

## Body Dysmorphic Disorder (BDD)

Body Dysmorphic Disorder (BDD) is a clinically recognised condition defined as a preoccupation with a perceived defect in one's appearance. If a slight defect is present, which others hardly notice, then the concern is regarded as markedly excessive.

In 1891, an Italian doctor, Enrico Morselli, first coined the term dysmorphophobia, from the Greek word 'dysmorph' meaning misshapen. He described it as a subjective feeling of ugliness despite a normal appearance. Freud once described a patient whom he called the 'Wolf man' who had classical symptoms of BDD. The patient believed that his nose was so ugly that he avoided all public life and work. The media sometimes refer to BDD as 'Imagined Ugliness Syndrome' although for the person with BDD, the ugliness is very real. BDD was not published in the Diagnostic and Statistical Manual of Mental Disorders until 1987. It was subsequently renamed Body Dysmorphic Disorder in 1997 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) under the somatoform disorders.

In order to obtain a diagnosis of BDD, the preoccupation must cause significant distress or handicap in social, school or occupational life. The degree to which people experience BDD varies so that some people will acknowledge that they may be blowing things out of all proportion. Others are so firmly convinced about their defect that they are regarded as having a delusion.

Whatever the degree of insight into their condition, people with BDD often realise that others think their appearance to be 'normal' and have been told so many times. They usually distort these comments to fit in with their views (for example, "They only say I'm normal to be nice to me" or "They say it to stop me being upset"). Alternatively, they may firmly remember one critical comment about their appearance and dismiss 100 other comments that are neutral or complimentary.

According to the NICE guidelines, it is estimated that approximately 0.5-0.7% of the UK population have BDD. Clinical samples tend to have an equal proportion of men and women across all age groups. In children and young people, body dysmorphic disorder usually has an early-adolescence onset at about age 13. Although symptoms can be found in children as young as 5, it is rare for children under 12 to be diagnosed with BDD. It is important for parents and physicians to recognise the debilitating nature of BDD and not dismiss it as simply a passing phase

There are various proposed causes of BDD but no definite answer. A psychological explanation would argue certain stresses or life events such as teasing or bullying during adolescence may precipitate the onset and would emphasize a person's low self-esteem and the way they judge themselves almost exclusively by their appearance as a contributing factor to the disorder. Alternatively, some people with BDD have high aesthetic standards and an impossible ideal. There seems to be certain environmental triggers which contribute to the disorder and an individual's personal psychology. Alternatively researchers have argued that there is a genetic link and possibly genes which predispose someone to BDD, hence the large number of individuals who have family members also suffering the same disorder or a related one. Finally a chemical biological explanation would emphasize low levels of serotonin, a chemical in the brain which is thought to regulate mood, pain and anxiety. Finally sometimes the use of drugs such as Ecstasy may be associated with the onset. Although the causes of BDD are still unknown it is more important to recognise its treatability.

BDD operates in a self fulfilling cycle. An individual paying excessive attention to their appearance develops a heightened perception of how they feel about their body. They become increasingly focused about every imperfection or slight abnormality. The way they feel about their body depends upon a number of factors such as mood and their expectations as well as psychological ideas and beliefs the individual has. In the end there is a big disparity between how they see themselves and what they believe they should look like.

Most people with BDD are preoccupied with some aspect of their face and often focus on several body parts. The most common complaints concern the face, namely the nose, the hair, the skin, the eyes, the chin or the lips. Typical concerns are slight flaws on the face or head, such as hair thinning, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion or excessive hair. People with BDD may also be concerned about a lack of symmetry, or feel that something is too big or swollen or too small, or that it is out of proportion to the rest of the body. Any part of the body may however be involved in BDD including the breasts, genitals, buttocks, tummy, hands, feet, legs, hips, overall body size, body build or muscle bulk. Although the complaint is sometimes specific 'My nose is too red and crooked'; it may also be very vague or just refer to ugliness.

A person with BDD often uses avoidance strategies or certain safety behaviour to avoid feeling anxious or uncomfortable. They will often avoid a range of social and public situations because of the way they feel, Alternatively, they may enter such situations but remain very anxious and self-conscious They may also monitor and camouflage themselves excessively to hide their perceived defect by using heavy make-up, brushing their hair in a particular way, growing a beard, changing their posture, or wearing particular clothes, for example a hat. This perpetuates the fear of others rating them and maintains their excessive attention on themselves. It is important to remember people with BDD are not vain or narcissistic, and certain behaviours such as spending hours in front of a mirror are anxiety driven.

There is also a compulsive element to the disorder. People with BDD feel compelled to repeat certain time-consuming rituals such as: checking their appearance either directly or in a reflective surface (for example mirrors, CDs, shop windows); excessive grooming, by removing or cutting hair or combing; picking their skin to make it smooth; comparing themselves against models in magazines or on television; dieting and excessive exercise or weightlifting. These are also, in part, safety behaviours to alleviate anxiety. However, such behaviours usually make the preoccupation worse and exacerbate depression and self-disgust. This can often lead to periods of avoidance such as covering mirrors or removing them altogether.

BDD has a high rate of co-morbidity, which means that people diagnosed with the disorder are highly likely to have been diagnosed with another psychiatric disorder; most commonly associated disorders are major depression, social phobia, or obsessive compulsive disorder (OCD), alcohol/substance misuse or eating disorders. According to the NICE guidelines, co-morbidity also includes people with mild disfigurements or blemishes attending dermatology clinics or seeking cosmetic surgery.

Other conditions that frequently exist in combination with BDD or are confused with BDD include *Anorexia Nervosa*: This is a disorder where individuals are more preoccupied by self control of weight and shape but still have anxiety regarding their image. *Skin picking and trichotillomania*: Skin picking is self explanatory; trichotillomania involves an urge to pluck one's hair or eyebrows repeatedly. If the skin picking or hair plucking is out of concern with one's appearance then BDD is the main diagnosis; *Obsessive Compulsive Disorder (OCD)*.

A separate diagnosis of OCD should only be made if the obsessions and compulsions are not restricted to concerns about appearance; *Hypochondriasis*: The suspicion or conviction that s/he is suffering from a serious illness which leads a person to avoid certain situations and to check their body repeatedly.

It is important to recognise that the disabling nature of the disorder can lead to feelings of futility and depression. Suicidality is higher in people who are experiencing body dysmorphia. While studies have shown that if BDD is not treated correctly in adolescence, it can become chronic, when it is treated appropriately most people eventually get better.

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This leaflet is part of a series that includes;

1. What is OCD?
2. Assessment and Diagnosis
3. Accessing Treatment – your rights
4. What is Cognitive Behavioural Therapy?
5. Medication for OCD
6. Young people and OCD
7. Supporting a person with OCD
8. Habit Disorders
9. **BDD**

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