Body dysmorphic disorder: Clinical features

AUTHOR: Katharine A Phillips, MD
SECTION EDITOR: Joel Dimsdale, MD
DEPUTY EDITOR: David Solomon, MD

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Literature review current through: **Oct 2023.**
This topic last updated: **Nov 28, 2022.**

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 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 professionals as well as other clinicians, such as dermatologists, plastic surgeons, primary care physicians, pediatricians, and dentists. Most patients seek nonpsychiatric cosmetic treatment (most commonly dermatologic and 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 clinical features of BDD. The epidemiology, pathogenesis, assessment, diagnosis, differential diagnosis, treatment, and prognosis of BDD are discussed separately:

- (See "Body dysmorphic disorder: Epidemiology and pathogenesis".)
- (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis".)
- (See "Body dysmorphic disorder: General principles of treatment".)

- (See "Body dysmorphic disorder: Choosing treatment and prognosis".)

CLINICAL MANIFESTATIONS

Body dysmorphic disorder (BDD) is characterized by preoccupation with nonexistent or slight defects in physical appearance, such that individuals with BDD believe that they look abnormal, unattractive, ugly, or deformed, when in reality they look normal [1,2]. The preoccupation with perceived flaws leads to repetitive behaviors (eg, checking their appearance in mirrors), which are difficult to control and are not pleasurable. BDD causes clinically significant distress and/or impaired psychosocial functioning, and is often associated with suicidal ideation and behavior.

In addition, BDD is often a severe illness. A study of inpatients with BDD (n = 16) and without BDD (n = 106) [3], and a study of outpatients with (n = 16) and without BDD (n = 484) [4], both found that clinical severity and functional impairment were greater in patients with BDD than patients without BDD.

Patients with BDD typically do not reveal their symptoms unless specifically asked [3-5]; patients are often embarrassed and ashamed, afraid of being misunderstood and negatively judged, and many are unaware that effective treatment is available [6].

Appearance preoccupations — Patients with BDD are preoccupied with nonexistent or slight defects in the physical appearance of one or more body parts [1,2,7-9]. The appearance preoccupations are difficult to resist or control, and occur for an average of three to eight hours a day [9,10]. The body areas are perceived as unattractive, repulsive, abnormal, or deformed, and some patients describe themselves as looking like a freak, a monster, a burn victim, or the "Elephant Man." The preoccupations with appearance are distressing in part because they focus on perceived unacceptability of oneself to others, and in many cases, involve an inaccurate belief that other people mock and reject the person because of how they look. (See 'Social anxiety and avoidance' below.)

Most patients over the course of illness are preoccupied with the appearance of multiple body areas (average of five to seven different areas) [7,9,11]. However, some patients are excessively preoccupied with just one body area, whereas others dislike virtually every aspect of their appearance. The most commonly disliked body parts are [7,12-14]:

- Skin (eg, acne, scarring, blemishes, color, or wrinkles)
- Hair (eg, balding or too much facial or body hair)
- Nose (eg, size or shape)
- Stomach

- Breasts/chest
- Eyes

However, any area of the body can be the focus of concern. In addition, symmetry concerns are common (eg, uneven nostrils, eyes at a different level, or uneven sideburns).

Among patients with BDD, females are more likely than males to be preoccupied with their weight, hips, buttocks, breasts, legs, and excessive facial or body hair [15]. Males are more likely than females to be preoccupied with thinning hair and genitals, and to have muscle dysmorphia. (See 'Muscle dysmorphia' below.)

Repetitive behaviors (compulsions and rituals) — A core aspect of BDD is compulsions (rituals), which are repetitive behaviors or mental acts that are driven by appearance preoccupations [7,9,11,14]. The belief that one looks unacceptable causes emotional distress (eg, anxiety, depressed mood, and shame). These negative feelings in turn fuel compulsive behaviors that are intended to reduce emotional distress by attempting to fix, hide, inspect, or obtain reassurance about the disliked body parts. These time-consuming behaviors are usually difficult to control and are not pleasurable. Most compulsions are motoric and observable by others, but mental rituals (eg, comparing) are common as well. These behaviors often increase rather than decrease anxiety and distress induced by the appearance concerns.

All individuals with BDD perform repetitive behaviors at some point during the course of their illness. These behaviors may be clues that a person has BDD; patients who present with these behaviors should be assessed for BDD. The following compulsive behaviors are most common; all percentages are for lifetime (past and present) occurrence [7,11,15]:

- **Camouflaging** – Approximately 90 percent of patients try to hide or cover up the disliked body areas. Camouflaging can include using a hat, heavy make-up, clothing, hair, sunglasses, or one's hands. Approximately one-quarter of BDD patients excessively tan to darken "pale" skin, minimize perceived acne or wrinkles, camouflage areas such as a "bald spot" on the head, or diminish other BDD concerns. Many patients camouflage by positioning their body to make the disliked areas less visible to others. Camouflaging often involves repetitive, compulsive behavior, such as repeatedly applying makeup or frequently adjusting one's clothing or body position. However, camouflaging is also avoidant in nature (ie, a safety behavior), in the sense that the goal is to avoid feeling the shame that occurs when the "flawed" body areas are seen by others.

- **Comparing –** Nearly 90 percent of patients frequently compare their disliked features with those of other people in their surroundings, as well as people in newspapers, magazines, online, or on television. This behavior can preoccupy patients so much that they have

difficulty focusing upon conversations or tasks. In addition, comparing often increases distress because patients with BDD tend not only to underestimate their own attractiveness but also overestimate the attractiveness of others.

- **Mirror checking –** Nearly 90 percent of patients compulsively check their perceived defects in mirrors and other reflecting surfaces (eg, windows, backs of spoons, cell phones, and shiny appliances), often doing this for hours each day. While mirror checking, patients may perform other behaviors, such as excessive grooming or skin picking.

- **Excessive grooming –** More than half of patients excessively groom; patients may repeatedly style or comb their hair, repeatedly apply make-up, or pull or pluck their hair (eg, to remove “excessive” facial hair or to “even up” eyebrows or sideburns). However, hair pulling may be due to trichotillomania (hair-pulling disorder) rather than BDD; the differential diagnosis between BDD and trichotillomania is discussed separately. (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Trichotillomania (hair-pulling disorder)'.)

- **Seeking reassurance of others** – Approximately half of patients frequently seek reassurance from others about how they look and whether they look acceptable. However, patients typically do not believe the reassurance they receive because they usually have little or no insight. (See 'Poor insight and delusions' below.)

- **Clothes changing** – Nearly half of patients change their clothes many (eg, ≥4) times a day to try to camouflage disliked body areas.

- **Skin picking –** More than one-third of patients compulsively pick their skin to try to make their skin look better (eg, smoother or completely blemish free). Some patients use sharp implements, such as pins, needles, razor blades, or knives. Injury to the skin, which can cause scarring and is occasionally life-threatening (due to infections or ruptured blood vessels), can occur. However, patients do not intend to injure or harm themselves. Thus, patients who pick their skin can be an exception to the rule that those with BDD do not have obvious appearance flaws. The differential diagnosis between skin picking (excoriation) disorder and BDD is discussed separately. (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Skin picking (excoriation) disorder'.)

- **Excessive exercising or weight lifting –** Excessive exercising or weight lifting is especially common in men with the muscle dysmorphia form of BDD. (See 'Muscle dysmorphia' below.)

- **Compulsive shopping –** Some individuals compulsively shop for skin or hair products, make-up, or clothes to minimize their "flaws." They are usually disappointed with the results.

- **Other behaviors –** Patients may perform many other behaviors to check, try to fix, or hide the perceived appearance flaws. As an example, patients may frequently check online for ways to fix the perceived flaws, compulsively check their image on videoconferencing platforms, measure disliked body areas, take repeated selfies, scrutinize photos of themselves or others, touch disliked areas to examine them, or excessively wash their face or shower to prevent acne.

Poor insight and delusions — BDD beliefs are typically characterized by either overvalued ideas (poor insight) or delusions, such that insight regarding the perceived appearance defects is usually poor or absent [16]. Thus, most patients are mostly or completely certain that the disliked body areas truly look ugly or abnormal. In addition, approximately 60 percent of patients have ideas or delusions of reference, believing that other people take special notice of the "defective" body areas, talk about the patient in a negative way because of appearance, or make fun of the patient's physical appearance, all of which can contribute to social avoidance. (See 'Social anxiety and avoidance' below.)

The delusional variant of BDD represents a more severe subtype [16-18]. In addition, poor or absent insight often make it difficult to engage patients in psychiatric treatment, and many seek surgery and other cosmetic procedures instead. (See 'Cosmetic interventions' below.)

Social anxiety and avoidance — Social anxiety and social avoidance are common in BDD [11,19]. Many patients isolate themselves because they fear that other people will see the "deformity," or fear rejection or ridicule because of their "ugliness." Thus, some patients are housebound, and many avoid dating and physical intimacy. Social isolation may cause patients with BDD to be misdiagnosed with social anxiety disorder. (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Social anxiety disorder'.)

Muscle dysmorphia — Muscle dysmorphia is a form of BDD that occurs almost exclusively in males and consists of an inaccurate belief that one's body is too small, or should be more lean or muscular [10,20,21]. These patients look normal or even very muscular if they abuse androgenic steroids or work out excessively. Patients with muscle dysmorphia engage in multiple repetitive behaviors and are usually preoccupied with other body parts such as skin or hair. (See 'Repetitive behaviors (compulsions and rituals)' above and 'Appearance preoccupations' above.)

One review found that the prevalence of muscle dysmorphia among college students was approximately 6 percent, and that the condition was present mostly in males [21]. Among male weightlifters, the disorder occurs in approximately 15 to 45 percent.

Most patients with muscle dysmorphia scrupulously diet (eg, eat high-protein, low-fat meals) and excessively exercise (eg, lift weights); the inordinate amount of exercise sometimes damages joints or muscles [10,20,22]. These individuals may use or misuse a large variety of nonprescription supplements as well as prescription drugs (usually obtaining them without a prescription), such as thyroid hormone, selective estrogen receptor modulators, androgenic steroids, and human growth hormone, with the goal of losing fat and building muscle. As an example, among men with muscle dysmorphia, approximately 20 to 40 percent abuse potentially dangerous androgenic steroids in an attempt to become bigger and more muscular [22]. Side effects of androgenic steroids are discussed separately. (See "Use of androgens and other hormones by athletes", section on 'Side effects and complications'.)

Emotional distress — BDD is associated with low self-esteem as well as high levels of depressed mood, anxiety, anger/hostility, hopelessness, guilt, shame, disgust, perfectionism, perceived stress, and neuroticism (enduring tendency to experience negative emotional states and to respond poorly to environmental stress) [8-10,23].

Somatic symptoms — BDD may be marked by the presence of somatic symptoms. In a nationally representative survey, the number of somatic symptoms (eg, headache, abdominal pain, or palpitation) was nearly twice as great among individuals with BDD than individuals without BDD [24]. In addition, a study of outpatients with BDD (n = 75) found that somatic symptoms were elevated compared with healthy controls, but not compared with psychiatric outpatients [25].

Neurocognitive dysfunction — Multiple studies suggest that executive function, which involves cognitive processes such as planning, making decisions, and response inhibition, is impaired in BDD. (See "Body dysmorphic disorder: Epidemiology and pathogenesis", section on 'Neurocognitive dysfunction'.)

Emotional processing deficits — Patients with BDD may also have deficits in recognizing emotions conveyed by the facial expressions of other people. (See "Body dysmorphic disorder: Epidemiology and pathogenesis", section on 'Emotional processing deficits'.)

Cosmetic interventions — Most patients with BDD seek and obtain dermatologic, surgical, or other cosmetic treatments in an attempt to “fix” their perceived appearance flaws [26-29]. As an example, a retrospective study (n = 200) found that cosmetic treatments were sought by 71

percent and obtained by 64 percent [28]. The primary reasons for seeking but not receiving cosmetic interventions were physician refusal and cost [29,30].

Patients with BDD most frequently seek dermatologic and surgical treatments [28,29]. The most common dermatologic treatments received by patients are topical and oral medications (eg, antibiotics or isotretinoin) for perceived acne; other treatments include dermabrasion, finasteride, and topical minoxidil. The most common surgical procedures are rhinoplasty, breast augmentation, and maxillofacial (jaw and chin) surgery. However, patients may seek any type of cosmetic treatment, including dental procedures and electrolysis. The prevalence of BDD among patients who present for cosmetic treatment is discussed separately. (See "Body dysmorphic disorder: Epidemiology and pathogenesis", section on 'Clinical settings'.)

However, BDD symptoms appear to rarely improve after cosmetic procedures and may even worsen [26,27,29-32]:

- In a retrospective study of patients with BDD who received 419 cosmetic treatments, outcomes for BDD symptoms after the treatments were as follows [28]:
  - No change – 91 percent
  - Worse – 5 percent
  - Improved – 4 percent
- A prospective study enrolled patients who received rhinoplasty and followed them for five years; postoperative quality of life in the patients who screened positive for BDD (n = 5) did not improve and their mental health was worse [33]. Among patients who screened negative for BDD (n = 46), quality of life improved during follow-up.
- A survey of aesthetic surgeons included 178 who had operated on patients who were thought to be appropriate for surgery, only to realize afterwards that the patients had BDD. Poor outcomes occurred in 82 percent of the cases (patients were more preoccupied with the perceived defect, or were focused upon an imagined or slight defect in a different body part) [34].

Poor outcomes are perhaps to be expected, because BDD involves distorted body image, aberrations in visual processing, and a tendency to obsess about minimal or nonexistent flaws. Although a “surface” change such as that accomplished by surgery may provide temporary improvement in concerns about appearance, it is unlikely to treat the disorder.

Among patients with BDD who receive surgery and view the outcome as a failure, symptoms of BDD may worsen, and patients may become more preoccupied with their perceived defects and

seek additional operative procedures or other interventions. In a retrospective study of 128 patients who were treated with cosmetic interventions, the average number of different treatments was three [28].

The poor outcomes of cosmetic interventions may extend to clinicians in that dissatisfaction with treatment may lead patients to become litigious, threatening, or violent toward clinicians who administer the treatment [26,27]. In a survey of aesthetic plastic surgeons (n = 265), legal threats by patients with BDD were reported by 29 percent of the surgeons, physical threats by 2 percent, and both legal and physical threats by 10 percent [34].

A practice guideline from the American Academy of Otolaryngology states that BDD is a contraindication to elective rhinoplasty and that patients seeking surgery should be screened for BDD [31,35]. Similarly, the American College of Obstetricians and Gynecologists (ACOG) states that individuals younger than age 18 years who request breast or labia surgery should be screened for BDD; if the obstetrician-gynecologist suspects that an adolescent has BDD, referral to a mental health clinician is appropriate [36]. A more recent publication from the ACOG regarding elective female genital cosmetic surgery states that if indicated, individuals should be assessed for BDD; if the condition is suspected, the individual should be referred for evaluation before considering surgery [37].

Screening for BDD and management of patients with BDD who are pursuing cosmetic interventions is discussed separately. (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Screening instruments' and "Body dysmorphic disorder: General principles of treatment", section on 'Discourage cosmetic interventions'.)

Comorbidity — Comorbid psychopathology in patients with BDD is common [38]. The approximate lifetime rate of specific comorbid mental disorders is as follows [7,39-41]:

- Unipolar major depression – 75 percent of patients with BDD
- Social anxiety disorder – 40 percent
- Personality disorders – 40 to 100 percent
- Substance use disorders – 30 to 50 percent
- Obsessive-compulsive disorder (OCD) – 33 percent
- Eating disorders – 33 percent
- Panic disorder – 13 to 20 percent

The mean number of lifetime comorbid mental disorders in patients with BDD is approximately 2.5 [4,39]. In a study of psychiatric outpatients with BDD (n = 16) and without BDD (n = 484), the mean number of comorbid disorders was greater in patients with BDD than non-BDD patients [4].

Onset of BDD usually precedes the occurrence of unipolar major depression and substance use disorders [39]. Many patients attribute their depressive symptoms and their alcohol or drug problem to their BDD symptoms and the distress caused by BDD [40,42,43]. The most strongly endorsed motive for drinking alcohol in patients with BDD is to cope with negative affect [42]. Approximately half of individuals with BDD report that they drink or use illicit drugs because their body image concerns are upsetting, to forget about their body image concerns, or to feel more comfortable about their appearance around others [42,43].

BDD is also associated with maladaptive personality traits, including perfectionism, unassertiveness, emotional over-reactivity to rejection and criticism, low self-esteem, low levels of extraversion, and high levels of neuroticism (which reflects anxiety, depression, self-consciousness, anger, and feelings of vulnerability) [11].

Substance use disorders are more likely to occur in males with BDD than females with BDD, whereas eating disorders are more likely to occur in females with BDD [10]. These findings are consistent with those for the general population.

Functioning and quality of life — Psychosocial functioning involves one's objective level of performance in areas such as work and social relationships, and quality of life involves the subjective perception of one's functioning in different domains (eg, physical, emotional, and social functioning). On average, functioning and quality of life for patients with BDD is poor [44]:

- A study of patients with BDD (n = 176) found that work and social functioning were each worse than the published norms for patients with depression, type II diabetes, or acute myocardial infarction; clinically large differences were observed in most comparisons [45]. In addition, quality of life was worse than published community norms.

  Among a subset of the patients (n = 141), only 42 percent were employed full time, 38 percent were unemployed, and 23 percent received disability pay [46]. Among currently employed patients, occupational impairment due to psychopathology was present in 80 percent, and 39 percent did not work for at least one consecutive week in the past month due at least in part to psychopathology (BDD was the primary diagnosis for most).

- A nationally representative survey in Germany found that unemployment was nearly two times greater among individuals with BDD than individuals without BDD (13 versus 7 percent) [13].

- Compared to individuals without BDD, those with BDD are more likely to be divorced and to have lower income, less education, more sick days, and higher rates of suicidality [47].

Many patients with BDD stop working, refuse to attend school, drop out of school, and avoid activities and other people because of beliefs they are ugly and because they don't want to be seen [11]. The distracting and time-consuming nature of the preoccupations and repetitive behaviors can also substantially interfere with functioning. The proportion of patients with BDD who have been housebound for at least one week because of BDD symptoms is approximately 30 percent [7].

In addition, poor psychosocial functioning in patients with BDD generally persists over time. A prospective observational study followed 176 patients for up to three years [48]. On average, occupational and social functioning was seriously impaired at baseline; during follow-up, functional remission (defined as no more than slight impairment in occupational and social functioning for two consecutive months) occurred in only 6 percent of patients. Poorer functioning was associated with more severe BDD symptoms, but not with delusional BDD beliefs.

Suicidality — BDD is often characterized by suicidal ideation and suicide attempts [49]; in addition, suicidality may be greater in BDD than other psychiatric disorders. A study included patients (n >1600) who were treated for anxiety disorders, BDD, major depression, OCD, and posttraumatic stress disorder (PTSD) in a partial hospital program; each patient received a suicide risk score based upon suicidal thoughts and behaviors [50]. After adjusting for age and gender, the analyses found that more patients with BDD had a moderate/severe suicide risk, compared with other patients (64 versus 49 percent). In addition, the likelihood of clinical deterioration and necessity of inpatient hospitalization was greatest in those with BDD than other disorders.

- **Suicidal ideation** – Suicidal ideation is common in BDD [49]. A meta-analysis of 14 studies (sample size not reported) found that suicidal thoughts occurred in 53 percent of patients [51].

  In addition, multiple studies have consistently found that individuals with BDD are at increased risk of suicidal ideation [49]. In a meta-analysis of nine studies (sample size not reported) and in subsequent studies (n = 498, 3454, and 6027), individuals with BDD were compared to controls without BDD, including healthy controls and individuals with anxiety disorders, eating disorders, depressive disorders, OCD, or PTSD [51-53]. Suicidal ideation was four to seven times more likely to occur in those with BDD than controls.

- **Suicide attempts** – Suicide attempts are also common in patients with BDD [49]. A meta-analysis of 14 studies found that suicide attempts occurred in 24 percent of patients [51].

In addition, multiple studies have consistently shown that individuals with BDD are at increased risk of attempting suicide [49]. In a meta-analysis of nine studies (sample size not reported) and in subsequent studies (n = 498, 3454, and 6027), individuals with BDD were compared to controls without BDD, including healthy controls and individuals with anxiety disorders, eating disorders, depressive disorders, OCD, or PTSD) [51-53]. Suicide attempts were two to six times more likely to occur in those with BDD than controls. Furthermore, suicide attempts requiring hospital admission were seven times more likely in those with BDD (odds ratio 7, 95% CI 3-17) [53].

Patients with BDD may attempt suicide multiple times. As an example, a four-year prospective study found that nine patients who attempted suicide made a total of 30 suicide attempts [54].

Risk factors for suicide attempts in BDD include [49-53,55-57]:

- Greater severity of BDD
- BDD age of onset ≤17 years
- Currently an adolescent
- Greater lifetime functional impairment due to BDD
- Perceived childhood maltreatment
- BDD-related restrictive food intake
- Comorbid psychiatric disorders – The relationship between BDD and elevated suicidality is independent of comorbidities, but the following comorbidities or number of comorbidities may further strengthen the relationship:
  - OCD
  - PTSD
  - Substance use disorder
  - Unipolar major depression
  - Three or more comorbid disorders
- **Suicide** – Studies of suicide deaths in BDD are scarce [51]. In one prospective study of patients with BDD who were followed for up to four years (n = 185), two patients committed suicide [54]. This suicide rate was approximately 45 times higher than the rate in the general population; however, the confidence interval was large.

General information about the evaluation and management of patients with suicidal ideation and behavior is discussed separately. (See "Suicidal ideation and behavior in adults".)

Aggressive/violent behavior — Hostile, aggressive, or violent behavior also appears to be common among patients with BDD [25,49]. This behavior is often triggered by BDD symptoms, such as anger about being "deformed," inability to fix the perceived appearance problem, delusions of reference and misperception of others' neutral facial expressions as contemptuous or angry, use of anabolic steroids, and dissatisfaction with the outcome of cosmetic treatment [49].

COURSE OF ILLNESS

Although body dysmorphic disorder (BDD) may remit, the disorder is typically chronic. A prospective observational study followed patients (n = 166) for up to four years; at some point during follow-up, 88 percent of the patients received psychiatric treatment, which in most cases was not focused upon or adequate for treating BDD [58]. The primary findings were as follows:

- Recovery occurred in approximately 20 percent of patients. Predictors of recovery included less severe symptoms at study intake and shorter lifetime duration of BDD. The presence of delusional BDD beliefs or comorbid unipolar major depression did not decrease the probability of recovery.
- Among patients who recovered, relapse occurred in approximately 40 percent. Relapse was associated with more severe symptoms at intake and earlier age of onset of BDD. The presence of delusional BDD beliefs or comorbid major depression did not increase the probability of recurrence.
- On average, patients met full criteria for BDD for 69 percent of the follow-up time.

Another study from the same dataset found that among patients with BDD and comorbid unipolar major depression, improvement of either disorder predicted remission from the other disorder [59].

In an eight-year, prospective observational study of patients with anxiety disorders at study intake who also had current, comorbid BDD (n = 17), the estimated median time to full recovery from BDD exceeded five years [60]. Recovery eventually occurred in approximately 80 percent of patients; following recovery, recurrence occurred in approximately 15 percent.

Despite the chronicity seen in these observational studies, patients with BDD who receive recommended treatment usually improve. (See "Body dysmorphic disorder: Choosing treatment

and prognosis", section on 'Prognosis'.)

INFORMATION FOR PATIENTS

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

SUMMARY

- Body dysmorphic disorder (BDD) is characterized by preoccupation with nonexistent or slight defects in physical appearance that lead to repetitive behaviors as well as clinically significant distress and/or functional impairment. However, patients typically do not reveal their symptoms unless specifically asked. (See 'Clinical manifestations' above.)

- The preoccupation with appearance is difficult to resist or control, and occurs for an average of three to eight hours a day. Most patients over the course of illness are preoccupied with the appearance of multiple body areas, which are perceived as unattractive, repulsive, abnormal, or deformed. The most commonly disliked body parts are skin, hair, and nose. (See 'Appearance preoccupations' above.)

- A core aspect of BDD is compulsions (rituals), which are repetitive behaviors or mental acts that are driven by appearance preoccupations. The compulsive behaviors are intended to fix, hide, inspect, or obtain reassurance about the disliked body parts. These behaviors usually take three to eight hours a day, are usually difficult to control, are not pleasurable, and often fail to relieve distress. Repetitive behaviors include camouflaging, comparing one's disliked features with those of other people, mirror checking, excessive grooming, seeking reassurance from others, and skin picking. (See 'Repetitive behaviors (compulsions and rituals)' above.)

- BDD is typically characterized by either overvalued ideas (poor insight) or delusions, such that insight regarding the perceived appearance defects is usually poor or absent. (See 'Poor insight and delusions' above.)

- Muscle dysmorphia is a form of BDD that occurs almost exclusively in males and consists of an inaccurate belief that one's body is too small, or should be more lean or muscular. (See 'Muscle dysmorphia' above.)

- Most patients with BDD obtain dermatologic, surgical, or other cosmetic treatments in an attempt to “fix” their perceived appearance flaws. However, BDD symptoms appear to respond poorly to cosmetic procedures in the large majority of cases and may even worsen. (See 'Cosmetic interventions' above.)

- Patients with BDD commonly manifest comorbid psychopathology, including unipolar major depression, social anxiety disorder, personality disorders, substance use disorders, obsessive-compulsive disorder, and eating disorders. (See 'Comorbidity' above.)

- Suicidal behavior is common among individuals with BDD. In addition, the risk of suicidal behavior may be greater in those with BDD than other psychiatric disorders, such as anxiety or depressive disorders. (See 'Suicidality' above.)

- Other clinical manifestations of BDD include social anxiety and avoidance, emotional distress, neurocognitive dysfunction, emotional processing deficits, poor psychosocial functioning and quality of life, and hostile/aggressive behavior. (See 'Social anxiety and avoidance' above and 'Emotional distress' above and "Body dysmorphic disorder: Epidemiology and pathogenesis", section on 'Pathogenesis' and 'Functioning and quality of life' above and 'Aggressive/violent behavior' above.)

- BDD is typically chronic. However, patients who receive recommended treatment usually improve. (See 'Course of illness' above and "Body dysmorphic disorder: Choosing treatment and prognosis".)

Topic 14825 Version 7.0

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