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Research Paper

Body Dysmorphic Disorders: A CHALLENGE IN CONTEMPORARY NURSING (A seminar presentation in the Department of Nursing Science, PAMO University of medical sciences, Port Harcourt- Nigeria)

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I. Introduction

Body dysmorphia also known as body dysmorphic disorder (BDD) is a disorder that is characterized by the preoccupation with a nonexistent or minimal flaw in appearance. In a bid to look better, people resort to excessive exercises, cosmetic surgeries, taking drugs such as steroids and even eating disorders. However, because BDD is a disorder of self-perception, regardless of the numerous procedures and interventions to look better, individuals with BDD are usually not satisfied with their appearance. Body dysmorphic disorder (BDD) is an under-recognized psychiatric disorder that disproportionately presents in dermatology and plastic surgery patient populations. Individuals with BDD are preoccupied with flaws in their physical appearance that are either not detectable or appear minimal to others(American Psychiatric Association (APA), 2013). While these manifestations may appear to be relatively minor, untreated BDD can manifest as repetitive behaviors that cause

significant impairment in multiple areas of life functioning. In more severe cases, patients are unable to leave their homes or engage with others to fulfill important social and occupational responsibilities (Zakhary et al., 2017). BDD is comorbid with major depressive disorder, social anxiety disorder, and obsessive-compulsive disorder, and patients who suffer from BDD have higher rates of suicidal ideation (46%) and suicide attempt (18%). Onset is most commonly observed during childhood and adolescence, and the disorder follows a chronic course. Additionally, patients often delay seeking treatment due to feelings of embarrassment and shame (Möllmann et al., 2017; Frias et al., 2015; Angelakiz et al., 2016).

Gender differences play an important role in the course and symptomatology of BDD. Although gender incidence is roughly equal, men are less likely to seek treatment (Reddy &Bessen, 2015; Hartmann &Buhlmann, 2015). Men tend to be older, single, and living alone, while the majority of women BDD patients presenting to dermatologists and cosmetic surgeons are 27-35 years old (Sun & Evan, 2021). Men are preoccupied with their genitalia, body build, and hair, are more likely to lift weights excessively, and have a higher risk for comorbid substance use (Sun & Evan, 2021). In contrast, women tend to focus more on their skin, weight, and body/facial hair, and are preoccupied with a larger number of body areas, including the stomach, chest, buttocks, and thighs. Women also display more repetitive behaviors and are more likely to hide their perceived flaws (referred to as camouflaging), check mirrors, change clothes, engage in skin-picking, and have a comorbid eating disorder (Sun & Evan, 2021). While BDD symptoms appear to begin earlier in women and are reported at higher levels of severity, men seem to be more functionally impaired and have a higher likelihood of not working and receiving disability due to psychopathology (Sun & Evan, 2021).There is an increasing prevalence of BDD especially when considering patients who present to aesthetic physicians. According to a recent meta-analysis, 12.65% of dermatology patients and 15.04% of plastic surgery patients meet diagnostic criteria for BDD (Veale et al., 2016). Because the primary areas affected by a preoccupation of appearance commonly relate to facial features, the skin, and hair, dermatologists are the physicians most often consulted by BDD patients (Veale et al., 2016). Preoccupations with appearance can also lead to compulsive behaviors that cause considerable damage to the skin and hair. Approximately one-third of BDD patients engage in skin-picking (excoriation disorder) and to a lesser degree, hair-pulling (trichotillomania) (Phillips & Stein, 2015). Some patients report spending 8-12 hours a day picking at minor acne lesions, keratosis pilaris, and facial hairs with implements ranging from fingers and needles to staple removers, razor blades, and knives. Patients undertake this obsessive behavior in an attempt to remove their perceived imperfections but can end up causing scarring, ulcerations, and bald patches that intensify their original dissatisfaction with their appearance (Ribeiro, 2017). In cases where individuals are concerned about looking too pale, similar BDD-associated compulsions can lead to excessive tanning that burns the skin and potentially increases further risk for dermatologic malignancies (Koblenzer, 2017).

A study carried out by Akinboro et al, (2019) in Ogbomoso, Nigeria showed that 36% of patients presented with BDD. It is noted that so many persons in the nation do not know about this condition, this can be evident in the little or no researches about BDD and at such many live with this condition without seeking any medical attention; hence it is important to create further awareness to the general public about this condition.

II. OBJECTIVES

The objectives of this paper are to:

1. Describe Body Dysmorphic Disorder (BDD).
2. Discuss the diagnosis and management of Body Dysmorphic Disorder (BDD).
3. Discuss the nursing implications in Body Dysmorphic Disorder (BDD).

Body Dysmorphic Disorder (BDD)

Body dysmorphic disorder (BDD) is a seriously impairing psychiatric condition characterized by excessive preoccupation with a perceived defect in one's appearance or overemphasis on a slight defect. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies body dysmorphic disorder under the obsessive and compulsive spectrum (OCP) disorders, due to its similarity to obsessive-compulsive disorder (OCD).BDD was previously known as 'dysmorphophobia'which was originally described by a psychiatrist Morselli in 1886 and is usually characterized with the preoccupation with a nonexistent or minimal flaw in appearance and a marked obsession for perfection. According to Vashi (2016), such patients complain of supposed deformities, ranging from warped eyebrows, oversized nostrils, tiny genitals, to monstrous mouths, etc., making them feel excruciatingly ugly.They sit in odd positions to hide body parts, excessively tan to mask supposed facial and skin deficits, acid bath to bleach their skin, pick at their skin, avoid dating and public places, and frequently visit the dermatologist given that skin, hair, and nose concerns are the most frequently disliked areas.

BDD most commonly starts in adolescence and is often unnoticed. BDD affects about 1.9% of the adult population and about 1.7 – 2.2% of the adolescents; in adult psychiatric outpatients, about 5.8% suffer from BDD, in adult psychiatric inpatients, about 7.4% suffer from BDD; in adolescent psychiatric patients,

about 6.7 – 14.3% suffer from BDD; in general cosmetic surgery, up to at least 20% suffer from BDD; in cosmetic dentistry, about 5.2% and in dermatology outpatients, about 11.3% suffer from BDD(Hungate, 2021).

Types of Body Dysmorphia

Body dysmorphia can be classified into two (2) types. These types present based on an individual's preoccupation. They include:

1. **Muscle dysmorphia (MD)**: MD is a subtype of BDD involving preoccupation with the entire body. MD is present when an individual is preoccupied with their body build being either too small or having inadequate muscle definition (Hungate, 2021). They often spend an excessive amount of time exercising or taking anabolic steroids to build and enhance muscle.
2. **BDD by Proxy (BDDBP)**: BDDBP refers to body dysmorphia with the primary preoccupation fixated on perceived imperfections of another person. Individuals with BDDBP spend time repeating rituals to "fix" another person's appearance in an attempt to alleviate distress or anxiety (Hungate, 2021). This may have a profound impact on an individual and their ability to socially function and interact.

Causes of Body Dysmorphic Disorder

The exact etiology of BDD is unknown but it is postulated to be caused by a combination of multiple risk factors which include biological, psychological and sociocultural factors (Vashi, 2016).

The biological factors include genetics; the psychological factors include anxiety, depression and/ or obsessive-compulsive disorder (OCD), low self-esteem, personality such as perfectionism; while the sociocultural factors include abuse or bullying, peer teasing, peer victimization, cultural beliefs (Vashi, 2016 &Hungate, 2021).

However, there is an ongoing research on the neurobiology of BDD. Studies have found that people with body dysmorphia have evidence of differences in memory, executive functioning (planning and organizing), emotional processing, visual processing, white matter connection in the brain (Vohnoutka, 2021).

Symptoms of Body Dysmorphic Disorder

People with BDD are focused on flaws in their appearance. These perceived flaws are often only minimally visible to others or not visible at all. The person may then engage in behaviours that they hope will relieve their anxiety by "fixing" the flaws. They present with compulsive behaviours such as: camouflaging or trying to cover up certain areas of the body, comparing themselves to others, seeking cosmetic surgery, checking their appearance in a mirror, skin picking, excessive grooming, excessive exercise or weight lifting, use of anabolic steroids, frequently changing clothes, excessive tanning, acid bath or skin bleaching, excessive shopping, social anxiety and avoidance or social withdrawal (Vohnoutka, 2021).

People with dysmorphia often report feelings of shame, hopelessness, low self-esteem, anger, depression and anxiety. They may feel like the only solution to their problems is cosmetic surgery and are usually dissatisfied with the results and pursues additional surgeries. Some of the surgeries carried out by these persons include:

Facelift (rhytidectomy), brow/forehead lift, eyelid lift (blepharoplasty), ear pinning, ear reshapping, hair replacement or transplantation, rhinoplasty, chin, cheek or jaw reshaping/ facial implants, facial rejuvenation, lip augmentation, breasts augmentation, breast reconstruction, breast reduction, breast lift (mastopexy) with or without the placement of an implant, abdominoplasty (tummy tuck), liposuction (lipoplasty), dermabrasion/dermaplaning, brachioplasty, laser skin resurfacing, scar revision, botox/filler injections, vaginal rejuvenation, etc.

Diagnosis and Management of Body Dysmorphic Disorder (BDD)

Diagnosis

According to DSM – V, BDD is classified under the OCD spectrum. Patients with BDD have a preoccupation with an imagined or slight physical defect that causes clinically appreciable impairment in social, occupational, and/or other functioning. In addition, they exhibit repetitive behaviors or mental acts. The diagnosis of BDD includes 4 facets as outlined below:

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g. mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g. comparing his or her appearance with that of others) in response to the appearance concerns.

C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Diagnosis of BDD is based on a psychological evaluation that assesses risk factors and thoughts, feelings and behaviours related to negative self-image; personal, social, family and medical history; signs and symptoms.

A self-assessment quiz by the recovery village can help one identify if he/she has BDD, however it is always advisable to consult a healthcare professional to give a formal diagnosis. The following questions are answered based on experiences for six (6) months and above. Answer yes or no to the following questions:

i. Been extremely preoccupied with one or more perceived flaws in your physical appearance?
ii. Compulsively checked the mirror to examine your appearance?
iii. Repeatedly measure or touched your perceived flaw?
iv. Experienced a preoccupation about your perceived physical flaws that have contributed to problems in your social life?
v. Had difficulties performing at school or work because of a preoccupation about your appearance?
vi. Constantly compared your appearance with others?
vii. Strongly considered cosmetic procedures to fix a perceived flaw in your appearance?
viii. Expressed shame or embarrassment over your physical appearance?
ix. Attempted to hide a perceived physical flaw with clothes or makeup?
x. Struggled to control your negative thoughts about your perceived flaws?
xi. Believe that others take particular notice of perceived flaws in your appearance?
xii. Repeatedly sought reassurance that your perceived flaw is not visible or too obvious?

(Recovery Village, 2021).

If majority of the answers to the above questions is a'yes', it is suspected that the person may be dealing with BDD, it is important to note that the results are not a diagnosis and this quiz is not a diagnostic tool. However, one may benefit from a consultation with a licensed mental health professional if there are difficulties in daily life.

Management

Singh and Veale, (2019) stated that management of BDD often includes a combination of Psychotherapy such as cognitive behavioural therapy (CBT) and pharmacotherapy particularly Selective Serotonin Reuptake Inhibitors (SSRIs). SSRIs includes fluoxetine, sertraline, paroxetine, citalopram, escitalopram and fluvoxamine).

Congnitivebehavioural therapy (CBT) involves the identification and modification of problematic, appearance-related cognitions and behaviours. Strategies used in CBT include self-monitoring of thoughts and behaviours related to appearance, cognitive techniques and behavioural exercises. CBT for BDD focuses on:

i. Helping the patient learn how negative thoughts, emotional reactions and behaviours maintain problems over time.
ii. Challenging automatic negative thoughts about his/her body and learning more flexible ways of thinking.
iii. Learning alternative ways to handle urges or rituals to help reduce mirror checking, reassurance seeking, and excess use of medical services.
iv. Teaching the patient other behaviours to improve his/her mental health, such as addressing social avoidance and increasing engagement with healthy supports and activities.

(Singh & Veale, 2019).

The patient and the mental health provider sets goals for therapy and develop a personalized treatment plan to learn and strengthen coping skills and involving family members in treatment may be particularly important (Veale &Bewley, 2015).

Nursing Implications to BDD

Body Dysmorphic Disorder is an under diagnosed and often misdiagnosed mental health condition due to the similarity of symptoms it shares with other psychiatric disorders including depression, anxiety, agoraphobia, social anxiety disorder, eating disorder and obsessive-compulsive disorder to name a few.

As healthcare providers, nurses need to learn more about the disorder if they are working in the field, especially in cosmetic surgery and therefore be effective in dealing and interaction with these types of patients. Nurses can help the patient to prevent undergoing unnecessary cosmetic surgery, prevent the development of further body issues and be able to help effectively treat the disorder. Nurses should do the following:

i. Observe the patient with their complete attention (notice body language, facial expressions, does the patient actively cover the flaw?).
ii. Use open ended questions and encourage the patient to give more detailed information regarding grooming rituals and habits.
iii. Be an active listener and evaluate patient's stress, paraphrase comments verbalized by the patient.

The role of the nurse also, as a family life educator is to educate the family on the importance of accepting every member of the family the way they are; as rejection, criticism and making jest of them may lead them to having BDD.Also, nurses should monitor and observe patients with steroids prescription.

III. Summary

In the course of this paper, the following were highlighted:
Body dysmorphic disorder is a disorder of self perception that usually starts in adolescence, it can be found in both men and women, BDD is classified into two, the cause of BDD is unknown but there are predisposing factors, BDD can be managed via cognitive based therapy and use of selective serotonin reuptake inhibitors.

IV. Conclusion

As discussed in this paper, it is observed that body dysmorphia is an under-diagnosed mental health disorder. It is often diagnosed as an eating disorder due to the similarities in some symptoms and sometimes presents as comorbid with other mental health disorders. It is relatively not recognized in the nation, and this can be evident in the scanty to no recorded researches. It is also usually overlooked as people tend to ignore their feelings. There are also, little or no awareness programs on certain mental illnesses like body dysmorphia and people tend to ignore the signs.

The Way Forward

1. Steroids should be taken as prescribed and not for weight gain.
2. Exercises should be done for the health benefits and not as a punishment.
3. Plastic surgeries should only be done when necessary as corrective measures recommended by healthcare providers and not as a means for beautification

A number of ways to prevent BDD and to help patients with BDDincludes:

i. Early detection of BDD
ii. Learn what triggers compulsive behaviours
iii. Accept their feelings
iv. Be a good listener
v. Help them seek treatment
vi. Support them in their self-help practices
vii. Offer practical support
viii. Acknowledge small wins
ix.

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