patients with body dysmorphic disorder (BDD), a mental illness that is treatable with psychotherapy and/or pharmacological management, will not get better with cosmetic surgery. In fact, undergoing cosmetic surgery is likely to worsen the patient’s condition. Yet, patients with BDD are far more likely to visit a cosmetic surgeon than a psychiatrist. This troubling reality creates a challenge for aesthetic clinicians, who have an ethical duty to avoid treating patients with BDD and to encourage such patients to seek psychiatric treatment, even though few affected patients will be receptive to such referrals.

WHAT IS BDD?

Body dysmorphic disorder is, in general terms, a psychiatric condition in which the patient has a real or imagined deficit that causes him or her extreme distress and associated impairment. (See sidebar for DSM definition.) “Extreme” distress indicates that the degree of concern or preoccupation associated with a deficit is out of proportion to the degree of the deficit.

A diagnosis of BDD requires that there is impairment in social or occupational functioning. Such impairment may be identified via patient statements, such as, “I can’t get a job because my nose is too big,” or “I can’t get a boyfriend because my hips are the wrong shape.”

As an objective observer, the surgeon may note some mild deficit—a bump on the nose, perhaps—but the patient’s response to the mild deficit is out of proportion to it. In many cases of BDD, the surgeon will detect no deficit at all.
Any cosmetic treatment undertaken to correct the patient-identified deficit—even if the outcomes are objectively excellent—will not assuage the patient’s concern. In fact, a cosmetic intervention can actually worsen the patient’s level of distress.

BDD comes in different severities, from fairly mild (although it still has social or functional impairment) to a frankly delusional form, a point emphasized by modifications to the definition of BDD in DSM-V.

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Aside from the patient’s well-being, which is, of course, the physician’s primary concern, there are practical reasons to avoid cosmetically treating the patient with BDD. Because the patient will not be satisfied with even the most successful intervention, the physician will face the task of managing a dissatisfied patient who may very likely believe that additional surgeries will provide the patient’s desired outcome.

RECOGNIZING BDD

Simple screening questionnaires administered in the waiting room are effective to identify patients who may have signs or symptoms of BDD. See the sidebar for a list of sources for questionnaires. The questionnaires are brief and therefore easy to administer to all new patients.

The questionnaire is an important first-line source of data, but it is not the only item to consider. The patient consult allows the cosmetic surgeon to assess the patient’s concern and the relative severity of his or her associated distress. The physician can explore any concerns revealed during the patient consult.

BOTTOM LINE

If the patient shows clear signs of BDD, it is incumbent upon the aesthetic physician to not provide cosmetic treatment and to make a psychiatric referral.

BDD SCREENING QUESTIONNAIRES

A number of scales are available that can be adapted for use in the aesthetic practice. Here are a few sites with published scales.

- http://www.rhodeislandhospital.org/services/body-dysmorphic-disorder-program/questionnaires/screening-questionnaire-for-adults-do-I-have-BDD.html

MAKING THE REFERRAL

- Be matter-of-fact
- Be non-judgemental
- Have a specific colleague in mind for referral
- Recognize that patients may not accept the referral
- Be emphatic
- Remain calm and not angry or argumentative

RED FLAGS

- Patient obsessively checks their appearance in the mirror or avoids mirrors.
- Patient continuously touches the area of the perceived flaw.
- Obvious use of clothing or make up to obscure the perceived flaw.
- Patient seeks agreement/affirmation of their perceived flaw.
- History of various cosmetic interventions or procedures targeting the perceived flaw.
- History of doctor-shopping and dissatisfaction with results of past procedures.
- Statements indicating occupational/academic/social/functional impairment (“I can’t go out because of this.” Or, “I can’t get a job because of this.”)
- Patient reports that he or she believes others think about or discuss the perceived flaw.
- Patient reports spending substantial amounts of time thinking about or trying to correct/camouflage the flaw.
by questionnaire responses through the use of patient questioning.

Patient reports of doctor-shopping can also be a clue to BDD. If previous physicians were unable to diminish the patient’s distress, you will not be successful, either.

RESPONDING TO BDD

If the patient shows clear signs of BDD, it is incumbent upon the aesthetic physician to not provide cosmetic treatment and to make a psychiatric referral. Doctors may worry that patients will respond negatively, possibly angrily, to a psychiatric referral and may be tempted, therefore, to say nothing. However, psychiatric conditions must be viewed the same way as any other medical conditions. If in the course of a pre-surgical consult you determined that a patient had hypertension or signs of diabetes, for instance, you would refer him or her for an appropriate medical evaluation. The same holds for the patient with BDD; he or she requires evaluation and possible treatment by a competent expert.

This is not to say that patients will not respond negatively and perhaps angrily. In fact, because the patient’s insight is impaired by virtue of their condition, he or she may not accept the diagnosis or the referral.

The cosmetic surgeon has the responsibility at least to try. It is better to have a would-be patient leave your office angry because you refused treatment—documenting appropriately—than to deal with the ramifications of establishing a treatment relationship with a patient with BDD.

When addressing the patient, be matter-of-fact and straightforward. Be emphatic to the patient’s distress, and be honest. Say something like, “I don’t think I can help you, but I think there is a way to help you feel better about this concern.” Be prepared with a referral to a psychiatrist with whom you are familiar and whom you trust to help this patient.

If you have already rendered treatment in a patient who shows signs of BDD, be willing to stop providing cosmetic treatment (document appropriately) and make a referral. Remain calm, and avoid a defensive posture when addressing the patient.

If BDD is suspected but not clearly identifiable in a new patient, it is best to refuse any invasive procedures. However, it may be acceptable to provide a minimally invasive procedure to such a patient.

A relatively inexpensive and non-permanent treatment, such as a filler or neurotoxin injection, may provide an opportunity for the surgeon to assess the patient’s response to cosmetic interventions. Even if the patient is not satisfied, they will have spent only a bit of money and will endure no permanent changes to their appearance. It is better to determine at this stage that the patient has a disordered perception than after he or she has invested $20,000 in unnecessary surgeries that may entail risk for both the patient and the surgeon. The patient’s condition will not improve and could deteriorate, while the surgeon could be open to a lawsuit from the patient who will not be satisfied.

RESPONSIBLE CARE

Data regarding the prevalence of BDD among patients presenting to aesthetic practices are variable, however, across studies there is a much higher proportion of such patients presenting at dermatology or plastic surgery practices, compared to psychiatric practices. Cosmetic surgeons, therefore, should be attentive to the signs and symptoms of BDD. The most important thing that cosmetic surgeons can do for patients with BDD is to withhold treatment and make a psychiatric referral. While this may be challenging for the physician, the short- and long-term consequences of providing aesthetic treatments to such patients are far more troubling.

If BDD is suspected but not clearly identifiable in a new patient, it is best to refuse any invasive procedures. If you have already rendered treatment in a patient who shows signs of BDD, be willing to stop providing cosmetic treatment (document appropriately) and make a referral.