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Mini Review

Body Dysmorphic Disorder in Dermatology: Prevalence, Challenges and Clinical Implications

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ABSTRACT

Body Dysmorphic Disorder (BDD) is a psychiatric disorder characterized by a preoccupation with perceived physical flaws, resulting in significant distress and impairment. The prevalence of BDD in the general population ranges 0.7% to 2.4%, with significantly higher rates observed in dermatological settings (9% to 12%) and cosmetic surgery settings (3%-53%). BDD patients frequently seek dermatological rather than psychiatric help, often undergoing unnecessary cosmetic procedures, increasing physical and psychological risks. Effective diagnosis of BDD in dermatologic settings requires screening tools such as the Body Dysmorphic Disorder Questionnaire-Dermatology Version (BDDQ-DV) and the adolescent version. Treatment typically involves Selective Serotonin Reuptake Inhibitors (SSRIs) combined with Cognitive Behavioral Therapy (CBT). Dermatologists can play a crucial role in identifying and managing BDD by screening patients with chronic dermatological conditions and aesthetic concerns. Collaboration with mental health professionals is essential for comprehensive care. Increased vigilance among dermatologists regarding BDD can lead to timely diagnosis, intervention, and can improve patients' quality of life. In conclusion, the high prevalence of BDD in dermatological settings highlights the need for multidisciplinary approach to improve patient outcomes.

Keywords: Body dysmorphic disorder; Dermatology; Psychosocial; Quality of Life (QoL)

INTRODUCTION

Body Dysmorphic Disorder (BDD) is a psychiatric disorder characterized by a preoccupation with perceived flaws in physical appearance, with such flaws being unobservable or minimal to others [1]. This intense focus on perceived flaws results in great distress for BDD sufferers, causing psychological, physical, and functional impairment, disrupting daily activities, social interactions, and overall quality of life [2].

BDD's preoccupation with appearance most commonly affects the face and head, particularly the skin, nose and hair [3]. Insight into the distorted appearance-related beliefs is often poor, with 32% to 38% of individuals experiencing delusional beliefs about their appearance [4]. Consequently, these individuals are more likely to seek the assistance of dermatologists rather than psychiatrists, as they perceive their concerns to be primarily physical rather than psychological. In fact, dermatologists are the physicians most likely to be seen by patients with BDD [5]. Despite dermatological treatment, and even objectively favorable treatments, most patients with BDD remain dissatisfied and continue their preoccupation with their flaws, with one study showing that 72% of non-psychiatric treatment procedures led to no change in their BDD symptoms while 16% experienced worsening of symptoms [5].

LITERATURE REVIEW

In this review, further exploration and comprehensive information on BDD is provided in the context of dermatologic care. The aim is to enhance understanding of the manifestation

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of BDD in dermatologic settings, identify patterns and challenges faced by patients and clinicians, and highlight research gaps in current literature to help inform clinical practice and improve patient management.

BDD prevalence in dermatology patients

Several studies have examined the prevalence of BDD in dermatological settings. A recent systematic review of the prevalence of BDD in the Dermatology setting to be a mean of 12.5% and in cosmetic dermatology patients as high as 25% compared to 2% in the general population [6,7]. Mixed results have been published regarding gender and age trends among patients with BDD and dermatological conditions, however, most show that BDD is associated more with females between 18 and 24 with a slight male preponderance in the cosmetic surgery setting [7,8]. This significantly higher prevalence of BDD in dermatological setting compared to the general population underscores the need for dermatologists to be vigilant in identifying potential markers of BDD in their practice, especially among younger patients seeking care.

Understanding the behaviors and characteristics of BDD patients is essential for effective identification and management. Individuals with BDD typically exhibit behaviors preoccupied with perceived flaws that are minor or nonexistent, often spending excessive amounts of time scrutinizing their appearance [9,10]. These individuals frequently engage in repetitive behaviors like mirror checking, skin picking, and seeking constant reassurance about their appearance [4]. These behaviors can influence treatment-seeking patterns, and the potential risks involved.

Potential dangers exist in patients with BDD seeking treatment, including undergoing excessive or unnecessary cosmetic procedures. One review showed that around 76% of BDD patients undergo aesthetic treatments in order to 'repair' perceived defects in their physical appearance [5]. These patients often pursue both dermatological and surgical interventions, such as chemical peels, microdermabrasion, rhinoplasty and other corrective measures, in the hopes of achieving their ideal self-image [11]. Unfortunately, undergoing any range of procedures comes with its own set of adverse effects. Even when treatments are performed safely, they carry increased risk of physical harm due to the invasive nature of some procedures, such as surgeries or aggressive dermatological treatments like isotretinoin and laser or surface dermabrasion even when not warranted by clinical findings [11]. Financial hardship is another significant concern, as costs associated with repeated and often ineffective treatments can accumulate quickly, placing a potential burden on the individual. Thus, dermatologists should be aware of treatment seeking behavior in the patient population and understand that further dermatological treatment may cause further patient dissatisfaction [11].

Mechanisms linking BDD and dermatological conditions

Psychological stress is a well-documented factor that plays a critical role in the development and exacerbation of various skin diseases. While there is no established pathophysiological link between BDD and dermatological conditions, various associations have been identified. Koblenzer, [12], reference a developmental connection between BDD, body image, and self-esteem that forms early in life, with nearly 75% of BDD patients reporting a history of childhood maltreatment. Additionally, a potential neuropsychiatric link may involve the size of the orbitofrontal cortex and network associations found in BDD patients. Stress likely plays a significant role in BDD, as patients with the disorder experience higher perceived stress levels, which can act as a bidirectional trigger, increasing their risk of developing various dermatologic conditions such as acne, urticaria, erythema, dermatitis, and eczema [12]. While treatment of dermatological disorders may serve as a temporary solution, the persistence of BDD may not cease, thus requiring psychological intervention.

The impact of social media on self-image and confidence is particularly significant for individuals with Body Dysmorphic Disorder (BDD). The pervasive nature of social media amplifies beauty standards and ideals, altering perceptions of attractiveness [2]. Constant exposure can exacerbate their preoccupation with perceived physical defects, potentially leading them to seek dermatological or surgical interventions to align with these ideals [13]. This cycle of exposure and dissatisfaction highlights how social media can contribute to the ongoing distress and treatment-seeking behaviors in BDD patients.

Assessment and diagnosis of BDD in dermatology settings

Diagnosing BDD in dermatology settings presents unique challenges. Unlike psychiatric settings, where patients may present explicit concerns about their mental health, individuals with BDD often approach dermatologists due to perceived flaws in their appearance [14]. This makes early recognition and intervention important, as untreated BDD can lead to severe psychiatric problems such as depression, anxiety, social isolation, or even suicidal ideation [2].

Due to the complexity and sensitivity of BDD symptoms, patients may feel embarrassed or reluctant to disclose the extent of their distress, which can result in misdiagnosis or under diagnosis [15]. Therefore, it is essential to use effective screening tools that are both sensitive and specific to BDD symptoms in dermatology settings.

One of the most widely used screening tools is the Body Dysmorphic Disorder Questionnaire-Dermatology Version (BDDQ-DV). This is a validated self-reporting screening tool specifically designed for use in adult dermatology settings. Created as a brief questionnaire with yes/no answers make in office administration time both efficient and effective. It has demonstrated a sensitivity of 100% and a specificity of 92.3%, making it highly effective at identifying patients with BDD [16]. Additionally, a modified version of the BDDQ has been created for adolescents (BDDQ-Adolescent Version) who are at risk for developing BDD [15].

DISCUSSION

Management and treatment strategies

Treatment approaches for BDD typically include a combination of pharmacotherapy with Cognitive Behavioral Therapy (CBT) to change negative thought patterns. Selective Serotonin Reuptake Inhibitors (SSRI) are the first line pharmacotherapy for BDD, commonly fluoxetine and escitalopram. They have been shown to improve core symptoms of BDD including quality of life and suicidality in more ill patients [15].

Clomipramine can be used, but it is typically reserved for patients who have not responded to SSRI's as it has a more negative side effect profile [17]. It is important to note that therapeutic dosing for treatment of BDD tend to be significantly higher than doses of SSRI's used to treat other psychiatric disorders, posing potential problems regarding tolerance and use in pediatric populations [18].

Like most psychiatric conditions, BDD shows superior outcomes with multimodal treatment, combining CBT and medications, compared to either treatment alone. Rautio et al. evaluated the impact of a combination of CBT and pharmacotherapy in adolescents with BDD and found significant reductions in Yale-Brown Obsessive Compulsive Disorder Scale Modified for BDD, Adolescent Version (BDD-YBCOS-A) scores (coefficient=-16.33) with continued improvement in scores at 12 months follow up [19].

Role of dermatologists and multidisciplinary care

The impact of BDD on a patient's health is significant, with treatment usually falling into the hands of mental health professionals and psychiatrists. Dermatologists, however, can act as a crucial link for patients to obtain the help they need. Experts suggest that adult dermatologist patients with aesthetic chief complaints that appear to be high risk should be screened for BDD [2]. This is less clear in adolescent dermatology patients, with experts advising screening patients with conditions such as acne, atopic dermatitis, psoriasis, hidradenitis suppurativa, bullous diseases, and prurigo nodularis that are seeking aesthetic treatments, as BDD has a higher incidence in these patients [8]. Dermatologists concerned that an adolescent patient has BDD should screen them patients using the BDDQ-Adolescent Version and inquire about the extent of social media use, as it has been linked to increased risk of negative body image [2]. Ultimately, dermatologists can support patients with BDD by screening patients, offering educational mental health resources, and collaborating with a network of mental health professionals to ensure seamless and timely referrals to appropriate mental health services [2,20].

CONCLUSION

Body dysmorphic disorder is a significant psychiatric condition that profoundly affects individuals' daily lives by distorting their perception of self-image, leading to potentially harmful behavior and emotional distress. The prevalence of BDD in dermatological and cosmetic surgery settings is notably high compared to the general population, underscoring the need for dermatologists to act as a bridge in identifying treatment and care. The unique challenges posed by BDD necessitate a comprehensive approach to diagnosis and management, especially in dermatology settings where patients may present with appearance-related concerns or aesthetic treatment requests, rather than psychiatric symptoms. Enhancing the understanding and awareness of BDD among dermatologists and other healthcare professionals is essential for providing timely diagnosis and intervention, as well as assisting in defining and delineating achievable cosmesis for these patients. Further collaboration between dermatology and psychiatry is important in developing effective strategies and treatment implementation for management of BDD, hopefully resulting in improved quality of life for affected individuals.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition. 2013.
2. Sejdiu Z, Stitzlein E, Rieder EA, Andriessen A, Greenberg JL, Oza VS, et al. Appearance dissatisfaction and body dysmorphic disorder in the dermatology Patient. J Drugs Dermatol. 2024;23(7):545-550.
3. Neziroglu F, Khemlani-Patel S, Veale D. Social learning theory and cognitive behavioral models of body dysmorphic disorder. Body image. 2008;5(1):28-38.
4. Singh AR, Veale D. Understanding and treating body dysmorphic disorder. Indian J Psychiatry. 2019;61(S1):S131-S135.
5. Phillips KA, Grant J, Siniscalchi J, Albertini RS. Surgical and nonpsychiatric medical treatment of patients with body dysmorphic disorder. Psychosomatics. 2001;42(6):504-510.
6. Saade N, Chedraoui CP, Mitri MT, Salameh P, Said Y, El Khoury JE. The prevalence of body dysmorphic disorder in outpatient dermatology clinics: A systematic review. Clin Exp Dermatol. 2024:llae204.
7. Veale D, Gledhill LJ, Christodoulou P, Hodsoll J. Body dysmorphic disorder in different settings: A systematic review and estimated weighted prevalence. Body image. 2016;18:168-186.
8. Schut C, Dalgard FJ, Bewley A, Evers AW, Gieler U, Lien L, et al. Body dysmorphia in common skin diseases: Results of an observational, cross-sectional multicentre study among dermatological outpatients in 17 European countries. Br J Dermatol. 2022;187(1): 115-125.
9. Phillips K. Understanding body dysmorphic disorder: An essential guide. Oxford Press. 2009.
10. Bjornsson AS, Didie ER, Phillips KA. Body dysmorphic disorder. Dialogues Clin Neurosci. 2010;12(2):221-232.
11. Crerand CE, Phillips KA, Menard W, Fay C. Nonpsychiatric medical treatment of body dysmorphic disorder. Psychosomatics. 2005;46(6):549-555.
12. Koblenzer CS. Body dysmorphic disorder in the dermatology patient. Clin Dermatol. 2017;35(3):298-301.
13. Laughter MR, Anderson JB, Maymone MB, Kroumpouzos G. Psychology of aesthetics: Beauty, social media, and body dysmorphic disorder. Clin Dermatol. 2023;41(1):28-32.
14. Phillips KA, Dufresne Jr RG, Wilkel CS, Vittorio CC. Rate of body dysmorphic disorder in dermatology patients. J Am Acad Dermatol. 2000;42(3):436-441.
15. Phillips KA. The broken mirror: Understanding and treating body dysmorphic disorder. Oxford University Press. 2005.

16. Dufresne Jr RG, Phillips KA, Vittorio CC, Wilkel CS. A screening questionnaire for body dysmorphic disorder in a cosmetic dermatologic surgery practice. Dermatol Surg. 2001;27(5):457-462.
17. Hong K, Nezgovorova V, Uzunova G, Schlussel D, Hollander E. Pharmacological treatment of body dysmorphic disorder. Curr Neuropharmacol. 2019;17(8):697-702.
18. Phillips KA. Differentiating body Dysmorphic disorder from normal appearance concerns and other mental disorders. Body dysmorphic disorder: Adv Res clin practice. 2017:227-239.
19. Rautio D, Gumpert M, Jassi A, Krebs G, Flygare O, Andrén P, et al. Effectiveness of multimodal treatment for young people with body dysmorphic disorder in two specialist clinics. Behav Ther. 2022;53(5):1037-1049.
20. Sweis IE, Spitz J, Barry DR, Cohen M. A review of body dysmorphic disorder in aesthetic surgery patients and the legal implications. Aesthetic Plast Surg. 2017;41:949-954.