Body dysmorphic disorder in patients with acne: treatment challenges

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Adv Dermatol Allergol 2022; XXXIX (1): 221–222
DOI: https://doi.org/10.5114/ada.2022.113616

Body dysmorphic disorder (BDD) is defined as a constant preoccupation with one or more non-existent or slight defects or flaws in the physical appearance, often resulting in repetitive behaviours like mirror checking and camouflaging. The prevalence is around 2% in the general population with up to 10% in dermatology patients [1, 2]. The prevalence of BDD in patients with acne ranges between 9% and 15% [3]. BDD is associated with considerable psychosocial deterioration, poor quality of life, and development of comorbid mental health disorders, including obsessive compulsive disorder, depression, social anxiety and alcohol or illicit drug use [4]. Such patients suffer tremendously and are at high risk of suicide. The rate of suicidal ideation reaches 79.5%. Of this number, nearly 27.6% make failed suicidal attempts each year and 0.3% of these attempts are successful [5].

We present a case of body dysmorphic disorder in a patient with acne as they are usually underdiagnosed and left without adequate treatment and referral. We stress the importance of screening for this condition by dermatologists and engaging a mental health professional so as to manage these challenging patients in the view of high prevalence, functional impairment and risk of suicide.

A 23-year-old man presented to the dermatology clinic requesting isotretinoin treatment for acne. Medical examination revealed mild signs of acne and scaring on the face and back. During consultation, the patient was very insecure and expressed intense emotional suffering due to his skin condition. He had been treated ineffectively for acne with antibiotics since the age of 13. At the age of 18 he was successfully treated with isotretinoin. However, since the age of 20 he has visited numerous dermatologists pressing for isotretinoin treatment. The dermatologist referred the patient to a psychologist, not without resistance. During psychotherapy sessions, the patient admitted to spending several hours daily looking after and camouflaging his acne. He complained of panic attacks when leaving home. Consequently, he developed symptoms of social phobia, started to take anxiolytics in an irresponsible way and overused alcohol. At first, the therapy was irregular as the patient often felt unable to go out. The treatment was complex and consisted of fluoxetine, cognitive therapy for negative thoughts and distortions, working on diminishing rituals, expressing emotions and childhood traumas, relaxation techniques and psychoeducation on the disorder. The therapy appeared to be successful and helped him to return to social life. However, a long-term therapy and follow-up are needed to maintain the improvement.

BDD in patients with acne is often underdiagnosed in dermatological practice, even though research shows its high prevalence in that group of patients [6]. The condition may be confused with body dissatisfaction and left without adequate treatment. Patients are usually distant and do not talk freely about their distress, housebound, and preoccupation with their skin defects unless they are asked specific questions about appearance and a good doctor-patient relationship has been established. Regular screening for suspected cases of BDD may include Body Dysmorphic Disorder Questionnaire (BDDQ), which is characterized with high sensitivity (94%) and specificity (90%) in detecting BDD [7]. It is important to provide patients with psychoeducation on BDD and to assure them that this condition is well known and treatable. It is not advisable to confront the patient saying that they are only imagining the skin condition. BDD patients have a poor insight and suffer greatly [4]. Dermatologists should be empathetic and understanding, and focus on patients' distress and lowered quality of life.

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Received: 8.05.2020, **accepted:** 23.06.2020.

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Such psychoeducational approach may result in referring patients with BDD to a mental health professional specializing in cognitive behavioural therapy (CBT) and familiar with pharmacological treatment of BDD. Patients should always be screened for suicidal ideations and severe depression. More detailed recommendations on how to approach patients with BDD are provided in the literature [8, 9].

CBT and selective serotonin reuptake inhibitors (SSRI) are the treatment of choice for BDD. However, not all patients benefit from this therapy due to poor adherence or other comorbidities. A recent study suggests that greater motivation and readiness to change, greater treatment expectancy, and better baseline BDD-related insight are significant predictors of a better post-treatment CBT response [10].

BDD treatment appears to be effective in most cases. However, only 17.4% of patients with BDD report receiving a CBT psychotherapy [11]. Most patients feel ashamed, stigmatized and sceptical about initiating face-to-face psychotherapy. Some do not have access to CBT due to the difficulty of finding trained therapists in BDD, treatment costs, or logistic and geographical barriers [11]. Researchers suggest alternative ways of delivering evidence-based psychological therapies. Initial research on therapist-guided internet-based CBT (*BDD-NET)* and smartphone-based CBT pilot study (*Perspectives*) for BDD resulted in lessening severity symptoms of BDD and depression, improving BDD-related insight, functional impairment, and quality of life. *BDD-NET* and *Perspectives* study reported 50% to 90% post-treatment and 3-month follow-up response, respectively [12, 13]. Results suggest that digital-based CBT for BDD seems a promising solution. It is believed to provide immediate access to effective, standardized, low cost CBT treatment for mild to moderate cases with a low suicide risk, as well as offering a stepped-care approach. However, it should not entirely replace traditional CBT, especially for more complex cases.

In the past, BDD was an ignored mental disorder. For the last few years it has been better understood by dermatologists and given more attention. Yet, BDD is still underdiagnosed in patients with acne. Hence, it is important for dermatologists to be aware of BDD and to properly conduct consultations with acne patients, which will allow them to screen for possible cases of this condition and be able to suggest a referral to a mental health professional. Specific questions about appearance should always be asked. To facilitate treatment, new interventions based on digital technology are becoming accessible.

Acknowledgments

The article was financed by the Medical University of Lodz using research grant No. 503/1-137-04/503-11-001-19-00.

Conflict of interest

The authors declare no conflict of interest.

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