Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis

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INTRODUCTION

Body dysmorphic disorder (BDD) is characterized by preoccupation with nonexistent or slight defects in physical appearance, such that patients believe that they look abnormal, unattractive, ugly, or deformed, when in reality they look normal. The preoccupation with perceived flaws leads to repetitive behaviors (eg, checking their appearance in mirrors), which are usually difficult to control and are not pleasurable. BDD is common but usually underrecognized, causes clinically significant distress and/or impaired functioning, and is often associated with suicidal ideation and behavior.

Patients with BDD may present to mental health clinicians as well as dermatologists, plastic surgeons, otolaryngologists, primary care clinicians, pediatricians, gynecologists, and dentists. Most patients seek nonpsychiatric, cosmetic treatment (most commonly dermatologic or surgical) for their perceived physical defects; this treatment appears to be ineffective for most patients and can be risky for clinicians to provide. By contrast, pharmacotherapy (selective serotonin reuptake inhibitors or clomipramine) and/or cognitive-behavioral therapy tailored specifically to BDD are often efficacious.

This topic reviews the assessment, diagnosis, and differential diagnosis of BDD. The epidemiology, pathogenesis, clinical features, treatment, and prognosis of BDD are discussed separately:

- (See "Body dysmorphic disorder: Epidemiology and pathogenesis".)
- (See "Body dysmorphic disorder: Clinical features".)
- (See "Body dysmorphic disorder: General principles of treatment".)
- (See "Body dysmorphic disorder: Choosing treatment and prognosis".)

ASSESSMENT

The initial clinical evaluation of patients with a possible diagnosis of body dysmorphic disorder (BDD) includes a general psychiatric history, general medical history, and mental status examination, with emphasis upon suicidal ideation and behavior, delusional BDD symptoms, substance abuse, and depressive symptoms [1-3]. As with all psychiatric patients, a physical examination is indicated and typically is performed by the patient's primary care clinician or an internal medicine consultant; however, many patients refuse examinations because they do not want their bodies seen by others. Laboratory tests are obtained on the basis of the history and examination.

Screening instruments — Screening instruments can facilitate diagnosis of BDD, but are not intended to make the diagnosis by themselves. For patients who screen positive, a clinical interview is required to establish the diagnosis.

We suggest the self-report Body Dysmorphic Disorder Questionnaire to screen for BDD, which is displayed in the table (table 1). This measure includes four questions and takes one to five minutes to administer [4]. A positive screen requires each of the following:

- Question 1: Yes to both parts
- Question 3: Yes to any of the four parts
- Question 4: Answer b or c

The Body Dysmorphic Disorder Questionnaire was modified to create another self-report screening tool, called the Body Dysmorphic Disorder Questionnaire – Dermatology Version [5]. Both scales have good to excellent psychometric properties for BDD in multiple populations:

- Psychiatric and dermatology samples – Sensitivity 100 percent, specificity 89 to 93 percent, and positive predictive value 70 percent [4-6].
- Facial plastic and reconstructive surgery sample – Sensitivity 100 percent, specificity 90 percent, and positive predictive value 64 percent [7].
- Community sample – Sensitivity 94 percent, specificity 90 percent, and positive predictive value 71 percent [8].

Both a systematic review of BDD screening instruments [9], as well as rhinoplasty practice guidelines from the American Academy of Otolaryngology [10,11], recommended using the Body Dysmorphic Disorder Questionnaire in cosmetic surgery settings.

A reasonable alternative is the self-report Body Image Disturbance Questionnaire, which is also a modified version of the Body Dysmorphic Disorder Questionnaire [12]. The Body Image Disturbance Questionnaire demonstrated strong psychometric properties in a nonclinical population, but lacks sensitivity and specificity data.

Clinical interview — Many patients with BDD do not spontaneously reveal their appearance concerns to clinicians because they are too embarrassed, fear being negatively judged (eg, considered vain), feel that the clinician will not understand their appearance concerns, or do not know that their body image concerns are amenable to psychiatric treatment [6,13]. To detect BDD, clinicians usually must ask patients about specific BDD symptoms (table 2). We suggest asking about BDD symptoms when interviewing patients in mental health and substance abuse settings, as well as settings that administer cosmetic treatment.

If patients acknowledge having appearance concerns, clinicians should invite patients to say more about their concerns (eg, what body areas the patient worries about), and probe for resulting distress and impairment in social, academic, occupational, and other aspects of functioning. Level of insight into the BDD beliefs should also be assessed. In addition, the appearance concerns should not be better explained by anorexia nervosa (table 3), bulimia nervosa (table 4), or another eating disorder. However, BDD and eating disorders can co-occur, in which case both disorders should be diagnosed, as each needs to be targeted in treatment. Diagnosis of eating disorders is discussed separately. (See "Eating disorders: Overview of epidemiology, clinical features, and diagnosis" and "Anorexia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Diagnosis' and "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Diagnosis'.)

Avoiding pitfalls — To avoid potential pitfalls during the assessment, we recommend that clinicians [4,14,15]:

- Express empathy – BDD usually causes substantial suffering; do not confuse BDD with vanity. It is best not to minimize the patient's concerns, express surprise, or reassure the patient that they look fine. At the same time, it is important not to tell patients that a defect is clearly visible when it is not.

- Ask patients if they think there is something wrong with their physical appearance, rather than with their body – A question about the body may be too broad to detect BDD;

patients may misinterpret questions about the body to mean physical or bodily functioning. In asking patients whether they are worried or unhappy with how they look, it can be helpful to normalize the question by first stating that many people are unhappy with their appearance and then asking patients if they also have this concern.

- Do not ask about “imagined” flaws in physical appearance – This term is not patient friendly. Also, many patients have little to no insight and thus consider their flaws to be real and obvious to others, not imagined.

- Avoid asking about “defects” or “deformity” in physical appearance – These words may be too harsh for some patients to endorse.

- Do not argue with patients about what they actually look like or try to convince them that you are right and they are wrong; this approach is usually unsuccessful (one cannot impose insight when it is absent).

DIAGNOSIS

Patients are diagnosed with body dysmorphic disorder (BDD) if they are preoccupied with nonexistent or slight defects (eg, size of nose) in appearance that lead to repetitive behaviors and cause clinically significant distress or impairment in functioning [16]. In addition, the appearance preoccupations must not be better explained by an eating disorder [15,16].

Diagnostic clues — The presence of BDD is suggested by several clues, including [15,17,18]:

- Compulsive (repetitive) behaviors. (See "Body dysmorphic disorder: Clinical features", section on 'Repetitive behaviors (compulsions and rituals)'.)

- Misperceptions that other people take special notice of the person in a negative way or make fun of them because of how they look (ideas or delusions of reference).

- Being housebound.

- Treatment-resistant depression or anxiety.

- Social anxiety (self-consciousness in social situations).

- Avoidance behavior – Avoiding work, dating, family events, activities that involve other people, eye contact, and situations in which others may pay attention to one’s body (eg, the beach or a clothing store).

- History of past cosmetic treatments that the patient considered unsatisfactory.
- Refusal to allow contact with current or past mental health clinicians when requesting surgical, dermatologic, or other cosmetic treatment.
- Desire for or pursuit of cosmetic treatments that others consider unnecessary.
- Substance abuse that appears motivated by a desire to alleviate body image concerns or anxiety, depression, or other distressing emotions.
- Unusual patient behavior in the clinic (eg, requesting off-hour appointment times so as to avoid being seen by other people or bringing many pictures of desired features to appointments).

Diagnostic criteria — We diagnose BDD according to the criteria in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (table 5) [16]:

- Preoccupation with at least one nonexistent or slight defect in physical appearance (eg, thinks about the perceived defects for at least one hour per day).
- Concerns about appearance lead to repetitive behaviors (eg, mirror checking, excessive grooming, or skin picking) or mental acts (eg, comparing one's appearance with that of others) at some point during the course of the illness.
- Clinically significant distress or psychosocial impairment resulting from the appearance concerns.
- Appearance preoccupations are not better explained by an eating disorder.

For patients who meet criteria for a diagnosis of BDD, the degree of insight regarding BDD beliefs is specified as follows:

- Fair to good – Patient recognizes that the beliefs about physical appearance (eg, "I look deformed") are probably not true (good insight) or that they may or may not be true (fair insight).
- Poor – Patient thinks that the beliefs are probably true.
- Absent (delusional beliefs) – Beliefs are firmly held despite what others think.

If patients with BDD are preoccupied with the belief that their body build is too small or insufficiently muscular, they should receive the diagnosis "BDD with muscle dysmorphia" [16]. If

BDD triggers panic attacks (eg, after seeing oneself in the mirror), the DSM-5 panic attack specifier is included in the diagnosis ("BDD with panic attacks"). Information about panic attacks is discussed separately. (See "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis", section on 'Panic attacks'.)

The description of BDD in the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11) is similar to the DSM-5 criteria [19].

DIFFERENTIAL DIAGNOSIS

Symptoms of body dysmorphic disorder (BDD) (table 5) can overlap with symptoms of other psychiatric disorders, and some of these other disorders may be comorbid with BDD. As a result, BDD is usually misdiagnosed as another disorder or missed altogether [4,15]. BDD needs to be distinguished from the following conditions [16,20,21]:

Normal appearance concerns — Concerns with appearance are common in the general population [15]. BDD is distinguished from normal concerns in that BDD is characterized by time-consuming and excessive appearance-related preoccupations with minimal or nonexistent flaws and repetitive behaviors that are usually difficult to resist or control, and that cause clinically significant distress and/or impairment in functioning.

Obvious bodily defects — Concerns about clearly noticeable bodily defects are not diagnosed as BDD. If body flaws are clearly visible and obvious to others, but the rest of the BDD criteria are met, a diagnosis of "other specified obsessive-compulsive and related disorder (body dysmorphic-like disorder with actual flaws)" is used.

However, skin picking caused by BDD can cause noticeable skin lesions and scarring; BDD is diagnosed in such cases. Skin picking (excoriation) disorder is discussed separately. (See 'Skin picking (excoriation) disorder' below and "Skin picking (excoriation) disorder and related disorders".)

Dysmorphic concern — Dysmorphic concern is not a diagnostic entity in DSM-5 or in the ICD-11, but it is a concept that overlaps substantially with BDD [16,19]. Dysmorphic concern is defined as an excessive concern with an imagined or slight flaw in physical appearance in addition to other excessive bodily concerns, such as concern with emitting a body odor and somatic complaints [22]. Concern with emitting a body odor and somatic complaints are not widely recognized as symptoms of BDD. Also, the diagnosis of BDD requires the presence of repetitive behaviors that are performed in response to the appearance concerns as well as distress or impaired functioning that result from the appearance preoccupations.

Eating disorders — Both BDD and eating disorders (eg, anorexia nervosa and bulimia nervosa) involve distorted body image and dissatisfaction with one's appearance. Other shared clinical features between eating disorders and some patients with BDD include weight concerns, dieting, and excessive exercise [15,23]. Although some patients with BDD have concerns about being overweight or believe that parts of their body, such as their stomach, are too fat, appearance concerns in BDD commonly involve the face or head. If a patient is only concerned about being overweight or fat, and meets diagnostic criteria for an eating disorder, the eating disorder should be diagnosed and BDD should not. Nevertheless, eating disorders and BDD can co-occur; in such cases, both should be diagnosed. Diagnosis of eating disorders is discussed separately. (See "Anorexia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Diagnosis' and "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Diagnosis'.)

Unipolar major depression — Dysphoria, worthlessness, suicidal ideation and behavior, poor concentration, guilt, and distress can occur in both BDD and unipolar major depression. In addition, many patients with BDD meet diagnostic criteria for unipolar major depression (table 6); depressive symptoms in BDD often appear to be secondary to the distress and impairment that BDD causes. BDD is distinguished from unipolar major depression in that BDD is characterized by prominent preoccupation with the appearance of specific body areas (eg, skin, hair, and nose) and excessive compulsive and repetitive behaviors; these preoccupations and behaviors are not a symptom of unipolar major depression. Clinicians should not assume that appearance concerns are due to a depressive syndrome [15]. Patients who meet criteria for both BDD and unipolar major depression should be diagnosed with both disorders. Diagnosing unipolar major depression is discussed separately. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Unipolar major depression'.)

Social anxiety disorder — Social anxiety disorder (formerly called social phobia) and BDD share anxiety about social situations, shame, rejection sensitivity, and avoidance of others, as well as distress and functional impairment. In addition, fear of negative evaluation by others is a symptom of social anxiety disorder and often occurs in BDD [20]. However, patients with social anxiety disorder fear negative evaluation of their behavior or what they say, whereas patients with BDD fear negative evaluation of their physical appearance [15]. In addition, repetitive behaviors occur in BDD but are not considered a key symptom of social anxiety disorder. Thus, if social anxiety is due solely to embarrassment and shame about perceived appearance flaws, and if diagnostic criteria for BDD are met, BDD should be diagnosed rather than social anxiety disorder. However, many patients manifest social anxiety and avoidance due to excessive appearance concerns as well as other social situations (eg, public speaking) and can therefore fulfill criteria for both disorders; in these cases, both disorders are diagnosed. Diagnosing social

anxiety disorder is discussed separately. (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Diagnosis'.)

Agoraphobia — Agoraphobic patients are anxious about being in a variety of situations (eg, using public transportation or attending the cinema) and often avoid these situations; BDD is similarly associated with intense anxiety and avoidance. However, if situations are avoided solely because of fears that others will see the person's perceived appearance defects, and if diagnostic criteria for BDD are met, BDD should be diagnosed rather than agoraphobia. In patients who meet diagnostic criteria for each disorder, both disorders should be diagnosed. Diagnosing agoraphobia is discussed separately. (See "Agoraphobia in adults: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis", section on 'Diagnosis'.)

Avoidant personality disorder — Patients with avoidant personality disorder are socially inhibited, have feelings of inadequacy, and are hypersensitive to negative evaluation; these traits are also manifested by many patients with BDD. If these clinical features are due solely to embarrassment and shame about perceived appearance flaws, and if diagnostic criteria for BDD are met, BDD should be diagnosed rather than avoidant personality disorder, and a separate diagnosis of avoidant personality disorder should not be made. However, in patients who meet diagnostic criteria for each disorder, both disorders should be diagnosed. Diagnosing avoidant personality disorder is discussed separately. (See "Overview of personality disorders", section on 'Avoidant'.)

Panic disorder — Panic disorder is characterized by recurrent panic attacks, which can also occur in BDD. However, the panic attacks in panic disorder occur in the absence of a cue ("out of the blue") [15]. By contrast, the attacks in BDD occur in response to distress about physical appearance (eg, attacks are triggered by seeing one's reflection in a store window, or by the belief that others are staring at the patient). If the panic attacks are due solely to BDD, then "BDD with panic attacks" should be diagnosed rather than panic disorder, and a separate diagnosis of panic disorder should not be made. In patients who meet diagnostic criteria for each disorder, both disorders should be diagnosed. Diagnosing panic disorder is discussed separately. (See "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis", section on 'Diagnosis'.)

Generalized anxiety disorder — Excessive anxiety and worry occurs in generalized anxiety disorder, and is often observed in BDD as well. However, the anxiety and worry in generalized anxiety disorder are not focused upon the perceived appearance flaws that occur with BDD. If anxiety and worry are due only to concerns and preoccupation with perceived appearance flaws, and if diagnostic criteria for BDD are met, BDD should be diagnosed rather than generalized anxiety disorder. In patients who meet diagnostic criteria for each disorder, both

disorders should be diagnosed. Diagnosing generalized anxiety disorder is discussed separately. (See "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis", section on 'Screening, assessment, and diagnosis'.)

Obsessive-compulsive disorder — BDD and obsessive-compulsive disorder (OCD) are both characterized by recurrent, intrusive thoughts (obsessions/preoccupations) that typically persist for hours each day, as well as compulsive behaviors (rituals) that are performed in response to obsessions; in both disorders the obsessions and compulsive behaviors are often difficult to resist and control, and they are not pleasurable [15,24]. In addition, both BDD and OCD may be associated with shame such that symptoms are kept secret, even from clinicians.

However, BDD and OCD have several differences [25]. Unlike OCD, BDD preoccupations and repetitive behaviors focus exclusively upon perceived flaws in one's physical appearance. In addition, insight is usually poorer in BDD than OCD, and delusions related to the disorder (BDD or OCD), suicidal ideation and behavior, and comorbid unipolar major depression are more common in BDD than OCD [24,26,27]. Patients who are preoccupied with perceived asymmetry (eg, facial asymmetry) and who meet diagnostic criteria for BDD should be diagnosed with BDD, not OCD. In patients who meet diagnostic criteria for each disorder, both disorders should be diagnosed. Diagnosing OCD is discussed separately. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Assessment and diagnosis'.)

Trichotillomania (hair-pulling disorder) — Patients with trichotillomania (hair-pulling disorder) recurrently pull out their hair and find it difficult to resist or control this behavior. Some patients with BDD also pull out or pluck their hair compulsively, but in BDD the intent is to improve a perceived defect in their appearance (eg, "excessive" facial hair or "uneven" eyebrows). When hair removal (tweezing, plucking, pulling, or other types of removal) is intended to improve perceived defects in the appearance of body or facial hair, and diagnostic criteria for BDD are fulfilled, BDD should be diagnosed rather than trichotillomania, and a separate diagnosis of trichotillomania should not be made.

Skin picking (excoriation) disorder — Skin picking (excoriation) disorder is marked by recurrent skin picking that causes skin lesions as well as distress or impaired functioning due to the behavior. Many patients with BDD also pick their skin. The two disorders are distinguished in that picking behavior in skin picking disorder is not intended to improve a perceived defect in physical appearance, whereas skin picking in BDD represents an attempt to improve perceived skin flaws. If the skin picking occurs in response to a preoccupation with nonexistent or slight defects in appearance of the skin, and other diagnostic criteria for BDD are met, BDD should be diagnosed rather than skin picking disorder, and a separate diagnosis of skin picking disorder

should not be made. In addition, skin picking as a symptom of BDD can cause noticeable skin lesions and/or scarring; such cases can be diagnosed with BDD and are an exception to the rule that to diagnose BDD appearance defects must be nonexistent or only slight.

Diagnosing skin picking disorder is discussed separately. (See "Skin picking (excoriation) disorder and related disorders", section on 'Patient evaluation and diagnosis'.)

Illness anxiety disorder — Patients with illness anxiety disorder (formerly known as hypochondriasis) and BDD are both preoccupied with perceived body abnormalities, excessively perform behaviors such as checking their body, and exhibit maladaptive avoidance. However, the preoccupation in BDD is with being ugly, whereas the preoccupation in illness anxiety disorder is with having or acquiring a serious illness [23]. In addition, BDD is always marked by clinically significant distress and/or psychosocial dysfunction, whereas these features are not required for a diagnosis of illness anxiety disorder. If the preoccupation is about perceived appearance flaws, and if diagnostic criteria for BDD are met, BDD should be diagnosed rather than illness anxiety disorder, and a separate diagnosis of illness anxiety order should not be made. Diagnosing illness anxiety disorder is discussed separately. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis", section on 'Diagnosis'.)

Factitious disorder — Factitious disorder and BDD may each involve self-induced injuries. However, patients with factitious disorder intend to injure themselves to deceive clinicians. By contrast, patients with BDD do not intend to injure themselves. As an example, BDD patients may compulsively pick their skin and inadvertently produce skin lesions because they are trying to improve its appearance and the picking is hard to stop. In addition, some patients with BDD perform surgery on themselves in an attempt to improve the appearance of or remove the disliked body part. Unlike factitious disorder, these behaviors in BDD are motivated by the desire to improve one's appearance and do not involve deception and falsification of symptoms. Diagnosis of factitious disorder is discussed separately. (See "Factitious disorder imposed on self (Munchausen syndrome)".)

Psychotic disorders — Patients with psychotic disorders (eg, delusional disorder or schizophrenia) and those with BDD may have delusions about their physical appearance and delusions of reference (false, fixed beliefs that ordinary events have a particular meaning for oneself). However, in patients with BDD, delusional beliefs and delusions of reference focus specifically upon perceived ugliness or imagined defects in one's physical appearance, related compulsive behaviors are present, and other psychotic symptoms (such as hallucinations, grossly disorganized behavior, disorganized thinking, and negative symptoms) are not present. If patients present with delusions that involve preoccupation with perceived appearance flaws, and if diagnostic criteria for BDD are met, BDD should be diagnosed rather than delusional

disorder or other psychotic disorders. An overview of psychotic disorders is discussed separately. (See "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation", section on 'Factors differentiating medical versus psychiatric causes'.)

Gender dysphoria — Gender dysphoria and BDD are both marked by a strong desire to change physical features that are distressing, as well as resulting functional impairment. However, the focus of gender dysphoria is usually upon one's primary and secondary sex characteristics, which reflect one's natal sex and are incongruent with one's expressed or experienced gender. If concerns with other body areas are present, it is because they reflect the person's natal sex. BDD should not be diagnosed in patients who are preoccupied with only their primary and secondary sex characteristics or with other aspects of appearance that reflect their natal sex, and who meet other diagnostic criteria for gender dysphoria.

Olfactory reference disorder (olfactory reference syndrome) — Olfactory reference disorder is characterized by the false belief that one emits an offensive or foul body odor [28]. In both BDD and olfactory reference disorder, patients are preoccupied with a perceived somatic abnormality, engage in repetitive behaviors in response to the preoccupation, and often avoid social situations because of embarrassment and shame; in addition, most patients manifest poor insight or delusions regarding the somatic concerns, and there may be fears of negative evaluation by others [23]. The two disorders are distinguished in that patients with olfactory reference disorder are preoccupied with emitting a foul or offensive body odor, which is not observed in BDD.

Bipolar disorder — BDD is occasionally misdiagnosed as bipolar disorder if patients with BDD develop symptoms that resemble mania (table 7) or major depression (table 8). As an example, patients with BDD may become emotionally and physically agitated and dysphoric over their perceived ugliness, and go for days with little or no sleep because they spend their days and nights performing BDD rituals, such as looking in the mirror or trying to fix their perceived defects. Racing thoughts and distractibility may occur, as well as pressured speech (eg, when pointing out the perceived flaws to others, seeking reassurance about their appearance, or trying to convince others that they are ugly). Nevertheless, preoccupation with nonexistent or slight defects in physical appearance, as well as repetitive behaviors such as mirror checking, which are found in BDD, are not observed in bipolar disorder.

The assessment and diagnosis of bipolar disorder is discussed separately. (See "Bipolar disorder in adults: Assessment and diagnosis".)

Body integrity dysphoria — Body integrity dysphoria and BDD each involve discomfort with a body part and can involve surgery to remove the disliked body part [23]. However, patients with

body integrity dysphoria want to become physically disabled (eg, a major limb amputee or blind) and feel that their nondisabled body configuration is inappropriate [29]. The desire to become physically disabled in a significant manner is not observed in BDD. Another distinction is that patients with BDD perceive the appearance of their body as defective and are ashamed of it, whereas patients with body integrity dysphoria do not; rather, they view their nondisabled body configuration as incongruent with their identity.

INFORMATION FOR PATIENTS

Many patients can benefit from reading about their illness at websites such as those maintained by the International OCD Foundation and the author of this topic at her website.

SUMMARY

- The initial clinical evaluation of patients with a possible diagnosis of body dysmorphic disorder (BDD) includes a psychiatric history, general medical history, mental status examination, and a physical examination. Particular attention should be paid to suicidal ideation and behavior, delusional BDD symptoms, and co-occurring substance abuse and depressive symptoms. Many patients refuse examinations because they do not want their bodies seen by others. Laboratory tests are obtained on the basis of the history and examination. (See 'Assessment' above.)

- Many patients with BDD do not spontaneously reveal their appearance concerns to clinicians. To detect BDD, clinicians usually must ask patients about specific BDD symptoms (table 2). (See 'Clinical interview' above.)

- The presence of BDD is suggested by several clues, including compulsive behaviors; misperceptions that other people take special notice of the person in a negative way or make fun of them; being housebound; treatment-resistant depression or anxiety; social anxiety; avoidance of social situations; history of cosmetic treatments that the patient considers unsatisfactory; refusal to allow dermatologists, surgeons, or dentists to contact current or past mental health clinicians when patients request a cosmetic procedure; desire for or pursuit of cosmetic treatments that others consider unnecessary; substance abuse intended to alleviate anxiety and distress; and unusual patient behavior in the clinic. (See 'Diagnostic clues' above.)

- BDD is diagnosed according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria (table 5). (See 'Diagnostic criteria' above.)

- The differential diagnosis of BDD includes normal appearance concerns, obvious bodily defects, eating disorders, unipolar major depression, social anxiety disorder, agoraphobia, avoidant personality disorder, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, trichotillomania, skin picking disorder, illness anxiety disorder, factitious disorder, psychotic disorders, gender dysphoria, olfactory reference disorder (olfactory reference syndrome), bipolar disorder, and body integrity dysphoria. (See 'Differential diagnosis' above.)

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