Body Dysmorphic Disorder in Patients With Acne

There is growing evidence that the prevalence of body dysmorphic disorder (BDD) is significantly higher in specially selected populations as compared to the general population. The goal of the current study was to evaluate prevalence of BDD in Turkish patients with mild acne presenting to a dermatologist for treatment. This study was the first empirical investigation of BDD in acne patients in Turkey. One hundred fifty-nine outpatients diagnosed with acne who consulted to the dermatology clinic were included in the study. The diagnosis of BDD was based on DSM-IV criteria and the Structured Clinical Interview for DSM-IV (SCID-I). A study-specific questionnaire was administered to document and investigate the demographic and clinical characteristics of the cases. Fourteen (8.8%) patients were diagnosed with BDD. Three (21.4%) patients with acne and BDD also had concomitant psychiatric diagnoses. All of the patients were psychiatric management-naive, never received any psychological or physical treatments. BDD was a common psychiatric condition in acne cases. We suggest that dermatologists should routinely explore symptoms and screen such patients for BDD.

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Body Dysmorphic Disorder (BDD) is a relatively common yet underdiagnosed psychiatric disorder.1–2 BDD is characterized by the presence of preoccupation about an imagined or exaggerated physical anomaly. In patients with BDD any aspect of the appearance can be the focus of concern. As a consequence, preoccupation with appearance causes significant impairment of social and occupational functioning.3

BDD was previously known as “dysmorphophobia” and was originally described by Morselli in 1886. In 1987, BDD was described as distinct psychiatric diagnosis in DSM-III-R.4 However, research on BDD is still at an early stage, with no existing large controlled studies of BDD. Prevalence in the general population has been estimated to be 1% to 3%.2,5,6 The true prevalence may be much greater because these patients usually tend to hide their complaints and many cases never come to the attention of psychiatrists.2,7,8 Affected individuals generally prefer to consult an internal medicine, cosmetic surgery, or dermatology clinic for treatment.1,9–11 Thus the prevalence of BDD is much higher in selected populations than in the general population. In a large survey of dermatology patients, Phillips et al.10 found that the diagnostic rate of BDD in patients seeking treatment was 11.9%. According to these investigators, dermatologists may be the type of physicians most often consulted by patients with BDD.

Acne is a distressing condition that affects the majority of adolescents,12 and it is one of the reasons for dermatologic treatment of BDD patients.10 Subjects with BDD frequently request inappropriate and excessive cosmetic procedures, including laser therapy, dermabrasion, or corrective surgery, or request systemic retinoid therapy for minimal acne.13 However, the frequency of BDD among acne patients seeking dermatologic treatment is still unknown.

This study was the first empirical investigation of BDD in acne patients in Turkey. On the other hand, it was suggested that cultural norms and values may influence the content of BDD symptoms and might affect the prevalence of BDD.14,15 However, there are relatively few cross-cultural studies of BDD. The aim of the present study was to investigate the prevalence of BDD and related demographic characteristics in patients with acne in a Turkish sample consulted to the dermatology outpatient clinic.

METHOD

Participants

Participants were consecutive outpatient diagnosed with acne who applied to the general dermatology outpatient unit (Department of Dermatology, Gülhane School of Medicine, Ankara, Turkey) between February 2000 and March 2001. The original sample included 718 subjects. However, 541 subjects with moderate or severe acne were excluded from the study. Sixteen of the subjects who were asked to participate did not wish to take part, and two subjects who had a real defect of appearance and whose defect was found to be concordant with their com...
subjects who were dissatisfied with some aspect of appearance. However, in the clinical evaluation only 8.8% (14/159) fulfilled the criteria for BDD.

Of the 14 acne patients with BDD, eight (57.1%) were male and six (42.9%) were female. In the non-BDD group, 79 (54.5%) were male and 66 (45.5%) were female. The difference between the two groups was not statistically significant (Fisher’s exact test, \( P > .05 \)). Patients with BDD were significantly older (21.6 ± 1.9 years \( v \) 19.3 ± 4.0 years, \( z = -2.4, P < .018 \)) and had a higher level of education (13.3 ± 2.0 years \( v \) 11.3 ± 3.3 years, \( z = -2.1, P < .040 \)) than the patients without BDD. However, there were no differences between the two groups in terms of marital status (Fisher’s exact test, \( P > .05 \)), and economic status (Fisher’s exact test, \( P > .05 \)) (Table 1).

Age at the onset of the BDD was 17.9 ± 2.4 years (range, 14 to 21). Three (21.4%) of the BDD subjects also had seen an internist at least once. In nine cases (64.3%) repeated visits to a dermatologist were revealed. The mean number of visits to nonpsychiatric clinics was 2.4 ± 1.1 in acne patients with BDD, and 1.4 ± 0.7 in acne patients without BDD (\( z = -3.7, P < .000 \)). All of the patients with BDD had received nonpsychiatric treatment for their complaints. None of BDD patients had consulted a psychiatrist previously, and they had not received either psychological or psychiatric treatment for their BDD.

There was preoccupation about various body parts other than acne in all cases. Nine subjects showed dissatisfaction with two and five with one body part. The most common locations were the nose (\( n = 5; 35.7\% \)), head/face in general (\( n = 5; 35.7\% \)), teeth (\( n = 4; 28.6\% \)), and hips (\( n = 4; 28.6\% \)). Other areas reported were hair (\( n = 2; 14.3\% \)), bone structure (\( n = 2; 14.3\% \)), and breasts (\( n = 1; 7.1\% \)) (Table 2).

The rate of current comorbid psychiatric disorders was similar for the acne patients with and without BDD (21.4% \( v \) 24.8%; Fisher’s exact test, \( P > .05 \)). In the BDD group there were three (21.4%) patients with axis I comorbid psychiatric diagnosis. Two patients (14.3%) had diagnoses of dysthymia and one patient (7.1%) had diagnosis of social phobia. On the other hand, acne patients without BDD were also diagnosed with comorbid disorders. As shown in Table 1, the most common comorbid disorder was social phobia (\( n = 11; 7.6\% \)), followed by major depression (\( n = 9; 6.2\% \)), dysthymia (\( n = 7; 4.8\% \)), generalized anxiety disorder (\( n = 3; 2.1\% \)), somatization disorder (\( n = 3; 2.1\% \)), and obsessive compulsive disorder (\( n = 3; 2.1\% \)).

**DISCUSSION**

To our knowledge this report is the first empirical investigation of the prevalence of BDD in acne...
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