and I feel physically sick. I have huge bags under my eyes and my eyelids are red. My face is all swollen and the skin is terrible. I just collapsed in tears. My mum was angry with me because I didn’t go, and I just felt worthless. She said there was nothing wrong with me and I was ruining my life. I don’t want to be like this. Yesterday I cut myself all over my arms and my hands, and today it’s starting to hurt a bit as the wounds start to heal. I’ve been crying a lot. I thought maybe things were getting better but I was just kidding myself. Nothing can get better yet. I’m just trapped.’ (Anonymous 2002)

This personal account illustrates how distressing the disorder can be. To some extent, the preoccupations of body dysmorphic disorder can lie at one end of a continuum of ordinary appearance

concerns. However, the disorder covers a large spectrum of functionality, with some individuals merely being preoccupied with obsessive thoughts about appearance and others being completely housebound or subject to suicidal ideas.

Body dysmorphic disorder may lead to avoidant behaviours, culminating in extreme social isolation. In some cases, multiple surgery and attempts at body modification (including self-mutilation) are employed, although these generally fail to improve the person’s view of their ‘defect’. Depression is very common and occasionally leads to suicide. Body dysmorphic disorder sometimes occurs in episodic ‘attacks’, which are followed by a spell of normal functioning. In such episodes, the person will be consumed with self-doubt, comparing themselves to others and feeling extremely anxious.

Many of the symptoms (Box 2) and behaviours (Box 3) associated with body dysmorphic disorder are determined by the nature of the individual’s perceived defect (Box 4), for example, the (over) use of cosmetics is common in those with a perceived skin defect. Although the most frequent obsessions concern facial appearance, many women are plagued with body proportion concerns, while men tend to be preoccupied with the need to be larger and more muscular. Phillips & Diaz (1997) assessed gender differences in 188 individuals with body dysmorphic disorder (93 women and 95 men). Men and women did not significantly differ in terms of most variables examined, including rates of major depression, although women were more likely to be preoccupied with their hips and their weight, pick their skin and camouflage their skin with makeup, and have comorbid bulimia nervosa. Men were more likely to be preoccupied with body build, genitals and hair thinning, be unmarried and misuse alcohol. Men were as likely as women to have sought cosmetic surgery.

BOX 2 Common symptoms

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| <ul style="list-style-type: none"> • Preoccupation with perceived appearance of defect • Depressive symptoms • Delusional thoughts and beliefs related to appearance • Suicidal ideation • Anxiety, panic attacks • Chronic low self-esteem • Self-consciousness in social situations; thinking that others notice and | <ul style="list-style-type: none"> mock their perceived defect • Feelings of shame • Social and family withdrawal, social phobia, loneliness and self-imposed social isolation • Overdependence on others such as a partner, friend or parents • Inability to work or an inability to focus at work owing to preoccupation with appearance | <ul style="list-style-type: none"> • Decreased academic performance (problems maintaining grades, problems with school/college attendance) • Problems initiating and maintaining relationships (both intimate relationships and friendships) • Alcohol and/or drug misuse (often an attempt to self-medicate) |
|---|---|--|

Compulsive behaviours

Mirror-checking

Mirror-checking is one of the most common compulsive behaviours in body dysmorphic disorder, although often with much ambivalence. Individuals often check their appearance in other reflective surfaces such as shop windows. Others, meanwhile, avoid mirrors altogether, covering them, taking them down or turning off lights when they approach one. Because a body dysmorphic disorder attack often occurs during a stressful time, compulsive behaviour such as mirror-checking will increase as well. Therefore, many people find that they associate their self-hatred and hopelessness with mirrors and their reflection.

Cameras and photography

Many concerns focus on photographs. A person with body dysmorphic disorder may avoid intimate family gatherings just to prevent themselves from being photographed. Having their face caught on film creates much distress, as the person may become concerned about who will see it and what they will think. A photograph almost always convinces someone with body dysmorphic disorder that their negative self-image is justified. Most people with the disorder do not want to take a chance of being photographed, as looking at an image they consider to be unfavourable can bring about an attack.

Social and occupational functioning

Many individuals with body dysmorphic disorder are very uncomfortable in social situations as they have difficulty relating to other people. Their natural body language is often restricted, because they feel stressed that people around them might observe them and judge them unfavourably. Because of this fear, some people will not leave the house during the day time and avoid social situations. Some are able to hold down a job and keep a social life, but most are constantly worrying about what others think of them. They harbour feelings of inferiority and it causes much distress, often unseen by outsiders.

Academic functioning

Because the onset of body dysmorphic disorder typically occurs in adolescence, an individual's academic functioning may be significantly affected. Depending on the severity of symptoms, an individual may experience great difficulty maintaining grades and attendance or, in severe cases, may drop out of school and therefore not reach their academic potential. The vast majority of people with body dysmorphic disorder (90%) say that their disorder has an impact on their academic/occupational functioning, and 99% say that their disorder has an impact on their social functioning (Phillips 2005a).

Relationships

Despite a strong desire for relationships with other people, many individuals with body dysmorphic disorder will instead choose to be lonely rather than risk being rejected or humiliated about their appearance by getting involved with others. Many people with the disorder also have coexisting social phobia and/or avoidant personality disorder, making the individual's ability to establish relationships problematic.

BOX 3 Compulsive behaviours

- Mirror-checking, glancing in reflective doors, windows and other reflective surfaces
 - Alternatively, avoidance of one's own reflection or photographs of oneself; often the removal of mirrors from the home
 - Attempting to camouflage imagined defect (e.g. using cosmetic camouflage, wearing baggy clothing, maintaining specific body posture or wearing hats)
 - Excessive grooming behaviours (e.g. skin-picking, combing hair, plucking eyebrows, shaving)
 - Compulsive skin-touching, especially to measure or feel the perceived defect
 - Becoming hostile towards people for no known reason, especially those of the opposite gender
 - Seeking reassurance from loved ones
 - Excessive dieting and exercise
 - Comparing appearance/body parts with that of others, or obsessive viewing of favourite celebrities or models that the person with body dysmorphic disorder wishes to resemble
 - Use of distraction techniques: an attempt to divert attention away from the person's perceived defect (e.g. wearing extravagant clothing or excessive jewellery)
 - Compulsive information-seeking: reading books, newspaper articles and websites which relate to the person's perceived defect (e.g. hair loss or dieting and exercise)
 - Preoccupation with plastic surgery or dermatology procedures
 - Attempt to perform cosmetic surgery on themselves, including liposuction or removal of unwanted blemishes
 - Avoidant behaviour: avoiding leaving the home, or only leaving the home at certain times, for example, at night
- (Phillips 2005a)

Quality of life

A range of standardised quality-of-life measures have suggested that individuals with body dysmorphic disorder, regardless of whether or not they are involved in treatment, have remarkably poor functioning and quality of life (Phillips 2005b).

BOX 4 Common locations of perceived defects

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|-----------------------------------|--------------------------|-----------------------|
| • Skin (73%) | • Face size/shape (12%) | • Forehead (6%) |
| • Hair (56%) | • Lips (12%) | • Feet (6%) |
| • Nose (37%) | • Buttocks (12%) | • Hands (6%) |
| • Weight (22%) | • Chin (11%) | • Jaw (6%) |
| • Abdomen (22%) | • Eyebrows (11%) | • Mouth (6%) |
| • Breasts/chest/nipples (21%) | • Hips (11%) | • Back (6%) |
| • Eyes (20%) | • Ears (9%) | • Fingers (5%) |
| • Thighs (20%) | • Arms/wrists (9%) | • Neck (5%) |
| • Teeth (20%) | • Waist (9%) | • Shoulders (3%) |
| • Legs (overall) (18%) | • Genitals (8%) | • Knees (3%) |
| • Body build/bone structure (16%) | • Cheeks/cheekbones (8%) | • Toes (3%) |
| • Facial features (general) (14%) | • Calves (8%) | • Ankles (2%) |
| | • Height (7%) | • Facial muscles (1%) |
| | • Head size/shape (6%) | |
- (Phillips 2005a)

Comorbidity

Comorbidity with other psychiatric disorders is common. About 80% of people with body dysmorphic disorder will experience major depressive disorder at some point in their life, significantly more than the 10–20% expected in the general population (Phillips 2005a). About 37% also have social phobia and about 32% fulfil criteria for OCD. Eating disorders such as anorexia nervosa and bulimia nervosa are also sometimes found in women with body dysmorphic disorder, as are generalised anxiety disorder and trichotillomania. As comorbidity is the rule, it is more important clinically to differentiate when body dysmorphic disorder is the main problem and which comorbid features would disappear if the disorder was effectively treated, and which are true coexisting disorders.

Obsessive–compulsive disorder

Phillips *et al* (2007) compared the characteristics of patients with OCD ($n=210$), body dysmorphic disorder ($n=45$) and comorbid body dysmorphic disorder/OCD ($n=40$). Those with obsessive–compulsive disorder and body dysmorphic disorder did not significantly differ in terms of demographic features, age at onset or illness duration. However, patients with body dysmorphic disorder had significantly poorer insight than those with OCD and were more likely to have delusions. Individuals with body dysmorphic disorder were also significantly more likely than those with OCD to have lifetime suicidal ideation, as well as lifetime major depressive disorder and a substance use disorder.

Eating disorders

A number of studies have shown comorbidity with eating disorders. Rabe-Jablonska & Tomasz (2000) examined 36 adolescents with anorexia nervosa and 40 healthy controls. They found symptoms of body dysmorphic disorder in 25% of those with anorexia nervosa and these were generally present for at least 6 months before the eating disorder emerged. Phillips & Diaz (1997) have shown an association between body dysmorphic disorder and bulimia.

Personality disorders

At least 50% of individuals with body dysmorphic disorder have comorbid personality disorder. The most common are Cluster C personality types, with avoidant, paranoid, obsessive–compulsive and dependent personality disorders the most prevalent.

Suicidality

Studies have consistently found suicidal ideation and suicide attempts to be common in people with body dysmorphic disorder. Suicidality may increase when cosmetic surgery is denied. Veale *et al* (1996) found that 25–30% of patients with body dysmorphic disorder in a psychiatric clinic have had a history of attempted suicide.

A total of 200 individuals with DSM-IV body dysmorphic disorder recruited from diverse sources were assessed with standard measures (Phillips 2005b). Patients had high rates of lifetime suicidal ideation (78.0%) and suicide attempts (27.5%). Body dysmorphic disorder was judged to be the primary reason for suicidal ideation in 70.5% of those with a history of ideation and nearly half of those with a past suicide attempt.

In another study of 185 participants with body dysmorphic disorder, suicidal ideation was reported by 57.8% per year, and 2.6% per year attempted suicide. Two individuals (0.3% per year) completed suicide (Phillips 2006).

Aetiology

Body dysmorphic disorder usually develops in adolescence, a time when people are generally most sensitive about their appearance. As with other anxiety and somatic disorders, a multifactorial aetiology is presumed. Most likely, the cause comprises a complex combination of biological, psychological and environmental factors.

Biological factors

Genetic predisposition is suggested by family studies. Approximately 20% of people with body dysmorphic disorder have at least one first-degree relative who also has the disorder. It is not clear, however, whether this reflects genetic or shared environmental factors. No twin studies or genetic studies have been conducted specifically for body dysmorphic disorder. A family history of OCD has also been found to exist in those with body dysmorphic disorder suggesting a possible shared genetic vulnerability.

Abnormalities in serotonergic pathways have been postulated, given serotonin's purported role in regulating anxiety, as well as in such processes as sleep and memory function. It is hypothesised that people with body dysmorphic disorder may have blocked or damaged receptor sites that prevent serotonin from having its full effect (Phillips 2005a), although this is unconfirmed and not specific to body dysmorphic disorder. Nevertheless, many patients with body dysmorphic disorder respond positively to selective serotonin

reuptake inhibitors (SSRIs), lending support to the theory. Dysregulation of other neurotransmitters such as dopamine and gamma aminobutyric acid have also been proposed as contributory factors in the development of the disorder (Phillips 2005a).

Psychological and environmental factors

A range of environmental variables have been postulated as aetiological factors within a variety of theoretical frameworks such as social learning theory, operant conditioning and cognitive-behavioural models (Neziroglu 2008). Parenting attitudes may contribute to body dysmorphic disorder, for example where parents place excessive emphasis on aesthetic appearance. Bullying regarding appearance may play a contributory role – about 60% of people with body dysmorphic disorder report frequent or chronic childhood teasing (Phillips 2005a).

Personality traits which have been proposed as vulnerability factors include perfectionism, introversion, narcissism, schizoid personality and avoidant personality.

Life events such as physical or sexual trauma, rejection with subsequent insecurity, as well as social and academic stresses during adolescence have been postulated to precipitate the condition. Media influences, meanwhile, emphasising the necessity of aesthetic beauty, may contribute to body dysmorphic disorder in a similar way as is proposed for eating disorders (Neziroglu 2008).

Course

The course of the disorder is often chronic, with a poor prognosis for complete recovery. Even with specialised treatment, the recovery process is often long, and remission and relapse are common.

Treatment

Attitude to treatment and motivation

Although effective treatments are available either specifically for body dysmorphic disorder or comorbid symptoms, there are a number of obstacles to their effective delivery. Many people with body dysmorphic disorder have depression, making them unmotivated to work towards recovery. Others are highly sceptical of the idea that they have a psychological disorder at all and seek cosmetic procedures as an alternative to psychological treatment. Many are housebound and have extreme social phobia or are too anxious, embarrassed or ashamed to seek treatment and talk to a therapist. Finally, body dysmorphic disorder is often misunderstood by therapists and finding effective treatment can therefore be challenging.

Psychological interventions

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is considered the treatment of choice. Pathological processes such as ruminating and comparing are focused on using exposure and behavioural experiments (Veale 2010). There have been a small number of randomised controlled trials (RCTs) demonstrating the effectiveness of CBT.

Rosen *et al* (1995) randomly assigned 54 individuals with body dysmorphic disorder to CBT or no treatment. Patients were treated in small groups for eight 2-hour sessions. Therapy involved modification of intrusive thoughts of body dissatisfaction and overvalued beliefs about physical appearance, exposure to avoided body image situations, and elimination of body checking. Symptoms of body dysmorphic disorder were significantly decreased in the CBT group, and the disorder was absent in 82% of participants at the end of treatment and 77% at follow-up. Overall psychological symptoms and self-esteem also improved.

Veale *et al* (1996) conducted a small RCT in which 19 patients were randomly allocated to either CBT or a waiting list control group over 12 weeks. There were no significant pre-post differences on any of the measures in the waiting list group. There were significant changes in the CBT group on specific measures of body dysmorphic disorder and depressed mood.

Exposure and response prevention

Exposure and response prevention involves facing anxiety-provoking situations while resisting the typical (reinforcing) response to them. It is often given in conjunction with CBT. The individual draws up a hierarchical list of feared and avoided situations and then selects an item to address. Patients may be asked to consider an alternative explanation for their body image problem and to test this out to determine whether their method of coping (avoidance, checking, comparing, ruminating, being excessively self-focused) maintains their preoccupation and distress. Gradually, patients are encouraged to increase exposure to public and social situations while dropping their safety behaviours.

Pharmacological treatment

A range of antidepressants have been used in body dysmorphic disorder (most commonly SSRIs), but RCTs have been few.

Higher doses of SSRIs and longer durations of treatment than those used for other psychiatric disorders including depression are often needed,

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as with the treatment of OCD, and there is a possibility of relapse on discontinuation of SSRIs.

In a placebo-controlled parallel group study of fluoxetine (Phillips 2002), 67 patients were randomised to either fluoxetine or placebo: 18 (53%) responded to fluoxetine compared with 6 (18%) to placebo. Body dysmorphic disorder symptoms of patients with delusions were as likely as those of patients without delusions to respond to fluoxetine. Treatment response was independent of the duration and severity of the disorder and the presence of major depression, OCD or personality disorder. Fluoxetine was generally well tolerated.

A double-blind, crossover study of clomipramine *v.* desipramine involving 29 people with body dysmorphic disorder found clomipramine to be superior as measured by assessment of participants' obsessive preoccupation, repetitive behaviours and global ratings of symptom severity (Hollander 1999). This treatment efficacy was independent of the presence or severity of comorbid OCD, depression or social phobia. Clomipramine was also found to be effective in this study among patients with delusional beliefs.

Antipsychotic drugs have been disappointing according to retrospective case reports (Phillips 1996). Even delusional thoughts tend to be unresponsive and individuals may be troubled by adverse effects such as weight gain, which may exacerbate a body image problem. Augmentation of SSRIs with pimozide was found to confer no benefit over augmentation with placebo in a controlled trial (Phillips 2005c).

Non-psychiatric medical treatment

Non-psychiatric medical treatment does not appear to be effective for the majority of people with body dysmorphic disorder (Crerand 2006). In a study of 200 individuals with the disorder, dermatological treatment was most frequently sought, followed by surgery (most often rhinoplasty). Of the patients in this series, 12% received isotretinoin (for acne), but none of these treatments reliably improved body dysmorphic disorder.

Surgery is rarely helpful to patients with body dysmorphic disorder, with patients being vulnerable to transferring concern to another bodily 'abnormality' or increasing focus on the surgically altered one, seeing it as still ugly and in need of further attention. Cosmetic surgery can lead to never-ending requests for more surgery and consequent financial difficulty.

NICE guidance

The UK NICE guidelines for OCD and body dysmorphic disorder (National Collaborating

Centre for Mental Health 2005) suggest a stepped-care approach to treatment. For mild cases, or as a first step, guided self-help is recommended, using a book such as that by Veale and colleagues (2009). A meta-analysis of studies of psychological and pharmacological interventions (Williams 2006) supported the effectiveness of both psychological therapies (mainly CBT) and pharmacological treatment (mainly SSRIs). The NICE guidelines concluded therefore that individuals with a disorder of moderate severity should be offered an SSRI or CBT, with a combination of the two reserved for severe cases. The guidelines do not recommend the use of antipsychotics, as even patients with comorbid delusional disorder may respond to an SSRI. Those failing to make progress should be referred to a multidisciplinary specialist service for OCD/body dysmorphic disorder.

Conclusions

Body dysmorphic disorder remains poorly understood and rarely identified within generic mental health services. Guidance from NICE and revised classification systems which highlight links with obsessive-compulsive disorders should help establish the validity of the condition and clarify potential treatment approaches.

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MCQs

Select the single best option for each question stem

1 Females with body dysmorphic disorder:

- a outnumber males by 10 to 1
- b are more commonly preoccupied with their legs than their face
- c commonly use masking skin products
- d rarely have comorbid eating disorders
- e make frequent demands on primary care services.

2 Patients with body dysmorphic disorder:

- a usually experience onset of the disorder before puberty
- b are attention-seeking and enjoy social occasions

- c commonly check their appearance in mirrors
- d are highly critical of others' appearance
- e usually have a noticeable physical defect.

3 Pharmacological treatment:

- a is not indicated for body dysmorphic disorder
- b is effective in body dysmorphic disorder
- c comprises a benzodiazepine or similar anxiolytic
- d using SSRIs may require a higher dose than for depression
- e may reduce comorbid depression, but not the underlying dysmorphia.

4 Non-psychiatric medical treatment:

- a rarely produces a lasting benefit
- b is more effective than psychotropic drugs

- c comprising a single surgical procedure is generally effective
- d should include colonic irrigation
- e comprises a course of many operations.

5 The long-term outcome of body dysmorphic disorder:

- a often includes spontaneous remission
- b is unaffected by treatment
- c is better if the preoccupation focuses on the face
- d is better for men than women
- e may include suicide.