

Body dysmorphic disorder in men



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Background

Body dysmorphic disorder (BDD) is a condition associated with a perceived defect or flaw in physical appearance and repetitive behaviours related to this perceived imperfection. BDD affects men and women approximately equally, although a variant called muscle dysmorphia occurs more frequently in males.

Objectives

The aim of this article is to provide general practitioners (GPs) with information related to the identification and management of individuals with BDD, especially males.

Discussion

Diagnostic features, clinical presentation and screening tools for BDD are discussed. Recommendations for appropriate treatment and support are also supplied.

Body image concerns are often assumed to relate predominantly to females, yet a large proportion of males are troubled with how they look. In 2014, an annual survey carried out by Mission Australia, the National Survey of Young Australians, collected information from more than 13,000 young people aged 15–19 years.¹ Body image concerns were one of the top three issues of personal concern for young males and females. Furthermore, significant body dysmorphic concerns have been reported in a large sample of Australian university students, with one in 50 meeting the criteria for a probable diagnosis of body dysmorphic disorder (BDD).² Although the incidence of some body image disorders, such as eating disorders (including anorexia and bulimia nervosa), is substantially lower in males than females,³ other body image disorders such as BDD occur at similar rates in both genders.^{4,5} BDD has been estimated to have prevalence rates of 2.2% for male US adults and 2.5% for female US adults.⁶ Muscle dysmorphia is a variant of BDD, which is characterised by a perceived lack of muscularity, and largely affects males.⁷

Diagnostic criteria and associated features

BDD is a frequently under-recognised psychiatric condition. It is characterised by a preoccupation with one or more perceived defects or flaws in physical appearance that appear slight or are not observable to others, and repetitive behaviours or mental acts related to the perceived flaw(s)^{5,6} (Box 1). The preoccupation causes significant distress or impairment in social, occupational or other areas of functioning, and is not better explained by the diagnosis of an eating disorder. Preoccupation can involve any area of the body, but most commonly concerns the skin, hair or nose in both males and females.⁸ As previously mentioned, a preoccupation with perceived lack of muscularity (muscle dysmorphia) occurs almost exclusively in men. Muscle dysmorphia refers to a preoccupation with the idea that one's body is insufficiently muscular, too small or puny.⁷ Despite this belief, individuals with muscle dysmorphia are often very muscular.⁷ These individuals regularly engage in compulsive exercising and adhere to strict diets, often with meticulous attention to food constituents, aiming at a high-protein, muscle-building dietary regime.⁷ Dietary supplements

are also frequently used, and misuse of anabolic steroids is often reported.⁹ Furthermore, high rates of comorbid substance abuse are found in males with muscle dysmorphia.¹⁰

BDD in general is associated with high rates of comorbid mood and anxiety disorders, notably social anxiety disorder and obsessive compulsive disorder (OCD).^{11,12} Individuals with BDD often experience suicidal ideation and may engage in suicide attempts.¹³ Although more often occurring in females with BDD, increased rates of eating disorders are also reported in males with BDD.¹⁴ Eating disorders and muscle dysmorphia share a number of similarities, although they also differ in a number of ways. Unlike BDD, eating disorders are specifically related to a distorted perception of body weight and a fear of becoming fat, and affect a significantly larger proportion of females than males. However, muscle dysmorphia and anorexia nervosa share a range of symptomatic similarities including disturbances in body size and shape, disordered eating and excessive exercising.¹⁵ Indeed, some authors have suggested this variant of BDD – which used to be called ‘reverse anorexia’ – should be grouped with the eating disorders rather than as a subtype of BDD.¹⁵

Illness onset and course

The onset of BDD is typically in the mid-teens,¹² with subclinical symptoms usually occurring several years prior.¹¹ The course of BDD tends to be chronic, with only a small proportion of untreated patients achieving full or partial remission.¹⁶ However, appropriate psychiatric treatment can ameliorate the longitudinal course.¹⁶ Gender differences are not apparent in the course of BDD, with similar illness course and outcomes for males and females.¹⁶ The factors contributing to the onset and maintenance of BDD are unclear, although neurobiological and sociocultural factors are likely to contribute.⁷ Given the nature of BDD, sociocultural influences are often considered to play a key role in its development. For example, the ideal male image portrayed by celebrities and sports stars in Western media is typically a lean and muscular physique, and this may play a role in muscle dysmorphia. The presentation of muscular images has indeed been found to result in a greater

discrepancy between ideal and perceived muscularity in males.¹⁷ Attention has also been drawn to the often exaggerated muscular physiques depicted in comic strips such as Superman and male-gendered toys such as GI Joe.⁷

Screening

Brief screening questions may assist in the recognition of BDD. The dysmorphic concern questionnaire (DCQ) is a brief seven-item, dimensional questionnaire that has utility in screening for BDD. It is relatively non-threatening as the items are couched in broad terms regarding appearance concerns and help-seeking.^{18,19} Useful screening questions from DCQ that general practitioners (GPs) could use include:¹⁸

- Have you been very concerned about some aspect of your physical appearance?
- Have you considered yourself misformed or misshapen in some way (eg nose, hair, skin, sexual organs, overall body build)?
- Have you considered your body to be malfunctioning in some way (eg excessive body odour, flatulence, sweating)?
- Have you consulted or felt you needed to consult a plastic surgeon, dermatologist or physician about these concerns?
- Have you been told by others or your doctor that you are normal in spite of you strongly believing that something is wrong with your appearance or bodily functioning?
- Have you spent a lot of time worrying about a defect in your appearance or bodily functioning?
- Have you spent a lot of time covering up defects in your appearance or bodily functioning?

Alternatively, validated screening tools such as the Body Dysmorphic Diagnostic Module²⁰ or the Yale-Brown Obsessive-Compulsive Scale modified for Body Dysmorphic Disorder (BDD-YBOCS)²¹ can be used to capture the presence of BDD and the severity of symptoms, respectively.

Treatment

Although untreated BDD is often associated with a chronic course and poor outcome, a number of treatment modalities have established, or have emerging evidence for, efficacy. At the outset, it is important for clinicians to try to stop patients from undergoing procedures such as cosmetic surgery or dermatological treatments. These therapies often result in no improvement in BDD symptomatology.²² Indeed, patients often request repeated procedures and almost all are left feeling unhappy with the procedures even if they are objectively successful. This leads to an unfortunate cascade of increasing distress and an exacerbation of symptoms with despair and anger.²³ The clinician can try to engage with the patient in a discussion about the likely relentless and unsatisfactory journey they might be embarking upon to try to achieve a ‘perfect’ cosmetic outcome. They can then try to reframe the distress in terms of an underlying psychiatric condition that is amenable to treatment. Focusing on distress, disability and cost to the patient in terms of time (eg time in the gym), money (eg

Box 1. Examples of repetitive behaviours and mental acts experienced by individuals with BDD⁵

Excessive grooming (eg plucking, shaving, combing, styling)
 Skin picking
 Mirror checking or mirror avoidance
 Reassurance seeking
 Camouflaging (eg repeatedly applying make-up, covering areas with clothing or apparel)
 Touching disliked area
 Excessive exercise or weight lifting (particularly for muscle dysmorphia)
 Comparing appearance with that of others
 Seeking cosmetic procedures
 Excessive tanning

protein supplements) and lost opportunity (eg work, socialising) can help put the core problem in a broader context and enable a treatment-based discussion. In muscle dysmorphia, warnings about the potential problems associated with certain dietary peccadillos and anabolic steroids should also be stressed.

The most effective treatment approach for BDD is a combination of psychological and pharmacological interventions. In terms of medications, selective serotonin reuptake inhibitors (SSRIs) have been the most widely studied agents.²⁴ Similarly to the use of SSRIs in OCD, efficacy often takes some time to accrue (weeks to months) and higher doses are often required than in the treatment of depression (eg up to 400 mg of sertraline).²⁵ Patients need to be advised that the prescribed doses are higher than advised in the product information material and should also be educated about potential side effects. Clomipramine should be considered if high-dose SSRIs fail, although tolerability at high dose may be problematic for many patients.²⁵ The possible side effects of clomipramine include sedation, constipation and dry mouth; cardiac and drug levels monitoring is also advisable. Alternately, adjunctive use of antipsychotics such as quetiapine, risperidone and aripiprazole may be considered. All three are off-label and not available under the Pharmaceutical Benefits Scheme for BDD in Australia.^{24,26}

Comorbid psychiatric conditions also need to be addressed. Fortunately, serotonergic antidepressants are usually effective in targeting depressive and social anxiety symptoms as well as an associated OCD.²⁷ Our clinical experience shows that patients with severe generalised anxiety disorder can benefit from additional sedative antipsychotics such as quetiapine or pregabalin. Again, these are off-label in Australia for BDD.

Regarding psychological therapies, cognitive behaviour therapy (CBT) is the most studied of the psychological interventions deployed to attempt to treat BDD.²⁰ Some elements of CBT include mapping the avoidance behaviours (eg mirror avoidance, avoiding social occasions) and ritualised behaviours (eg mirror checking, extensive grooming regimes). CBT also may involve setting exposure or response prevention exercises, and dealing with the negative automatic thoughts and cognitive set that underpin the disorder. Other psychological strategies include specific attention to how people view themselves (eg getting them to 'pan out' and view themselves in wide focus rather than engaging in very narrow scrutiny of their perceived appearance 'defect'). Elements of mindfulness-based, non-judgemental strategies such as acceptance commitment therapy (ACT) may also be useful.²⁸

Recommendations for GPs

The GP plays a crucial role in the identification and management of BDD. As BDD is associated with poor insight,²⁹ treatment is often not sought directly for the underlying malady. Rather, a patient may visit a GP for referral to a cosmetic surgeon or dermatologist for their perceived flaw. It is therefore critical that

the GP is able to identify potential cases of BDD and perform screening when indicated.

A further key role of the GP is to assess illness severity and arrange for a referral to an appropriate mental health service if required. The GP should also aim to promote understanding of the condition, not only for patients, but also for families who may struggle to understand the behaviours and anxieties experienced by those with BDD. This may prove particularly challenging for male patients with BDD, as body image disorders are typically perceived as female conditions.

Conclusions

BDD is an often-severe body image disorder associated with significant distress and impairments in important areas of functioning. However, the condition frequently goes unrecognised. Given the chronic course of BDD, the role of the GP is imperative in the early identification of BDD. Key symptoms include a preoccupation with a perceived flaw in one or more body areas and repetitive behaviours related to this perceived imperfection. The preoccupation can involve any area of the body or aspects of body size in general, as in muscle dysmorphia. Muscle dysmorphia is particularly relevant to males and often associated with potentially dangerous dietary regimes as well as abuse of anabolic steroids.

People with BDD often demonstrate poor insight into their condition and will seek cosmetic or dermatological treatment rather than treatment for the underlying condition. Therefore, they may be difficult to engage in treatment, particularly male patients who may believe that body image concerns are held predominantly by females. A key role of the GP is also to deliver suitable treatment or provide referrals to appropriate treatment services rather than conceding to patients' requests to receive cosmetic treatments, which often exacerbate rather than alleviate symptoms. To facilitate appropriate treatment, it is also imperative for the GP to promote understanding of the condition for both patients and their families.

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