Nonpsychiatric Medical Treatment of Body Dysmorphic Disorder

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Many individuals with body dysmorphic disorder seek nonpsychiatric medical and surgical treatment to improve perceived defects in their physical appearance. However, the types of treatments sought and received, as well as the treatment outcome, have received little investigation. This study describes the frequency, types, and outcomes of treatments sought and received by 200 individuals with body dysmorphic disorder. Treatment was sought by 71.0% and received by 64.0%. Dermatological treatment was most frequently sought and received (most often, topical acne agents), followed by surgery (most often, rhinoplasty). Twelve percent of the subjects received isotretinoin. Such treatment rarely improved body dysmorphic disorder. Thus, nonpsychiatric medical treatments do not appear effective in its treatment.

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Body dysmorphic disorder (BDD), a distressing or impairing preoccupation with an imagined or slight defect in appearance, is associated with markedly impaired psychosocial functioning, suicidality, and notably poor quality of life.[1] Despite the morbidity that BDD causes, few studies have investigated the treatments that individuals who suffer from it seek and receive.

The plastic surgery and dermatology literatures contain anecdotal reports of patients with "minimal deformity" and "dermatological nondisease" who appear similar to patients with BDD.[2] Such reports typically noted poor outcomes and dissatisfaction with treatment. However, it was unclear whether they had DSM-defined BDD. Recent studies have suggested that DSM-IV BDD is relatively common in these settings. The rates of BDD among cosmetic surgery patients range from 7% to 15%; in dermatological settings, rates of 9% to 12% have been reported.[2]

Few studies have examined the converse—i.e., the rates of nonpsychiatric medical treatment received by individuals with BDD. In the largest study we know of,[3] 76% of 250 adults sought and 66% received nonpsychiatric treatment for their perceived appearance "defect," most commonly dermatological and surgical. A study of 50 patients with BDD[4] found that 48% had sought surgical or dermatological treatment, and 26% had received at least one procedure. In a chart-review study of 50 patients, 40% had undergone plastic surgery.[5] These findings are consistent with evidence that the skin (e.g., acne), hair (e.g., thinning), and nose (e.g., size or shape) are the most common areas of concern.[1] These results are also consistent with evidence that most patients have poor insight regarding their perceived defects, believing that they have actual physical deformities for which medical treatment or surgery is needed.[1]

Relatively little is known about the outcome of nonpsychiatric treatment. In a previously noted study (N = 250),[3] the most common outcome was no change in the overall severity of BDD. Two smaller studies[4,6] reported that patients with BDD experienced high levels of

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dissatisfaction after nonpsychiatric treatment, and in some cases, postoperative symptom exacerbations were noted.[6] In a survey of 265 cosmetic surgeons, 84% reported that they had operated on a patient with BDD, but only 1% of the cases resulted in complete symptom remission.[7] Furthermore, 40% of the respondents said that a patient with BDD had threatened them legally and/or physically.[7] These findings have led some to conclude that BDD is a contraindication for aesthetic treatments.[2,8]

Further investigation of nonpsychiatric treatment received by individuals with BDD is warranted. First, the largest study we found[3] consisted entirely of patients seeking or receiving psychiatric consultation or treatment. Such a group may be biased toward treatment failures because individuals whose symptoms do not improve with nonpsychiatric treatment may be more likely to remain symptomatic and to seek subsequent psychiatric care.[3] Only one small previous study (N = 25)[6] described the types of surgical procedures received by patients with BDD[6]; to our knowledge, no previous studies have comprehensively described the types of dermatological or other treatments sought and received. Finally, little is known about the clinical correlates of nonpsychiatric treatment.

Our primary aim in the present study was to examine the treatments sought and received, as well as outcomes, in a broader study group that included some individuals not currently seeking or receiving psychiatric care. We also examined a number of previously unasked questions, including the specific types of procedures sought and received, the number of visits to providers, the age at which such treatment was first sought, and the number of instances in which such treatment appeared to trigger the onset of BDD. Also, because of warnings that isotretinoin is linked with depression and suicidality,[9] we examined receipt of this treatment and its relationship to lifetime suicidality. A secondary aim was to examine the clinical correlates of receipt of nonpsychiatric treatment. We examined whether treatment receivers had more severe BDD, poorer insight, and poorer quality of life and psychosocial functioning than nonreceivers.

METHOD

Subjects

The study group consisted of 200 subjects (184 adults and 16 adolescents ages 17 and younger) in a naturalistic, prospective study of the course of BDD. Only data from the intake interview (including current and past nonpsychiatric treatment) were included in this report. The subjects met the following criteria: 1) had a diagnosis of DSM-IV BDD or its delusional variant (delusional disorder, somatic type), 2) were age 12 or older, and 3) were available to be interviewed in person. Persons with organic mental disorders were ineligible for participation. The study was approved by the hospital's institutional review board. The adults provided written informed consent; assent was obtained from the adolescents, along with the consent of their legal guardians. The subjects were obtained from a variety of sources, including mental health professionals (46.0%), advertisements (38.6%), our program's web site and brochures (10.2%), the subjects' friends and relatives (3.4%), and nonpsychiatrist physicians (1.7%). The study group had a mean age of 32.6 years (SD = 12.1, range = 14–64). The majority (68.5%) were female, 13.6% were members of a minority racial group, and 7.4% were members of a minority ethnic group; 63.5% were single, 24.5% were married, 11.5% were divorced, and 0.5% were widowed. The mean age of onset of BDD was 16.4 years (SD = 7.0); the mean duration of BDD was 15.8 years (SD = 12.3); 134 (67%) were receiving mental health treatment at the time of the intake interview.

Assessments

The BDD Form (Phillips KA, unpublished), a clinician-administered, semistructured measure used in previous BDD studies (e.g., reference 3), assessed demographic and clinical characteristics and treatment history, including the frequency of nonpsychiatric treatment sought and received. Information was retrospectively obtained on the types and numbers of providers and procedures and the numbers of visits for each treatment. Categories similar to those used by the American Society of Plastic Surgeons (http://www.plasticsurgery.org/public_education/2003statistics.cfm) were used to classify types of procedures. The Clinical Global Impression scale[10] determined responses to treatment for 1) the appearance of the treated body part, 2) concern/preoccupation with the treated body part, and 3) the severity of overall BDD. Ratings of "much" or "very much" improved indicated improvement; ratings of "much" or "very much" worse indicated worsening; and ratings of "minimally worse," "minimally improved," or "unchanged" represented no change.

The Medical Outcomes Study 36-Item Short-Form Health Survey[11] and the Quality of Life Enjoyment and Satisfaction Questionnaire,[12] both reliable and valid self-report measures, assessed current quality of life. The Social