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New Developments in the Diagnosis and Treatment of Body Dysmorphic Disorder

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ABSTRACT
Body dysmorphic disorder (BDD) is a moderately common and disabling mental health condition characterised by excessive and persistent preoccupation with perceived imperfections or flaws in one's appearance that are invisible to others, as well as repetitive behaviours that go along with it (eg, mirror checking). The disorder typically manifests throughout puberty, although it is extremely underdiagnosed and frequently goes unnoticed. BDD frequently worsens and creates clear functional impairment in several domains if left untreated. This clinical review takes into account current developments in the epidemiology and categorization of BDD, including its reclassification in the new "Obsessive-Compulsive and Related Disorders" chapter of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders.
The relevance of risk assessment in this population given the high rates of suicidality and improper use of aesthetic treatments, together with the use of validated screening instruments to reduce misdiagnosis, are highlighted as important assessment issues. Additionally, a summary of the most recent research on the mechanisms and causes of BDD is provided. Cognitive behavioural therapy (CBT) and antidepressants such selective serotonin reuptake inhibitors are the suggested therapies for BDD. In adult populations, CBT and medication have both been found to be effective therapies for BDD, and there is growing evidence to support their use in young individuals. Despite the fact that the majority of patients benefit from the current evidence-based treatments, a sizable number of them still have clinically significant residual symptoms. Therefore, the need to further improve and assess current interventions with the aim of enhancing treatment outcomes and expanding their accessibility is considered as one of the top priorities for future study.

1. INTRODUCTION

The diagnostic of body dysmorphic disorder (BDD) is an excessive and enduring obsession with perceived physical flaws or abnormalities. Even though these perceived defects are invisible to others or seem insignificant to them, they cause the sufferer great grief and damage. [1] Although BDD sufferers can get focused on any part of appearance, the most frequent worries are on face features such the nose, eyes, complexion, and hair. [2] The obsession with beauty in a person who satisfies the diagnostic criteria for an eating disorder cannot be explained any other way, such as by worries about body fat or weight. [1]The

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diagnostic criteria for BDD also state that at some point during the course of the illness, the person will have engaged in repetitive behaviours (such as mirror checking, excessive grooming, picking at their skin, or seeking reassurance) or mental acts (such as comparing their appearance to others' appearances) in response to their appearance concerns. [1]
BDD often has a chronic course[3] and is linked to severe functional impairment in a number of areas. Adults with BDD experience significant rates of social dysfunction, unemployment, and occupational disability. [2]Similar to adults, BDD in children and adolescents is linked to serious functional impairment, such as poor academic performance, social disengagement, and school abandonment. [2, 4] High comorbidity is frequently recorded, such as with major depressive illness, social anxiety disorder, and obsessive-compulsive disorder (OCD). Suicidal ideation rates have been observed to range from 17% to 77%, while suicide attempt rates have been reported to range from 3% to 63%. BDD has also been linked to startlingly high rates of suicidality. [5]
Despite the severity of the disorder, relative to comparable conditions like OCD, BDD has only recently attracted empirical attention. But more work has been done in recent years to understand the phenomenology, aetiology, and management of the illness. This article will discuss some significant recent developments with a focus on implications for clinical practise and potential directions for future study. It is written for non-specialist hospital doctors, general practitioners, and trainees in psychiatry and clinical psychology.

How would you classify BDD?

The reclassification of BDD in the diagnostic manuals as well as the improvement of its diagnostic criteria represent a significant advancement in the field in recent years. BDD was listed as a diagnostic under somatoform disorders in the revised version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), but DSM-5 underwent a number of substantial revisions. [11] First, BDD was included in the new chapter on Obsessive-Compulsive and Related Disorders together with OCD, hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin picking) disorder due to the phenomenological overlap and high rates of comorbidity between BDD and OCD7. Second, a brand-new diagnostic standard was included that identifies repetitive behaviours or mental processes as a crucial aspect of the disease. This criterion boosted the diagnosis' specificity and may have helped distinguish BDD from other conditions like social anxiety disorder and depression.
BDD is not recognised as a separate diagnostic category in the most recent edition of the International Classification of Diseases (ICD-10),10 but rather as an inclusion term under hypochondriacal disease. It is noteworthy that BDD symptoms are also included under a number of other diagnostic labels (such as delusional disorder, schizotypal disorder, and other persistent delusional condition), which may lead to diagnostic ambiguity and ineffective care. [8].Even though the new ICD-11 is not expected to be published until 2018, the current suggested guidelines for categorising BDD closely resemble the DSM-5 criteria, including identifying BDD as a discrete diagnosis inside a new Obsessive-Compulsive and Related Disorders chapter.[11]

How widespread is BDD?

The need of clinical monitoring for the condition is shown by a recent systematic analysis that assessed the weighted prevalence of BDD to be 1.9% in population samples of adults and 5.8%-7.4% in psychiatric settings.[12] Similar rates have been discovered among teenagers,

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with prevalence estimates varying between 1.7% and 2.2%. [12, 13] In psychiatric inpatient settings, the rates range from 6.7% to 14.3% in the community. The prevalence of BDD in older teens has been demonstrated[12] supporting reports that the average age of onset is around 16 years. [14] It is still unknown how prevalent BDD is in children because no study has looked at the prevalence of BDD in children under the age of 12. It is also unknown whether rates differ among cultures because the majority of community-based prevalence studies have been carried out in Europe and North America. [12]Females are more prone to be worried with hips, breasts, legs, and excessive body hair while males are more likely to be preoccupied with their genitals and thinning hair, according to data. BDD symptoms are generally comparable in both sexes. [9]The clinical presentation of BDD in males and females may differ, thus doctors need to be aware of this possibility.

How should BDD be evaluated?

The information we currently have suggests that BDD frequently stays misdiagnosed despite its prevalence and effects. [12] This may partially reflect BDD patients' unwillingness to seek mental health therapy because of their guilt and embarrassment about their symptoms, lack of understanding, and desire for a treatment like cosmetic surgery. [15] However, even when patients do visit mental health facilities, it is unusual that they will voluntarily mention their concerns about their appearance.[12] Therefore, during the anamnestic interview, it's frequently necessary to bring up BDD symptoms specifically. Lack of spontaneous symptom disclosure coupled with clinicians' limited knowledge of BDD may lead to misdiagnosis, with BDD symptoms being mistakenly categorised into other disorders that are common comorbidities, such as depression and social anxiety disorder[12] (for information on differential diagnosis, see table 1). Furthermore, it could be challenging to distinguish between minor BDD symptoms and typical concerns about appearance among adolescents in particular. [4]

Risk assessment should always be a part of BDD assessment. In a recent meta-analysis, it was discovered that individuals with BDD were more than twice as likely to have tried suicide compared to controls (mostly psychiatric patients with illnesses including eating disorders and OCD), underscoring the significance of gauging suicidality in this population.[5]

Furthermore, there is mounting evidence that BDD patients frequently seek aesthetic procedures in an effort to fix their perceived flaw in appearance, with 33%–76% of patients seeking surgical and/or minimally invasive cosmetic therapies.[20] This is troubling because aesthetic procedures for BDD are frequently accompanied by unfavourable results, such as low patient satisfaction, a continuation or exacerbation of BDD symptoms, and a higher incidence of postoperative problems. [20] This is why patients should be urged to seek evidence-based treatment for BDD rather than cosmetic therapies, and professional assessments of BDD should routinely include screening for aspirations and plans for aesthetic treatments.

How does BDD start?

Biological predisposing factors and environmental stressors interact to cause BDD, according to several stress models of the condition. According to the findings of twin research, environmental factors that are not shared by the twins account for the remaining variation in BDD-like symptoms, which ranges from 42% to 44% due to genetic factors. [11,12] No

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particular risk genes have been discovered so far in BDD due to the lack of genome-wide association research in this disease. Additionally, little is known about the particular environmental factors that influence BDD development. There is a dearth of research on environmental risk factors for BDD. Most studies have focused on methodological issues, such as an overreliance on cross-sectional and retrospective designs, a lack of multiple-informant assessment techniques, and insufficient control of potential confounding variables like comorbidity and genetic factors.

Bullying and BDD have been demonstrated to be related.[12] In clinicalsamples[19] and analogue samples[17], there are relationships between self-reported appearance-related teasing and BDD symptoms, particularly when the mocking is perpetrated by individuals of the opposite sex. [17] Peer victimisation in school students (as reported by the peer group) was prospectively associated with the onset of BDD symptoms [12] months later in one of the few longitudinal studies of environmental risk factors in BDD[3], in line with theories that bullying experiences may have a causative role in BDD. Understanding the involvement of environmental risk factors could have significant effects on BDD prevention and early intervention, while more research is definitely required in this area.

Commonly misdiagnosed conditions in BDD

	Comparability to BDD	**Major distinct characteristics**
OCD	repetitive, time-consuming behaviours, such as grooming rituals	In contrast to BDD, grooming rituals in OCD are not motivated by an effort to fix perceived imperfections in one's appearance. They may instead be motivated by worries about contamination or urges to get things "exactly right."
Excoriation disorder	skin picking repeatedly	Unlike BDD, when skin plucking is done to try to conceal perceived skin flaws, excoriation disorder is not motivated by an attempt to improve appearance.
Trichotillomania	hair pulled repeatedly	While hair pulling in BDD is done to try to conceal perceived flaws in facial or body hair, hair pulling in trichotillomania is not motivated by an attempt to improve appearance.
Eating disorders	anxiety about appearance that is both distressing and detrimental	In eating disorders, appearance obsession centres on body weight and shape, which results in dysfunctional eating habits in an effort to decrease weight.
Social anxiety disorder	avoiding and feeling uncomfortable in social situations	When someone has social anxiety disorder, they avoid social situations out of fear of embarrassing themselves. Social anxiety in BDD is only associated with a worry about others'

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		opinions of perceived flaws in appearance.
Depression	Associated with sentiments of ugly as a result of widespread poor self-esteem	In depression, worries about appearance are not the main preoccupation, and they are also not frequently linked to the repeated behaviours that characterise BDD (such as grooming and mirror checking).

What BDD treatments have been proven effective?

Clinical guidelines prescribe cognitive behavioural therapy (CBT) and serotonin reuptake inhibitors (SRIs) for the treatment of BDD in accordance with the body of available research. [3] In clinical trials, CBT for BDD typically entails 12–22 weekly sessions[12,13] with exposure with response prevention (E/RP) serving as a significant therapeutic technique. In order to achieve anxiety habituation, E/RP entails gradually exposing oneself to dreaded scenarios (such as bright lights, mirrors, and social situations) and resisting the impulse to engage in safety-seeking behaviours (such as camouflaging, overdoing the makeup, or turning one's attention inward). Psychoeducation, motivational enhancement techniques, cognitive restructuring, mirror retraining, and attention training are other techniques that have been applied in CBT for BDD. [4 12 13]

Despite the fact that CBT is an effective treatment for BDD, many patients still have severe symptoms. As a result, there is an urgent need to improve the current CBT packages for BDD in order to improve outcomes.Understanding the mechanisms behind the onset, maintenance, and recovery of BDD can guide these efforts.Given that the treatment is not broadly accessible, empirical emphasis should also be paid to creating evidence-based approaches for promoting CBT for BDD. For instance, internet-based CBT with therapist guidance has the potential to increase accessibility and availability. According to a recent RCT, 56% of BDD patients responded to a 12-week internet-based CBT programme with just 13 minutes of therapist support on average each week. [17]

In RCTs and meta-analytic studies, more investigation is required to determine the relative efficacy of various SRIs and to compare medication to CBT. Additionally, it is necessary to continue assessing potential augmentation techniques for BDD patients who do not react to SRIs. Only one small open trial and one RCT have been conducted to yet to examine pimozide and olanzapine as augmentation agents for fluoxetine in BDD, respectively. [17,20] Although these trials did not find any positive effects of augmentation, this merits exploration because clinical experience and recommendations indicate that atypical antipsychotic augmentation of SRIs may have positive effects. [11]

2. CONCLUSIONS

In conclusion, BDD is an illness that is relatively widespread and has the potential to be crippling, but research on BDD is still in its infancy in comparison to other psychiatric disorders. It is vital to spread knowledge about this deadly disorder and to encourage early discovery, diagnosis, and treatment. According to recent studies and clinical recommendations, the best therapies for BDD include CBT and SRIs. In contrast to other

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prevalent psychiatric illnesses like depression, expert clinical experience suggests that longer CBT courses (i.e., more sessions) and greater dosages of SRI medication are frequently necessary to treat BDD. Given the high rates of morbidity, risk, and complexity of treatment, it might be better to address severe BDD cases in specialised settings.While many patients benefit from the current evidence-based treatments, a sizable minority of them continue to have symptoms. The mechanisms underlying the aetiology of BDD and factors that predict treatment response may be clarified by ongoing research into these topics, which could ultimately result in the creation of new and more effective treatment options.

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