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## **Body Dysmorphic Disorder and Aesthetic Treatment**

### **Abstract**

Body Dysmorphic Disorder is a relatively common psychiatric condition, especially in aesthetic and surgical settings, resulting in disordered perception of body image, characterised by a preoccupation with non-existent or slight physical defects in appearance. It is often underdiagnosed even in psychiatric services and certainly in aesthetic and surgical clinics. Cosmetic intervention to the perceived abnormality is very unlikely to result in improvement and referral to specialist psychiatric services for psychological intervention and pharmacological treatment is recommended.

### **Key Words**

Body Dysmorphic Disorder, Aesthetic treatment, Cosmetic Surgery, Rhinoplasty, Screening Questions

### **Introduction**

Body Dysmorphic Disorder, BDD, is a distressing and potentially disabling condition characterised by a preoccupation with imagined or slight physical defects in appearance, this results in time consuming rituals causing significant psychological distress or impairment in personal, social and occupational functioning.

Common areas of concern are skin, face, hair, body build and breasts. Patients most common negative beliefs are that their skin is discoloured or a body part is deformed or flawed or that the size and shape of their body parts are not correct or there is an asymmetry present, for example in the eyes or nose. As a result, to improve or disguise these perceived flaws most patients engage in ritualised behaviours such as staring in the mirror, skin picking, hair pulling, excessive make up, intricate or elaborate rituals such as grooming routines, feeling the body part to test for smoothness, size and flaws, constant mirror checking, seeking reassurance from friends and family and shopping extensively for doctors for aesthetic or

surgical treatments. However, avoiding mirrors and bright lights and public places may also be a feature of Body Dysmorphic Disorder.

The main questions seem to be where does this normal concern with looking as good as possible and becoming preoccupied with looks change into becoming pathological? What are the implications for aesthetic practitioners and surgeons? Should such patients be treated by performing aesthetic and surgical procedures to rectify perceived cosmetic imperfections? This is a relevant question not only for those routinely performing cosmetic procedures, such as rhinoplasty, but for all doctors since these patients will present to varying degrees in many clinical settings.

## **Background and History**

Human beings have always been concerned with their appearance, and being content helps develop self-esteem, confidence and a place in family and society. Not having this emotional peace with one's own body and appearance may lead to significant psychological and social problems. Historically, Thersites was said to be the ugliest Greek in the Trojan War and from an ancient Greek point of view an ugly soul must inhabit an ugly body. Dysmorphia is a term was derived from the Greek word 'dysmorphia,' meaning misshapen or ugly. Excessive concerns with physical deformity has been known in the past as 'Quasimodo Complex'.

Sigmund Freud's Wolfman became famous and he was later described by Brunswick<sup>1</sup>:

“he neglected his daily life and work because he was engrossed, to the exclusion of all else, in the state of his nose. On the street he looked at himself in every shop window; he carried a pocket mirror, which he took out every few minutes. First he would powder his nose; a moment later he would inspect it and remove the powder. He would then examine the pores, to see if they were enlarging, to catch the hole, as it were, in its moment of growth and development. Then he would again powder his nose, put away the mirror, and a moment later begin the process anew. His life was centered on the little mirror in his pocket, and his fate depended on what it revealed or was about to reveal.”

The prevalence of BDD varies, for example, a German population study<sup>2</sup> gave a prevalence of 1.7%. However, the prevalence of Body Dysmorphic Disorder in cosmetic surgery settings and dermatology clinics suggest that the disorder is much more common in these populations, with a prevalence of between 3 and 10%, it affects men and women equally, however women seek treatment for BDD more frequently than men<sup>3</sup>, cultural factors may also play a part. In one study involving aesthetic rhinoplasty candidates 24.5% fulfilled the DSM IV criteria for BDD<sup>4</sup>.

Unfortunately, Body Dysmorphic Disorder is poorly diagnosed in psychiatric settings, so it follows that it is less frequently diagnosed in aesthetic clinics and surgical settings. Although the diagnosis is often missed, it is easy to make.

### **Co-morbid Conditions**

The picture may be complicated, however, by co-existing conditions, for example depression is present in 80 – 90%<sup>5</sup> of patients with BDD and over one third suffer from social phobia<sup>6</sup> amongst other psychiatric diagnoses. However, it seems that the social phobia onset was typically before that of Body Dysmorphic Disorder and not caused by concerns about appearance<sup>7</sup>. Although BDD is considered to be in the spectrum of Obsessive Compulsive Disorders it is interesting to note that patients with BDD do not get relief from their anxiety when they perform checking rituals, such as mirror checking, in fact these may increase the sense of despair, unlike in Obsessive Compulsive Disorders. Despair may be accompanied by feelings of self-loathing, guilt, shame, embarrassment and fear of being judged.

### **Frequency of Perceived Defects:**

- Skin (73%)
  - Hair (56%)
  - Nose (37%)
  - Weight (22%)    Abdomen (22%)
  - Breasts/chest/nipples (21%)
  - Eyes (20%)
  - Thighs (20%)
  - Teeth (20%)
  - Face size/shape (12%) • Lips (12%) • Buttocks (12%) • Chin (11%)
  - Eyebrows (11%) • Hips (11%) • Ears (9%) • Arms/wrists (9%) • Waist (9%)
  - Genitals (8%) • Cheeks/cheekbones (8%) • Calves (8%) • Height (7%) • Head size(6%)<sup>8</sup>.
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## Diagnosis and Difficulties

Most doctors have experienced patients expressing concerns about their appearance at some stage. Hence such concerns are very common and cultural factors may play a significant part, as well as sex, demographics and social subcultures. However, as in much of psychiatry, diagnosis is dependent on how significantly the problems impact on personal, social and occupational functioning or the degree of preoccupation, often proposed as one hour a day, despite the perceived defects or flaws being very slight or not observable to others then the concern and preoccupation reaches significant proportions in terms of psychological morbidity.

The relevance of Body Dysmorphic Disorder in aesthetic or surgical settings is important. Perhaps the most important thing to bear in mind is that most patients will not reveal their symptoms<sup>9</sup>. Very few reported these symptoms voluntarily to their psychiatrist although these were a significant factor towards their suicidality, perhaps due to embarrassment or fear of being judged. Many may even believe that they are fundamentally unacceptable and therefore unlovable. This often leads to high levels of social isolation and poor social support for sufferers of BDD and this must be a contributing factor to the fact that up to 80% of patients with BDD have experienced suicidal thoughts.

If the diagnosis is missed the consequences can be significant. It is unlikely that a person suffering from Body Dysmorphic Disorder will be satisfied with any aesthetic intervention or any number of cosmetic surgical procedures. Insight can vary in patients with BDD from excellent, which are fewer in number to poor or absent insight to delusional, which are the majority, about three quarters of all patients.

There is, of course, a continuum of preoccupations and there are many patients who are concerned about their appearance and do not suffer from BDD because they are not preoccupied or distressed or dysfunctional; when these patients seek aesthetic treatment and cosmetic surgical intervention to improve their looks, confidence and self-esteem, and these interventions appropriately performed can change someone's quality of life.

In other patients with BDD, however, this can lead to multiple surgery and even attempts at self-body modifications, some attempts may include self-mutilation. All of these attempts usually fail and the patient's flaws and defects in their perception are not improved and very rarely is quality of life improved.

The nature of the illness in BDD may fluctuate and there may be periods of fairly normal functioning. Many people with BDD have particular difficulties with photographs and may even avoid family events and photographs, which only seem to confirm their beliefs. It is commonly believed that media influences affect illnesses such as eating disorders it may also be the case that by emphasising the necessity of aesthetic beauty, these influences may also contribute to Body Dysmorphic Disorder in a similar way<sup>10</sup>.

## Screening Questions and Tests

It is possible to screen with screening tests, however sometimes a few simple questions may be sufficient to alert the physician that further inquiry, screening or referral may be appropriate. Many patients (and some doctors) do not realise that BDD is treatable and in fact research has shown that patients want their clinician to ask them about BDD symptoms, so if done in a sensitive manner, this should not be any more difficult than other routine questions a clinician asks in practice.

For example: ‘Some people worry a lot about their appearance. Do you worry a lot about the way you look and wish that you could think about it less?’ If this receives a positive answer, then follow up questions to clarify the extent and nature of bodily concerns can be asked. ‘Are you worried about the way you look?’ For example, questions may be asked about skin, acne, scars, hair, shape and size of your nose, mouth, jaw, lips, stomach, hips, or any other body part. ‘How has this problem affected your life? On an average day, how much time do you usually spend thinking about how you look?’ (Add up all the time in total in a day)<sup>11</sup>.

The COPS Questionnaire contains 9 pertinent questions to which graded responses are possible:

1. How often do you deliberately check your features? Not accidentally catch sight of them. Please include looking at your features in a mirror or other reflective surface like a shop window or looking at them directly or feeling them with your fingers.
2. To what extent do you feel your features are currently ugly, unattractive or ‘not right’?
3. To what extent do your features cause you a lot of distress?
4. How often do your features currently lead you to avoid situations or activities?
5. To what extent do your features currently preoccupy you? That is, you think about it a lot and it is hard to stop thinking about it?
6. If you have a partner, to what extent do your features currently have an effect on your relationship with an existing partner? (e.g. affectionate feelings, number of arguments, enjoying activities together). If you do not have a partner, to what extent do your features currently have an effect on dating or developing a relationship?
7. To what extent do your features currently interfere with your ability to work or study, or your role as a homemaker?
8. To what extent do your features currently interfere with your social life? (with other people, e.g. parties, pubs, clubs, outings, visits, home entertainment).
9. To what extent, do you feel that your appearance is the most important aspect of who you are<sup>12</sup>?

## Treatment Options

Although therapeutic interventions in terms of medications and psychological therapies are possible, BDD is often a chronic illness and even with specialist intervention and treatment

many relapses may occur and the prognosis for complete recovery is poor<sup>13</sup>.

In terms of treatment of BDD, Cognitive Behaviour Therapy, CBT, is considered to be the treatment of choice<sup>14</sup>, pharmacological therapy has been based around antidepressants mainly Selective Serotonin Reuptake Inhibitors, SSRI, which are needed in higher doses and for longer durations than usual. However, on discontinuation relapse rates are high.

The UK NICE guidelines for OCD and Body Dysmorphic Disorder (National Collaborating Centre for Mental Health 2005) make use of a graduated approach to treatment. For mild cases self-help books with guidance are recommended<sup>15</sup>. Some evidence from a meta-analysis exists for both psychological and SSRI treatment<sup>16</sup>. Moderate cases therefore should be offered CBT or a SSRI and a combination of both should be offered to severe cases.

In terms of patients with BDD seeking treatment from doctors, the most commonly visited doctors were dermatologists, followed by patients seeking surgical rhinoplasty<sup>17</sup>, and treatment for acne and surgical intervention did not improve the BDD. Surgical or cosmetic intervention can result in the patient transferring concern to another flaw or further increasing focus on the surgically altered one, which may never be seen as 'beautiful', with requests for further surgery that can become a vicious cycle, causing significant problems for the patient and doctor.

### **Relevance to Aesthetic and Surgical Interventions**

The relevance of BDD in aesthetic treatments and cosmetic surgery is clear. These patients present commonly and are on a spectrum, men are just as likely as women to have sought cosmetic surgery<sup>18</sup> and suicidality may increase when cosmetic surgery is denied and 25–30% of patients with Body Dysmorphic Disorder in a psychiatric clinic have had a history of attempted suicide<sup>19</sup>. Many patients with poor insight seek cosmetic treatments as an alternative to psychiatric or psychological treatment. Insight is not a significant factor in terms of aesthetic treatment; the outcome is likely to be poor even in those patients with relatively good insight since they may continue to see their defect or flaw as still ugly after treatment or surgery.

It is possible, with judicious selection, to greatly improve the quality of life of patients requesting aesthetic or surgical interventions since, of course, most people who attend aesthetic clinics or request surgical intervention are not suffering from BDD. However, it is important to realise that BDD is common in such settings, has significant implications in terms of dissatisfaction and it is not in the patients' best interest that aesthetic interventions

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are offered to them.

## Conclusion

In conclusion, in view of the prevalence of BDD, a case can be made for a screening questionnaire to be carried out on all patients requesting aesthetic interventions. It is interesting to note that BDD occurs on a spectrum and the milder end of the spectrum may be more difficult to detect in aesthetic or surgical clinics. However, by asking a few simple screening questions, which should be part of routine consultation prior to agreeing to undertake any aesthetic procedure it is relatively easy to screen for BDD. If positive answers are forthcoming from the patient, then advice can be given in a sensitive and empathetic manner and referral should be offered to appropriate psychiatric services.

This simple and easy process, which takes a few minutes during initial consultation may prevent significant heart ache in the future and would probably be in the best interest of the doctor and certainly be in the best interest of the patient who may be suffering from Body Dysmorphic Disorder.

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