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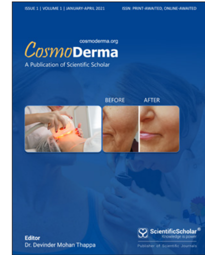

Editorial

Screening for body dysmorphic disorder in esthetic practice

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Received : 01 June 2023
Accepted : 01 June 2023
Published : 08 June 2023

DOI
10.25259/CSDM_115_2023

Quick Response Code:

The upsurge of cosmetic procedures places the dermatologist and cosmetic surgeon uniquely positioned to identify patients suffering from body dysmorphic disorder (BDD). At present, BDD is an under-recognized severe psychiatric illness. An excessive preoccupation with a perceived or minor defect in the physical appearance imperceptible to others characterizes BDD. It comes under obsessive-compulsive disorders and is distinct from eating disorders as per the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria.

The DSM-5 classifies "BDD as an obsessive-compulsive or related disorder and provides the following four criteria for the diagnosis:

a) Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others,
b) Repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, and reassurance seeking) or mental acts (e.g., comparing their appearance with that of others) in response to the appearance concerns,
c) The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, and
d) The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder."

Although BDD is primarily a psychiatric condition, patients with BDD are more likely to present to a dermatologist and plastic surgeon than to a psychiatrist. Because patients are typically ashamed of and embarrassed by their symptoms, they usually do not reveal them to clinicians unless specifically asked. To diagnose a case of BDD, the patients should satisfy the criteria laid out in the DSM-5 criteria.

The prevalence of BDD in the general population ranges from 1% to 3%. The frequency of BDD in dermatology outpatients ranges from 6% to 30% in patients seeking cosmetic treatment. Facial flaws have been reported to be the most common focus in BDD, but any part of the body can be of concern. BDD usually begins in adolescence, and the disorder appears to be chronic, and the establishment of an accurate diagnosis may take several years, considered to be more frequent in women. BDD may present as significant distress and functional impairment, extending to anxiety, depression, self-harm behaviors, or suicide. Early recognition may avoid unnecessary elective procedures with ethical and medicolegal consequences.

Patients with BDD usually exhibit unsatisfactory outcomes or symptoms aggravation following esthetic procedures. Esthetic surgeons are reluctant to perform esthetic procedures on patients

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with BDD, as it is generally considered a contraindication for elective treatments. There is an agreement regarding screening BDD before esthetic interventions and re-assess afterward for any emerging psychological condition. Failure to do so can result in adverse consequences for patients and physicians. There have been reports of threats of legal action and violence among BDD patients toward surgeons, with few cases culminating in murder. The reported rate of suicidal ideation of 57.8% in BDD patients alerts the clinician to the gravity of identifying patients with BDD. Thus, recognizing the signs of BDD and identifying vulnerable prospective patients is crucial, considering that the appropriate management involves a referral to a psychiatrist rather than an esthetic intervention. There are clear advantages to the early detection of BDD patients seeking esthetic interventions for the wrong reasons and with unrealistic expectations. Any suspected case of BDD may benefit from a multidisciplinary approach, a referral to a psychiatrist for timely management, and risk–benefit analysis. However, there are currently no clinical guidelines for the proper screening of BDD.

The sine qua non of BDD is the obsessive fixation on some perceived defect in one's appearance. Noteworthy red flags for patients at risk of BDD include those patients focusing on a minimal or even non-existent defect to the objective observer, excessive detailing of the perceived flaw or defect, or contrarily not being able to describe exactly what they are seeking to improve, or holding high expectations, or requesting for perfection, and repetitive behaviors such as mirror checking. BDD patients repeatedly seek treatments to find solutions for their defects, and the majority are dissatisfied with their results and consultations. Invariably, the obsession leads to various behaviors impairing the patient's functioning. These can vary from camouflaging the imagined defect to excessive mirror checking or mirror avoidance and may lead to social withdrawal for fear of others seeing the perceived deformity.

The attending surgeon should perform a personal, thorough initial interview to identify these patients correctly. Many patients with BDD will often be seen by a cosmetic surgeon before a psychiatrist and will not have a formal diagnosis. These patients believe they have a deformity that requires a surgical intervention rather than a psychological treatment for a psychiatric disorder. Therefore, the surgeon will be responsible for eliciting the diagnosis. Hence, a face-to-face consultation with good communication and observation skills, alongside some common-sense perspective, remains critical. This is particularly true considering that BDD patients tend to hide any practical signs that may preclude elective procedures.

From a legal standpoint, it is recommended that an additional checklist be included in the pre-procedure consent paperwork for any patient where there is any suspicion of BDD. Informed consent is legally required to ensure a patient knows all the possible procedure risks. The elements of informed consent include the patient understanding the nature of the treatment, possible alternative treatments, and the possible risks and benefits. Courts assess whether a patient gave informed consent by analyzing different elements.

Understandably, it may be challenging to turn away a patient who feels that an esthetic procedure will significantly improve their physical appearance and self-confidence. One must be aware that performing an elective procedure on a patient with BDD may result in a disappointing outcome for both the patient and the surgeon, putting the physician in danger too.

How to cite this article: Thappa DM, Thappa HA. Screening for body dysmorphic disorder in esthetic practice. CosmoDerma 2023;3:92.