Body and mind

In the first of a two-part article **Dr Steven Harris** explores the issue of Body Dysmorphic Disorder (BDD) in the aesthetic patient

Body Dysmorphic Disorder (BDD) is a problem of self-image where sufferers tend to preoccupy themselves with a physical feature (mainly involving the face and skin) which they consider defective. While the "defect" appears normal, or minimal to most others, people with BDD are convinced they look hideous and will often avoid social contact for fear of ridicule and humiliation. As a result, they may become increasingly more isolated and even housebound. Suicide is unusually common among sufferers.[1] Around three quarters of people with BDD will at some stage seek aesthetic treatments, however, these tend to lead to an exacerbation of symptoms and may account for the higher than normal suicide rate amongst aesthetic patients.[2,3] The following article (part 1) provides an overview of BDD and examines the aesthetic patient who presents with the disorder; The next article (part 2) will follow a first of its kind survey to assess the prevalence of the disorder amongst aesthetic practitioners.

BDD is relatively common at around 2% of the general population and is more common in women than men (60% versus 40%). It can affect people of almost any age (from age 4-5 to the very elderly) and most often begins early around age 12-13 (with an onset of two-thirds before age 18). It does not discriminate based on race, ethnicity, or socio-economic status.[4] Since it was only formally recognised as a mental disorder in 1997 (in DSM IV), BDD still remains under-reported and under-diagnosed. People with the disorder often feel too embarrassed to discuss their symptoms, or feel that they will be judged, or misunderstood. Around half of sufferers have poor insight into their condition and do not realise there is a mental problem. In addition, the diagnosis is often overlooked because of frequent co-morbidity with other conditions such as generalised anxiety disorder (GAD), Obsessive Compulsive Disorder (OCD), major depression and social anxiety disorder (social phobia).[5]

In the more recent DSM-5, BDD is classified in the chapter of "Obsessive Compulsive and Related Disorders." The criteria require at least an hour a day of being preoccupied with one or more nonexistent or slight flaws in physical appearance that are not observable or appear slight to

others. At some point, the individual responds by performing repetitive, compulsive behaviours (e.g., mirror checking, excessive grooming, skin picking, and reassurance seeking, or clothes changing) or mental acts (e.g., comparing one's appearance with that of others). The preoccupation causes clinically significant distress or impairment in important areas of functioning, and its symptoms are not better explained by normal concerns with physical appearance or by concerns with body fat or weight in individuals meeting diagnostic criteria for eating disorders. BDD symptoms may be associated with muscle dysmorphia and patients with BDD tend to have poor insight into their condition (or absent insight with delusional beliefs).[6]

CAUSE AND EFFECT

While the symptoms of BDD are well established, little is known about the underlying causes of the disorder. A number of studies support a biological model: People with BDD tend to have visual and emotional processing deficiencies; they recall specific parts of a drawing, rather than the overall structure and they struggle with recognising facial emotions. They also perform poorly in tasks related to decision making, specifically those involving memory, planning and organisation. Neurochemical studies have found decreased serotonin binding densities compared to healthy individuals and treatment studies have shown that Selective Seratonin Reuptake Inhibitors (SSRIs) decrease BDD symptoms overall. Brain imaging studies involving functional magnetic resonance imaging (fMRI) suggest that people with BDD have greater left sided brain activity when it comes to processing facial detail; they also show abnormal frontostriatal activity similar to that observed in OCD. Finally, there appears to be some evidence that the disorder is heritable.[7]

The psychological model of BDD explains that people with the disorder tend to have a history of childhood trauma. This may have involved bullying at school, or other forms of abuse leading to a negative self-image and low self-esteem. According to Cognitive Behaviour Therapy (CBT), people with BDD tend to overestimate the meaning and importance of a perceived minor flaw. They may also give themselves global ratings (e.g., worthless, unlovable) based on a single aspect of appearance. This kind of "distorted thinking" leads to unhealthy negative emotions (e.g. anxiety and depression) which they try to alleviate with repetitive rituals (e.g., mirror checking and cosmetic procedures) and avoidance (e.g., social gatherings). These unhealthy behaviours provide some temporary relief and are therefore negatively reinforced which in turn maintain the unhealthy negative emotions. A vicious cycle of stress and distress is thus formed to propagate the disorder.[8] It's important to mention that while the beauty and media industries have been linked to BDD, it is unlikely that they play a causal role; the disorder occurs in all parts of the world, even where access to media is very limited. However, it is possible that media pressure acts as a trigger in genetically predisposed individuals, especially during their teens, or can worsen existing BDD symptoms.[9]

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BDD AND AESTHETIC TREATMENTS

Around 75% of people with BDD seek aesthetic treatments and the condition has been reported in up to 15% of aesthetic dermatology patient populations and up to around half of plastic surgery ones. Unfortunately, aesthetic procedures are rarely beneficial for people with the disorder; only 2% show long-term improvement.[2] Most experience an exacerbation of symptoms with potential tragic consequences. The patients tend to be dissatisfied and are more likely than others to become aggressive, violent and seek legal compensation. They will often request a "revision procedure", seek help from other practitioners, or even perform dangerous procedures on themselves. In the worst-case scenario, they may become severely depressed and are more likely to commit suicide. For these reasons, it is best not to offer patients with BDD aesthetic treatments and instead refer them for specialist care.[10]

Patients with BDD tend to resist referrals to mental health services. The patients believe they have a physical problem, not a mental one and even if insight is present, they feel shame and embarrassment about their disorder; the need for psychiatric intervention may act as self-confirmation that they are worthless. Instead, patients will tend to continue along a destructive path in their quest for "perfection". The main role of the aesthetic doctor, or surgeon is then not to treat, but to prepare the patient for referral, preferably to a psychodermatology clinic. >

Figure 1: Body Dysmorphic Disorder Questionnaire – Dermatology Version (BDDQ-DV)10

Are you very concerned about the appearance of some part of your body which you consider especially unattractive? ***If no**, thank you for your time and attention. You are finished with this questionnaire	Y	N
If yes, do these concerns preoccupy you? That is, you think about them a lot and they're hard to stop thinking about?	Y	N
What are these concerns? What specifically bothers you about the appearance of these body parts?		
What effect has your preoccupation with your appearance had on your life?		
Has your defect often caused you a lot of distress, torment or pain? How much? Circle best answer) 1 No distress 2 Mild, and not too disturbing 3 Moderate and disturbing but still manageable 4 Severe and very disturbing 5 Extreme and disabling		
Has your defect caused you impairment in social, occupational or other important areas of functioning? How much? (circle best answer) 1 No limitation 2 Mild interference but overall performance not impaired 3 Moderate, definite interference, but still manageable 4 Severe, causes substantial impairment 5 Extreme, incapacitating		
Has your defect often significantly interfered with your social life?	Y	N
If yes, how?		
Has your defect often significantly interfered with your school work, your job or your ability to function in your role?	Y	N
Are there things you avoid because of your defect?	Y	N

It is therefore important that we educate ourselves about BDD and offer a screening program to all patients who present for aesthetic treatments. There are a number of validated screening questionnaires to confirm the diagnosis of BDD, such as the BDDQ-DV (figure 1), however, a short self-assessment questionnaire, the BDD Aesthetic Questionnaire is easier to institute in a busy aesthetic clinic and will help decide very quickly if a more formal assessment is required (figure 2). The patients should feel that they are in a safe and non-judgmental environment and we should allow time to listen and not dismiss any concerns, or try reassuring them that nothing is wrong with the way they look. The screening questionnaire offers a good way to open a discussion and educate the patients with respect to their condition. Another way is to ask them to rate their "defect" on a severity scale (0-10 where 10=extremely severe) and then discuss the difference with our own professional rating (patients with BDD are likely to rate their "defect"as extremely severe). It is important to explain that BDD is a recognised disorder which is relatively common and treatable. A follow-up appointment may then be necessary to discuss the appropriate referral. Given that they will feel shame and embarrassment, it is more likely that patients will accept a referral to a psychodermatology clinic rather >

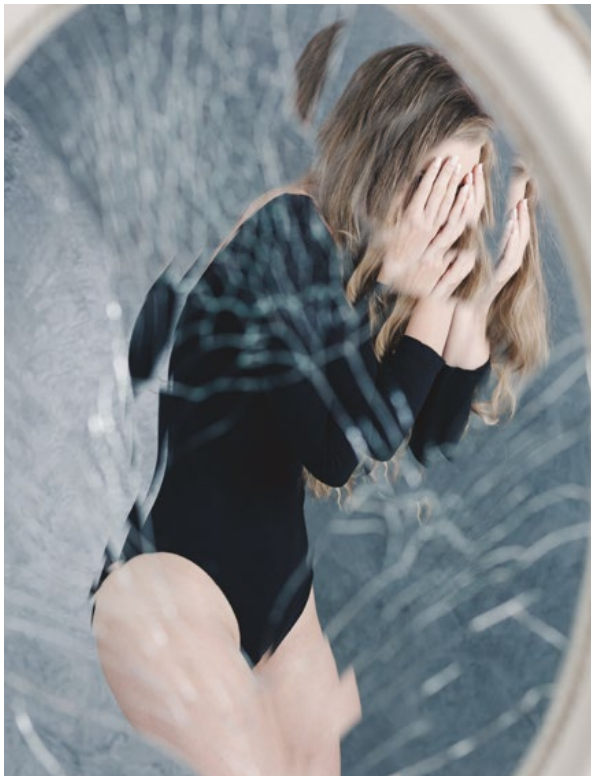
Figure 2: BDD Aesthetic Questionnaire (BDD-AQ) by Dr Steven Harris

1. Does your physical problem cause you severe distress?
2. Do you spend more than an hour a day worrying about your problem?
3. Do you spend a lot of time trying to change or conceal your problem?
4. Does your problem interfere with your work or relationships with others?
5. Do you avoid doing things because of your problem?
A **"yes"** answer to any one of the above questions would warrant a more formal assessment.

than a psychiatric unit. Psychodermatology promotes a multi-disciplinary management of BDD between dermatologists, psychiatrists and psychologists. There are a number of centres located across the UK where direct private referrals may be made. To find out more about these local services, it is best to contact the British Association of Dermatologists. On the NHS, referrals would normally be made by a GP. In such a case, it would be best to contact the patient's GP directly (with the patient's consent) to discuss the best referral options. These may include individual therapy at an Increasing Access to Psychological Therapies (IAPT) service, the community mental health team (CMHT), or in severe cases, a specialist service as an out-patient, or in-patient.' Support groups can play an important role in the recovery process and often involve family members; further information can be found on the BDD Foundation website (www.bddfoundation.org).

There are no large-scale controlled trials to determine the best treatment for BDD, however, evidence from smaller trials suggests that combinations of CBT and high dose SSRIs may offer the best treatment options. The prognosis in such cases is generally good. Common SSRIs includeCitalopram 40mg daily, or Escitalopram 20mg daily. The medication can take between 2-14 weeks to work and two thirds of people will experience around a 30% improvement in BDD symptoms, especially obsessional thoughts and depression. CBT offers patients a structured program of self-help where the patient learns to change their attitude toward their appearance and adopt a less demanding set of beliefs (cognitive restructuring). They learn to tolerate discomfort by gradually confronting their fears without camouflage (exposure therapy) and stopping "safety behaviours" such as mirror checking (response prevention). Behavioural type experiments may involve empirically testing hypotheses, i.e., dysfunctional thoughts and beliefs.[7,8,12]

In conclusion, BDD is a very serious mental health disorder with significant comorbidity and mortality. Most patients with BDD will present at some stage for aesthetic treatments and it is important that we are in a position to recognise this relatively common condition and refer for the appropriate care. To this end, we need to educate ourselves and offer regular screening at our clinics. We also need to consider industry and media guidelines to avoid triggering and driving the disorder in those vulnerable. While aesthetic treatments may provide some temporary relief of symptoms, they can have tragic consequences on the long run. When BDD is suspected, then it is our role to prepare the patient for a referral, preferably to a psychodermatology clinic. The best treatment options include CBT and SSRIs, both of which act to reduce distressing symptoms as well as comorbid conditions such as anxiety and depression. While awareness about aesthetic patients with BDD is slowly increasing, there is almost no information about the prevalence of the disorder amongst aesthetic practitioners and this is what we turn to next. **AM**



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