OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Body Dysmorphic Disorder

BDD

DSM-5-TR 300.7 | ICD-10-CM F45.22

Preoccupation with slight or unobservable appearance defects, driving mirror rituals, camouflage, cosmetic procedures, and high suicide risk.

POINT PREVALENCE	TYPICAL ONSET	SEX RATIO	LIFETIME ATTEMPTS
~2.4% (US adults)	Mean 16-17 yr; 2/3 before 18	Near equal; slight female	~24-28% suicide attempts

CLINICAL PICTURE

- Preoccupation most often targets skin, hair, and nose, though any body area may be involved; muscle dysmorphia predominates among men.
- Repetitive behaviors include mirror checking, camouflaging with clothing or makeup, skin picking, excessive grooming, and comparing with others.
- Patients present to dermatology and cosmetic surgery rather than psychiatry; procedures rarely satisfy and often shift or worsen the preoccupation.
- Insight is poor or absent in roughly a third of patients, yet delusional conviction does not change treatment, which remains an SSRI plus CBT.
- Social avoidance, school or work dropout, and housebound periods are common; many spend three to eight hours daily on appearance concerns.
- Patients describe themselves as ugly or deformed rather than fat, which is the key phenomenologic split from an eating disorder.

DIAGNOSTIC CRITERIA AT A GLANCE

- Preoccupation with one or more perceived appearance flaws that are unobservable or appear only slight to others, sustained rather than fleeting.
- At least one repetitive behavior or mental act, such as mirror checking, grooming, reassurance seeking, or comparing appearance with others.
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- If the concern centers on body fat or weight in someone meeting eating disorder criteria, the eating disorder diagnosis takes precedence.
- Specifiers cover muscle dysmorphia and insight level, ranging from good or fair through poor to absent and delusional conviction.

NEUROBIOLOGY & PHYSIOLOGY

- Visual processing is abnormally detail-oriented, with local rather than global configural analysis in occipitotemporal and parietal networks.
- Orbitofrontal-striatal circuitry overlaps substantially with OCD, which supports classification within the obsessive-compulsive and related disorders.
- Serotonergic dysfunction is inferred from selective SSRI response; noradrenergic and non-serotonergic antidepressants are comparatively ineffective.
- Family studies show elevated rates of OCD among first-degree relatives, and heritability estimates for BDD approach 40%.
- Functional imaging demonstrates amygdala hyperactivity and aberrant frontostriatal engagement when patients view images of their own face.
- Elevated rates of childhood teasing, abuse, and neglect suggest stress-related shaping of appearance-based threat detection systems.

PSYCHOLOGICAL MECHANISMS

- Selective attention to appearance detail, prolonged mirror gazing that magnifies perceived flaws, and appearance-contingent self-worth maintain the disorder.
- Core cognitive distortions center on being judged, rejected, or deemed unlovable specifically because of the perceived physical defect.
- Camouflage, avoidance, and reassurance seeking function as safety behaviors that prevent disconfirmation of the feared social outcome.
- Perfectionism and heightened aesthetic sensitivity are elevated, with unusually strict internal standards for symmetry and proportion.
- Early appearance-focused teasing, bullying, and family emphasis on looks are common developmental precursors to onset in adolescence.

DIFFERENTIAL & COMORBIDITY

- Separate from normal appearance concern by the time consumed, the distress generated, and the functional impairment that follows.
- Anorexia nervosa involves weight and shape with restriction; gender dysphoria involves sex characteristics and identity, not a perceived defect.
- Comorbid major depression occurs in roughly 75% of patients, social anxiety disorder in about 35%, and substance use disorders in about 30%.
- Lifetime suicidal ideation approaches 80% and attempts reach 24-28%, exceeding rates in OCD and major depression, so screen at every contact.
- Skin picking driven by appearance concerns is coded as BDD rather than as excoriation disorder, and the same rule applies to hair removal.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- High-dose **SSRIs** are first-line: **fluoxetine 40-80 mg/day**, **escitalopram 20-30 mg/day**, or sertraline 150-200 mg/day as tolerated.
- Allow 12-16 weeks at an optimized dose; response is slower than in depression, with roughly 53-70% of patients responding.
- **Clomipramine 150-250 mg/day** outperformed desipramine in controlled comparison, confirming serotonergic specificity; monitor ECG and anticholinergic load.
- Augment partial response with **buspirone 30-60 mg/day** or a low-dose antipsychotic; antipsychotic monotherapy fails even in delusional presentations.
- Continue medication at least one year after response, since relapse rates are high with premature discontinuation or dose reduction.

PSYCHOTHERAPY

- **CBT tailored to BDD** across 18-24 weekly sessions is first-line, built on mirror retraining, exposure, and ritual prevention.
- Perceptual retraining teaches holistic rather than detail-focused self-viewing and directly reduces mirror-checking time and distress.
- Cognitive restructuring targets appearance-contingent self-worth and mind reading about how others evaluate the perceived defect.
- Habit reversal training is layered in for BDD-related skin picking and hair pulling, which otherwise persist after core CBT ends.
- Motivational interviewing improves engagement in poor-insight patients who are seeking cosmetic rather than psychiatric intervention.

ADJUNCT & SUPPORTIVE

- Administer the **BDD-YBOCS** at baseline and every 4-6 weeks; a 30% score reduction is the conventional threshold for response.
- Explicitly discourage cosmetic, dermatologic, and surgical procedures, since satisfaction is rare and preoccupation typically migrates to a new area.
- Coordinate with dermatology and plastic surgery colleagues so that screened patients route back to mental health rather than to a procedure.
- Safety planning, lethal means restriction, and escalation to a higher level of care are warranted given the markedly elevated suicide risk.
- Residential and intensive outpatient OCD-spectrum programs help housebound patients and those with severe avoidance or delusional insight.

CLINICAL PEARLS

- Patients say ugly, not fat; that single word separates BDD from an eating disorder.
- Delusional BDD is a severity specifier, not psychosis: treat with SSRI plus CBT.
- Ask about cosmetic procedures; repeated dissatisfaction is a strong diagnostic clue.

References

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NOTE

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