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Dysmorphic Syndrome or Body Dysmorphic Disorder: A Major Underdiagnosed Mental Health Problem

Wendy Sanchez Cañate[1]*, Lazaro Valdelamar Gale[1], Katerine Perez Mejia[1], Tatiana Rodriguez Jimenez[1], Francesca Badel Salgado[1], Heliana Padilla Santos[2] and Nelson Villalba Ordosgoitia[3]

1 Faculty of Medicine, Rafael Núñez University Corporation, Cartagena de Indias, Colombia
2 Specialist in Aesthetic Medicine, Orthomolecular Medicine and General Surgeon, Cartagena de Indias, Colombia
3 General practitioner, Cartagena de Indias, Colombia

***Corresponding author:**
Wendy Sanchez Cañate

wsanchezc10@curnvirtual.edu.co

Faculty of Medicine, Rafael Núñez University Corporation, Cartagena de Indias, Colombia.

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Abstract

The Body Dysmorphic Syndrome (CDS) is a clinical entity that consists of an agonizing concern for imaginary or slight defects in appearance, this is commonly considered as an obsessive-compulsive spectrum disorder, based on the similarities it has with this condition.

Clinically, it is underdiagnosed because many patients are shy about showing their secondary problem, since most of the time it derives from the altered perception of the skin, hair or nose. However, the disorder can point to various aspects of the patient's appearance throughout his life, it arises if one believes himself to be ugly, deformed or unattractive in the presence of no or minimal culturally acceptable physical deformity and is related to strong feelings of shame accompanied by repetitive behaviors such as checking in the mirror, camouflage of "defects", among others.

The World Health Organization (WHO) has considered this disorder as one of the ten most disabling diseases, since the person can avoid social or personal contact. For this reason, CDS is currently considered one of the potentially fatal diseases due to abuse of surgical (cosmetic) procedures and the high rate of suicide attempts with 80% in patients with CDS generate suicidal ideation, but 50% run it.

Keywords: Body dysmorphic síndrome; Dysmorphophobia, Body dysmorphic disorder

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Introduction

Dissatisfaction with the body or with the body image is so common in our society that the Body Dysmorphic Syndrome (CDS) has been established and often goes unnoticed, so it can be confused with a totally normal attitude.

However, the disorder can target various aspects of the patient's appearance throughout their existence, which becomes a serious problem that is reflected in their behavior, that is, a chronic condition with persistent concern for perceived bodily defects not yet existing, which cause anguish and deterioration of social functioning. This disease arises when there is an excessive concern for minimal and culturally acceptable imperfections, where most of the time it is derived from the altered perception of the skin, hair or nose, repetitive behaviors such as frequently looking in the mirror, among others. In fact, it has a worldwide prevalence of 2%, being one of the main reasons why the appearance of CDS in cosmetic practice is high, with 13.2% being more likely to find these challenging patients who frequently request changes aesthetic; Likewise, a recent article in the psychology literature shows that the prevalence only in aesthetic dermatology consultation is 11.3%. In addition, the prevalence of patients who attend procedures has been recorded; outpatients with a prevalence of 1.8 - 6.7%, while in hospital patients it ranges between 13.1-16% [1].

Clinically, it is under-diagnosed because many patients are shy about showing their problem secondary to the deep shame they feel, however, plastic or cosmetic surgeons, to avoid performing operations on patients with this disorder, must be aware of the psychopathology of the disease and be well prepared on how to proceed legally. In the same way, there are many aspects that aggravate the disease, such as psychological alterations with a close relationship of emotions, such as guilt, feelings of inferiority, low self-esteem, and perhaps one of the most debilitating clinical characteristics is illusion. since many people with CPS are convinced that their perceived defects are real and people in the environment pay special attention to these defects.

Also, other factors include unpleasant childhood experiences and a dysfunctional family history, which lead to a persistent feeling of not being loved, insecurity, and rejection [2].

Historically, important events have emerged that have laid the fundamental foundation for the identification of the CDS. In 1980, the American Psychiatric Association entered this disease in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as an atypical somatoform disorder. In the revised DSMIII, IV and IV-TR, it was classified as a disorder automatically. In the DSM-V, published in 2013, the classification changed and since then this disease is under the spectrum of Obsessive Compulsive and Related Disorders. In the words of Enrico Morselli, who was the author who first described the disorder. «The life of the dysmorphic patient is really unhappy; In the midst of their daily routines, conversations, while they are reading, eating, anywhere and anytime, they are trapped by the doubt of deformity [3].

Unfortunately, there are more patients who come for cosmetic procedures than to the psychiatrist, which makes us ask what is being overlooked? ¿Are we really trained to recognize these patients?

Methodology

It is a narrative review of the literature, in which the selection of available original articles was carried out, written in English and/or Spanish, through recognized databases and with reliable information (Medline/ Pubmed, Scielo, Ovid, Science direct). Covering from the year 2000 to the present, using DeCS terms for the Spanish language (Body Dysmorphic Syndrome, Dysmorphophobia, Body Dysmorphic Disorder) and MESH-type terms (Body Dysmorphic Disorder, Dysmorphophobia, Body Dysmorphic Syndrome) for the search.

Results

Body dysmorphic disorder

BDD can only be clinically identified after the patient has been suffering from it for a certain time and is of a certain age; the disease is significantly more prevalent between 15 and 18 years, than between 12 and 14 years, a study carried out in women of different sexual orientation, with BDD generated by sensitivity to rejection based on appearance, cited by Jennifer Schmidt found that age Younger was positively associated with greater body verification, regardless of sexual orientation. Compared to bisexual women (MBI), with increasing age, homosexual women (MHO) and heterosexual women (MHE) showed a greater preference for an ideal body with significantly more body fat [4].

On the other hand, relevant data can be found regarding sexual orientation, as shown in her article Alina T. Henn regarding participation with the lesbian community, the correlation analyzes yielded two associations: a positive correlation with body size greater ideal in MHO and a negative correlation with the muscular impulse in MBI, which totally differs from that reported by Jennifer Schmidt considering that they found differences in that MHO showed a significantly lower degree of body verification than MBI, and both MHO and MBI preferred a larger ideal body size compared to MHE [5].

This shows that there is a great impact on the human being, in his psychological and mental state, which affects the beauty standards to a greater extent by different media, such as magazines, misleading advertisements, always highlighting the false prototype of the "ideal body", In all groups, the greater the experience of daily discrimination, the more pronounced the symptoms of depression and body dysmorphic disorder, as well as the alteration of body image and inversion behavior. In addition, discrimination is related to greater body dissatisfaction [6].

Following the same line of mental affectation of the patient, in a study carried out by M. Bender, it was shown that 33.9% showed a mild or strong indication of a body dysmorphic disorder. Patients who planned to undergo septorhinoplasty had significantly higher scores on the PISA scale compared to patients before septoplasty. 1.7% of the patients were depressed without a significant difference between the planned surgical procedure [6].

In body dysmorphic syndrome we can observe innumerable factors that lead to it becoming worse and producing many consequences for the life of the patient, which is why timely diagnosis is of utmost importance for optimal treatment and avoiding a fatal outcome; For this we can observe the results of different studies where the different factors involved in this disorder are evidenced, health professionals, especially those who are in the field of aesthetics, must diagnose body dysmorphic disorder in a timely manner in their patients to determine whether or not the procedure is feasible, since most patients with BDD express dissatisfaction with the procedure performed, which triggers countless decisions that end with a new procedure, with which they are also dissatisfied, that is why it is totally contraindicated [7].

Suicide rate

One of the drastic complications that usually occurs in these cases is the rate of suicidal ideation and suicide attempt; since there is a problem with emotional distress and worries that directly affect the self-esteem of these patients. Studies have shown that throughout life in patients with this syndrome it is as high as 80% in terms of suicidal ideation, but with a maximum of 25% of patients actually making a suicide attempt [8].

In the population, those who most represent this rate are adolescents (14-18 years) who, compared to adults, debut with CDS because they present more emotional vulnerability, therefore, they are more predisposing to suffer suicidal ideas and comorbidities (Schizophrenia, Major Depressive Disorder, Borderline Personality Disorder, among others). This is a darkening data that particularly highlights the high suicide rate in the SDC; It can be influenced by various risk factors, such as, psychiatric hospitalizations, unemployment, lack of social support, low self-esteem, and a history of abuse. All of the above, together with this condition, allows them to contemplate that the most viable solution is to take their own lives [9].

Treatment of cds

The treatment of Body Dysmorphic Syndrome (CDS) remains a

poorly investigated area and although untreated CDS is often associated with a chronic course and poor outcome, a number of modalities have been established, which have emerging evidence of efficacy. In the beginning, it is important that doctors try to stop patients undergoing procedures, as well as cosmetic surgery or cosmetic and/or dermatological treatments. These therapies often do not improve the symptoms of CDS since 81% of patients who attend these procedures remain dissatisfied, and 88% worsen their condition or there are no large-scale results. In fact, patients with great frequency request procedures that have been performed on many occasions that are even objectively successful. This leads to a problem with the patient and the patient in a state of disability because they do not assimilate their condition and it is believed that 15% of patients who consult for these procedures, suffer from this disorder [10].

The most effective treatment approach for CDS is a combination of psychological and pharmacological interventions; However, there is a relative failure of these approaches, due to studies already carried out, which show results on SDC with limitations in terms of its generalization, because they usually do not include suicidal individuals, as well as their methodological rigors; Furthermore, few randomized controlled trials have been performed with reference to this disorder [11].

In drug therapy and in terms of comorbidities, Selective Serotonin Reuptake Inhibitors (SSRIs) have been used in Obsessive Compulsive Disorder (OCD), efficacy often takes time due to neuronal sensitization (weeks to months). According to our hypothesis and previous research, vision related to body dysmorphic disorder, depressive symptoms, psychosocial functioning, and quality of life are significantly improved with Escitalopram. It is generally recommended for OCD and is sometimes used for CDS, that is, it has adherence to this comorbidity. No dose-finding studies have been performed in this disorder; suggesting that relatively high doses of Selective Serotonin Reuptake Inhibitors (SSRIs) are often needed to treat this disorder effectively. Symptoms include those with abnormal body dysmorphic disorder who were as likely as those with non-misleading beliefs that they respond to a scitalopramism examination consistent with previous SSRI studies. It is also consistent with data from a range of diagnostic validators indicating delusional and non-delusional body dysmorphic disorder constituting the same syndrome, specified in DSM-5. However, unlike previous studies, we found that people with non-delusional CPS claim to be more likely to respond to escitalopram [11].

Alternatively, the complementary use of antipsychotics such as Quetiapine, Risperidone, Haloperidol and Aripiprazole can be considered in case of psychomotor agitation. Fortunately, serotonergic antidepressants are often effective in targeting depressive and social anxiety symptoms, as well as being associated with OCD. Clinical experience shows that patients with severe generalized anxiety can benefit from additional sedative antipsychotics such as Quetiapine or Pregabalin [12].

Regarding non-pharmacological therapeutic management, psychological therapies stand out, such as Cognitive Behavioral Therapy (CBT). Some elements of CBT include the mapping of repetitive behaviors to avoid them (eg, Avoid looking in the mirror, avoiding social occasions), dominance of feelings of inferiority secondary to emotions triggered by minimal or absent defects and ritualized behaviors (eg, mirror control, extensive grooming regimes). Thus, CBT involves establishing exposure or response prevention exercises, and dealing with the negative automatic thoughts and cognitive ensemble that underpin the disorder. Patients with dysmorphophobia are more likely to be treated with psychosexual counseling, cognitive behavioral therapy, selective serotonin reuptake inhibitors, and other psychological therapies. Therefore, it should be considered that surgeries carry a significant risk of morbidity. Other psychological strategies are related to his "flawed" appearance. The elements of strategies based on mindfulness and without prejudice, such as acceptance commitment therapy (ACT) that can also be very useful in these patients [12].

Conclusions

CDS presents a high prevalence in the literature reviewed in our study, however, reviewing the diagnostic criteria according to DSM, we think that this prevalence may be much higher, especially in patients who come to improve cosmetic defects without first having been evaluated by a psychiatrist. due to ignorance of this síndrome [13].

The World Health Organization has considered this disorder as one of the ten most disabling diseases, since the person can avoid social or personal contact, it is for this reason that this syndrome is currently considered one of the potentially serious diseases. Fatal due to abuse of the performance of surgical procedures (aesthetic) and the high rate of suicide attempts, it is for this reason it is of vital importance to avoid as much as possible to subject patients diagnosed with this disease to submitting them to cosmetic procedures before having received adequate psychiatric treatment [13].

In relation to therapeutics, both psychotherapy and psychopharmacology have achieved efficacy in the perceptual and behavioral improvement, being the choice of cognitive behavioral psychotherapy simultaneously with the use of serotonergic drugs, which have shown greater effectiveness. In light of the shared nature, and therefore of the high simultaneity between CDD and OCD, it is recommended, essentially to psychiatrists, dermatologists and plastic surgeons, the routine search for dysmorphophobic aspects in patients with OCD and vice versa. Cosmetic plastic surgery in patients with BDD carries counterproductive results, as it would favor a worsening of symptoms [14].

It is for this reason an obligation of the doctor to detect these cases to guide and treat them in order to stop the evolution of this disease that is categorized within the obsessive compulsive disorder according to the DSM V.

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