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Body dismorphic disorder

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Abstract:

Dysmorphophobia (BDD), also called the obsession of perfection, is a disorder involving the extreme negative assessment of one's own appearance resulting from a slight defect that is exaggerated. Dysmorfophobia belongs to hypochondriac disorders. This disease affects 0.7-2.4% of the total population, but knowledge about it is still not common. Perceptual disorders

most often affect the skin, hair, nose, body weight, stomach, breasts, eyes, thighs and teeth. Legs, body build, face and face size are less often. In addition to typical psychotherapy, well-chosen relaxation techniques and cognitive-behavioral therapy as well as pharmacotherapy are also applied.

Introduction

Dysmorphophobia (BDD), also called the obsession of perfection, is a disorder involving the extreme negative assessment of one's own appearance resulting from a slight defect that is exaggerated. This disease is characterized by excessive anxiety caused by a non-existent or minimal physical defect. People with BDD show a sense of depression and constant sadness that may suggest depressive disorders. They have a tendency to ambivalent reactions - on the one hand, excessive observation and masking of exaggerated or imaginary flaws of their appearance, on the other the unwillingness to look in the mirror, because the view of their own body evokes their repugnance [1-3].

According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10), BDD belongs to hypochondriac disorders. Although it affects 0.7-2.4% of the total population, knowledge about it is still not common. Some studies indicate that BDD affects both sexes to the same extent, while others report a higher incidence of this disorder in women. In the ICD-10 classification, dysmorphophobia belongs to hypochondriac disorders. She was separated into a new group of obsessive-compulsive disorders and similar along with obsessive-compulsive disorder, pathological collection, trichotillomania[4].

The desire to strive for the best look applies to all age groups and nationalities. There are studies that show greater satisfaction with the lives of people considered beautiful. We often face dissatisfaction with our appearance, however, excessive care for external features may be a symptom of the disease. Often, it disturbs everyday functioning, because a person suffering from dysmorphophobia experiences anxiety, fear and constantly directs their attention to the aesthetic problem. The defect is evaluated by it subjectively and often inadequately to the real size. There is a steady increase in interest in procedures related to aesthetic medicine, certainly mass media are not without significance in this regard, as they promote stereotypes associated with ideal looks [5-11].

The criteria for diagnosing dysmorphophobia are as follows:

1. Excessive focus on an imaginary defect in your appearance. If there is real imperfection, then it is small, and its survival is disproportionate.
2. Preoccupation with an imaginary (or real small) defect is the cause of suffering or disturbance of social functioning in all important fields. The sick person is constantly busy thinking about the defect and about the possibilities of "repairing"
3. Symptoms do not result from the presence of other psychiatric disorders (eg, lack of satisfaction with the shape and size of your body in the course of anorexia nervosa).
4. The patient is accompanied by a high level of psychological stress related to the body. All behaviors are aimed at improving, concealing the defects, as well as making sure about the appearance. The patient has persistent repetitive behaviors and thoughts (for example, constantly comparing his appearance to the appearance of other people) [12].

Perceptual disorders most often affect the skin, hair, nose, body weight, stomach, breasts, eyes, thighs and teeth. Legs, body build, face and face size are less often.

The research results show that a high percentage of people with dysmorphophobia seek help in surgical, dermatological and cosmetic surgeries. It is estimated that 5-15% of people referring to aesthetic medicine doctors suffer from a perception of their own body. People with BDD often think that a variety of aesthetic treatments will solve the problem, but they rarely get full satisfaction from changing their appearance. The patients turn to doctors of various specialties: plastic surgeons and dermatologists, but also orthodontists. It also happens that they force unnecessary treatments, and in the absence of the expected effect, seek help from other specialists. It is extremely important to conduct an extensive interview prior to such procedures, including questions about the number, type and reason of the procedures performed, as well as cooperation of broadly understood aesthetic medicine staff with psychologists, as most patients with BDD are dissatisfied with the procedures they submit (speech here in particular about plastic surgery) [13-16]. Some of the patients blame doctors for erroneous surgery and often make claims in court. A large proportion of patients suffering from BDD become aggressive during the consultation not only to doctors but also to themselves. Their expectations are exaggerated, failure to meet them can cause aggression

Currently, there is no confirmed data on the causes of the development of dysmorphophobia, but it is known that both psychological and neurobiological factors are important. People suffering from dysmorphophobia have suicidal tendencies due to lack of acceptance of their own body. The suicidal ideation rate is as much as 80%, and even 25% of patients try to commit suicide. The correct choice of therapy is necessary, however, patients usually go first to aesthetic medicine doctors, dermatologists and cosmetologists, which does not allow to eliminate the cause of their treatment, only for a short time brings a solution to the problem. In addition to typical psychotherapy, well-chosen relaxation techniques and cognitive-behavioral therapy are also used, preferably combined with exposure with response prevention (ERP). Pharmacotherapy also brings good results, in more severe cases selective serotonin reuptake inhibitors (SRIs) are recommended for at least 12 weeks [7,9,11,13-15]. It should be emphasized that this disease is very debilitating, and its typically chronic nature makes it necessary to conduct therapy indefinitely, as this disease tends to be recurrent.

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