Dysmorphic practitioners

Dr Steven Harris and **Dr Neetu Johnson** on BDD in the aesthetic practitioner

In last month's edition of *Aesthetic Medicine*, we explored Body Dysmorphic Disorder (BDD) in aesthetic patients. BDD is a serious mental health disorder where patients become obsessed with a minor, or nonexistent flaw to the extent that they become severely depressed and suicidal. Around 75% of people with BDD seek aesthetic treatments, however, only 2% benefit. Most tend to be dissatisfied with the results and experience a worsening of their BDD symptoms; this may account for the higher than normal suicide rate among aesthetic patients.

The role of the aesthetic practitioner is then not to treat, but to prepare the patient for referral to specialist care. The disorder is treatable with combinations of Cognitive Behaviour Therapy (CBT) and high doses of Selective Serotonin Reuptake Inhibitors (SSRIs). There are studies to show that pharmacological augmentation, combination and switching strategies may be useful in treatment-resistant cases.[1]

BDD is relatively common at around 2% of the general population but is much more common at 9-15% of aesthetic dermatology patients and up to half of those seeking surgical rhinoplasties.[2] While there has been increasing focus on aesthetic patients with the disorder, very little is known about the practitioners. The thought patterns and suggestions of aesthetic practitioners are important when addressing our patients, as often our internal values and ideas are projected during this consultation process, even at an unintentional subconscious level.

A first of its kind survey was conducted to study the prevalence of BDD among aesthetic practitioners.

MATERIALS AND METHODS

Study design and subjects

A practitioner survey was distributed among 200 aesthetic practitioners during two separate aesthetic conferences set two weeks apart in September and October 2017.

The first involved aesthetic doctors at the British College of Aesthetic Medicine (BCAM) and the second involved aesthetic practitioners at the Clinical Cosmetic and Reconstructive Expo (CCR Expo). In total, 51 surveys were completed, 36 at BCAM's conference and 15 at CCR Expo.

The respondents included 30 women, 20 men and one non-disclosure, with a percentage of age ranges (Figure 1).

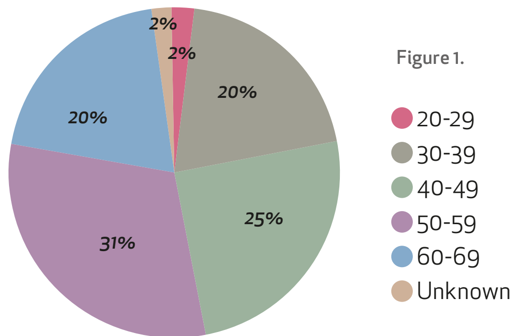

Figure 1.

Assessment

The practitioner survey was designed to record the following information from the respondents: age, gender, age range and the AAI (Figure 2). The latter is a self-report scale to help assess symptoms of BDD and has been found to have good reliability and validity.[3] The possible range of scores is 0-40, where a score of 19 or above indicates the likely presence of the BDD.

PRACTITIONER SURVEY

I am an: aesthetic doctor plastic surgeon nurse dentist beauty therapist (please circle relevant description)

Other: .... (please specify)

Age: 20-29 30-39 40-49 50-59 60-69 Gender: Male Female (please circle)

Please answer how often each of the following applies to you. The numbers refer to the following verbal labels:

0 Not at all	1 Rarely	2 Sometimes	3 Often	4 All the time

1.	I check my appearance (e.g. in mirrors, by touching with my fingers or by taking photos of myself).	0 1 2 3 4
2.	I compare aspects of my appearance to others.	0 1 2 3 4
3.	I avoid situations or people because of my appearance.	0 1 2 3 4
4.	I think about how to camouflage or alter my appearance.	0 1 2 3 4
5.	I avoid reflective surfaces, photos, or videos of myself.	0 1 2 3 4
6.	I try to camouflage or alter aspects of my appearance.	0 1 2 3 4
7.	I brood about past events or reasons to explain why I look the way I do.	0 1 2 3 4
8.	I am focused on how I feel I look rather than on my surroundings.	0 1 2 3 4
9.	I discuss my appearance with others or question them about it.	0 1 2 3 4
10.	I try to prevent people from seeing aspects of my appearance within particular situations (e.g., by changing my posture, avoiding bright lights).	0 1 2 3 4

Figure 2. The Practitioner Survey

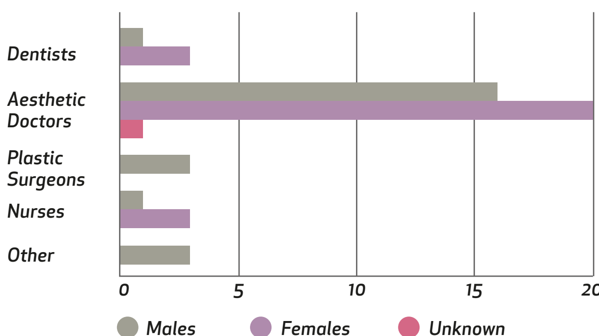

Figure 3. The demographic ratio of male to female practitioners consisted of the following:

37 aesthetic doctors (16 males, 20 females and 1 non-disclosure of gender)
3 plastic surgeons (3 males and 0 females)
4 nurses (1 male and 3 females)
4 dentists (1 male and 3 females)
1 female pharmacist
1 female beauty therapist
1 female non-disclosure of profession.

RESULTS

The results of the surveys were assessed independently by the authors who are experts in the fields of aesthetic medicine and mental health. The rate of response at the BCAM conference was 28% (36 out of 130 surveys) versus CCR Expo at 21% (15 out of 70 surveys). In total (from both conferences), one quarter (51 surveys) were returned fully completed.

From these, eight respondents (16%) had a score of 19 or above; they included three males and four females, with one gender non-disclosed with an average age range between 30-59 years old (Figure 4).

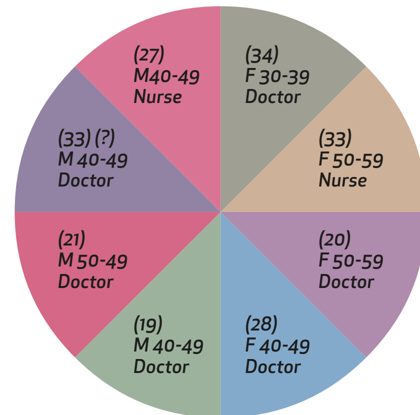

Figure 4.

The results were reported according to the recorded scores in the individual questions on the BBD survey. Appearance check and comparison: a significantly large number of respondents (96%) did not engage or rarely checked their appearance or compared aspects of their appearance to others.

> The prevalence rate of BDD amongst practitioners is higher than that found amongst aesthetic patients

Not engaging in avoidance behaviour of situations or reflections was also high in practitioners (76%).

Actual attempts of camouflaging and altering of appearance sometimes, often and all the time was reported in 29% of respondents. For the BDD questions involving rumination and focus on feelings, 20% of respondents reported having thoughts either sometimes or all the times.

When analysing the results per profession, BDD was most common among aesthetic nurses at 50%, who also had the highest average score of 30, followed by aesthetic doctors at 16% with an average score of 26 (Figure 4). Of note, prevalence of BDD symptoms was lowest within the dental profession.

DISCUSSION

To our knowledge, this survey is the first of its kind to study BDD in the aesthetic practitioner population. The authors recognise that there are limitations to this study. A larger group size would have provided more statistical power for more robust conclusions.

It is known that people with BDD tend to be embarrassed or ashamed by their condition to the extent that some may have decided not to respond. As there is a stigma related to the condition, practitioners may not have felt comfortable in disclosing their thoughts relating to their own appearance. >

Other reasons for the poor response rate may be that no specific time was allocated to the surveys; practitioners were asked to complete them during the course of the conferences and return at their leisure; some may have simply forgotten, while others may have not given the survey much significance despite the encouraging introduction.

The setting of the conferences with close proximity to colleagues may have introduced a respondent bias to conform to "normality". As insight into BDD can often be limited and poor, the chances of practitioners overlooking the importance of this request may have been present on receiving the survey.

Notwithstanding these limitations, the results of this survey found that the prevalence rate of BDD among practitioners is higher than that found among aesthetic patients (16% versus 9-15%). The disorder was proportionally most common in aesthetic nurses who also had the highest average score on the AAI, followed by aesthetic doctors.

In general, aesthetic practitioners have more access to aesthetic products and procedures, either performed by colleagues or performed by themselves (on themselves). As the psycho-social drivers for cosmetic procedures have increased in more recent years, pressures to defy the natural process of ageing seem clear within the industry itself.

Indeed it is the authors' observations that an increasing number of practitioners are appearing with exaggerated facial features (usually involving botulinum toxin and dermal fillers) at various aesthetic meetings and conferences.

It is important to remember that we not only have a duty of care to our patients, but our medical responsibility of "non nocere" is highly relevant here and specifically in this industry where both patients and practitioners are vulnerable and at risk of having unnecessary procedures with their potential complications. Our patients look up to us as medical professionals for guidance and if the consultation process is carried out with a therapeutic framework in place, the relationship and ideology of the practitioner can become quite powerful. This could lead to psychological damage if the patient is young and impressionable or is not mentally stable.

There are further implications for aesthetic patients being treated by practitioners with BDD; the latter have been found to have greater left-sided brain activity when it comes to processing facial detail and, therefore, may have a tendency to focus on certain areas rather than treating the face as a whole. A variant of BDD, named Body Dysmorphic Disorder by proxy (BDDBP), may also be prevalent among aesthetic practitioners and requires further research. Here, the primary preoccupation involves perceived imperfections with the appearance of others.

> It is time we realise that BDD is a part of our industry, we can no longer afford to ignore as it affects us all

SUMMARY

It is time we realise that BDD is a part of our industry we can no longer afford to ignore as it affects us all, either directly by those with the disorder or indirectly by its consequences. To this end we need to psychoeducate ourselves as well as our patients.

As practitioners, we should regularly screen all our patients with the diagnostic screening tools that have been discussed in the first part of this BDD series and ensure that patients are referred on to the appropriate pathways. We must also find a way to identify and help colleagues with the disorder as remaining undiagnosed and untreated may potentially lead to inappropriate and unsafe practice.

Without a doubt, BDD is the single greatest challenge facing our work as aesthetic practitioners and the integrity of our industry. We hope that by initiating this study we have at the very least created a platform for dialogue about this disabling condition. **AM**

REFERENCES

1. Phillips, K.A., et al. Pharmacotherapy relapse prevention in body dysmorphic disorder: A double blind, placebo controlled trial. The American Journal of Psychiatry, April 2016 (Online)
2. Harris, S. Body Dysmorphic Disorder. Aesthetic Medicine. 2007; 2: 20-22
3. Veale, D., et al. The Appearance Anxiety Inventory: Validation of a process measure in the treatment of body dysmorphic disorder. Journal of Behavioural and Cognitive Psychotherapy. 2014; 42(5): 605-616

Dr Steven Harris MB BCh, MSc, MBCAM, completed his medical studies in Johannesburg in 1997. He has been practising aesthetic medicine at his clinic in North London since 2004 and has gained a reputation for producing entirely natural looking results. Dr Harris also completed an MSc in Cognitive Behaviour Therapy in 2005 and specialises in the management of patients with Body Dysmorphic Disorder. He publishes and lectures regularly in both areas of aesthetic medicine and clinical psychology

Dr Neetu Johnson BSc(HONS) MBBS MRCPsych, is a London-based Consultant Psychiatrist and Aesthetic Medicine Doctor with expertise in Neurodevelopmental disorders such as Autism and ADHD. She is a member of the prestigious Royal College of Psychiatrists and the Royal Society of Medicine. Dr Johnson has a specialist interest in the modality of Psychodermatology; a new subspecialty encompassing the management of patients with primary skin conditions (such as acne) with an element of psychiatric or psychological morbidity (such as depression or anxiety).