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UNDERSTANDING THE ABCs OF BDD

Stelios Kiosses advises aesthetic practitioners on how best to manage patients with Body Dysmorphic Disorder (BDD) and details appropriate methods of assessment and recognition.

Body Dysmorphic Disorder (BDD) is a common problem in aesthetic practices, yet the condition still remains under-recognised and under-diagnosed especially within the aesthetic field.

As a faculty member of ESAG (European Society of Aesthetic Gynaecology), I have launched an accredited CPD course worldwide on "*Recognising and Assessing Body Dysmorphic Disorder in Aesthetic Practice*".

When people think of mental illness related to body image, the first thing that usually comes to mind is anorexia or associated eating disorders. But, the lesser known Body Dysmorphic Disorder is five times more prevalent than anorexia, and causes higher levels of psychological impairment. BDD was originally described as 'dysmorphophobia' by an Italian psychiatrist, Enrico Morselli, in 1891.

'Subjective feeling of ugliness or physical defect which the patient feels is noticeable to others, although the appearance is within normal limits. The dysmorphophobic patient is really miserable in the middle of his daily routines, everywhere and at anytime, he is caught by the doubt of deformity' (Morselli, 1891). Morselli coined the term 'dysmorphophobia', but it is used less often nowadays.

Patients with BDD have a pervasive, subjective feeling of ugliness regarding some aspect of their appearance, despite a normal or nearly normal appearance. They are convinced that some part of their body is too large, too small, or misshapen. To other people, the appearance is normal or there is a trivial abnormality. In the latter situation, it may be difficult to decide whether the preoccupation is disproportionate.

The common concerns are about the nose, ears, mouth, breasts, buttocks, or genitalia. BDD patients are constantly preoccupied by their beliefs, feeling that other people notice and talk about the supposed deformity, and they blame all their difficulties on it.

BDD is primarily a mental health problem yet patients usually consult dermatologists, plastic surgeons, other specialists or general practitioners, but not mental health specialists, because patients with BDD firmly believe that their disorder is a physical problem.

Freud (1959) and subsequently Brunswick described the most famous case of BDD, known as the 'Wolf Man', who was preoccupied by imagined defects of his nose. The Wolf Man was a Russian aristocrat who had a recurrent dream of white wolves sitting staring at him from the bare branches of a tree outside his bedroom window in winter. The interpretation was that his nose represented his penis and that he desired to be castrated and made into a woman.

BDD affects 2% of the general population with an even higher percentage seeking cosmetic surgery (8 to 15%). Regardless of the statistics, plastic surgeons can expect to see BDD patients in their office. As many as 10% of Clinical Practitioners will miss the diagnosis of BDD.

The suicide rate is 45 times higher than the general population.

Greater than 90% of BDD patients are unhappy after cosmetic surgery, which can actually worsen their condition.

Many experts on BDD strongly suspect that Michael Jackson suffered from this condition. The tragedy is that it was not recognised or treated.

Only someone with BDD would be able to understand the true depth of torment and self-hatred they have for the shape of their genitalia or nose and skin when looking in the mirror.

Unfortunately, the majority of individuals suffering with BDD don't possess a full insight into this disorder and can believe their problem is physical rather than psychological, making them seek cosmetic/surgical intervention instead of a psychological intervention. BDD shares many of the characteristics of OCD in that a lot of the behaviours associated with BDD is a result of misfiring in the amygdala region of the brain, which controls our emotions. This is the part of the brain that sounds an alarm and makes us stressed if things aren't right. Ordinarily the amygdala lights up in response to a stressful situation. However, brain scans show it lights up randomly in sufferers of BDD, who then seek to attach something to the stress.

Co-morbidities such as social avoidance, depression, anxiety and suicidal ideation are common lifetime prevalences, with 24-28% for suicide attempts. In an observational study of 200 people with BDD, followed up for almost five years, the rate of completed suicide was 22 to 36 times higher than the general population.

It is important to recognise patients with BDD in aesthetic practice for the following reasons:

- The prime pathology is psychological rather than physical.
- Psychosocial co-morbidities and suicidal ideation are common.
- Patients with BDD are rarely satisfied with the results of their aesthetic procedures.
- Patients quite often become litigious after 'failure' to resolve their 'defect'.

Once the diagnosis of BDD has been established, sympathetically discussing this with the patient is crucial, however it is important to still acknowledge that there is a visible difference in their appearance, (if there really is one). Dismissing the concern, trying to reassure the patient that they look fine, or telling them that they should not worry is usually ineffective. Do not argue about the diagnosis; listen carefully and with sympathy to the patient's story but allow enough time for discussion.

One technique is to ask the patient to allocate a severity score for their 'defect', (this is usually 10 out of 10 for most patients), and then compare that with your own assessment of the severity of the 'defect' (which can be considerably less than the patient's numeric severity assessment). A discussion about the 'gap' between the patient's and the practitioner's assessment can then be a way to open the discussion about the diagnosis of BDD.

Common Compulsions Seen in Body Dysmorphic Disorder (BDD)

- **Mirror-checking, glancing in reflective doors, windows and other reflective surfaces**
- **Alternatively, avoidance of one's own reflection or photographs of oneself; often the removal of mirors from the home**
- **Attempting to camouflage imagined defect (e.g., using cosmetic camouflage, wearing baggy clothing, maintaining specific body posture or wearing hats)**
- **Excessive grooming behaviours (e.g., skin-picking, combing hair, plucking eyebrows, shaving)**
- **Compulsive skin-touching, especially to measure or feel the perceived defect**
- **Becoming hostile towards people for no known reason, especially those of the opposite gender**
- **Seeking reassurance from loved ones**
- **Excessive dieting and exercise**
- **Comparing appearance/body parts with that of others, or obsessive viewing of favourite celebrities or models that the person with body dysmorphic disorder wishes to resemble**
- **Use of distraction techniques: an attempt to divert attention away from the person's perceived defect (e.g., wearing extravagant clothing or excessive jewellery)**
- **Compulsive information-seeking: reading books, newspaper articles and websites which relate to the person's perceived defect (e.g., hair loss or dieting and exercise)**
- **Preoccupation with plastic surgery or dermatology procedures**
- **Attempts to perform cosmetic surgery on themselves, including liposuction or removal of unwanted blemishes**
- **Avoidant behaviour: avoiding leaving the home, or only leaving the home at certain times, for example, at night**

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Clinical Characteristics of BDD: Common Symptoms

- **Preoccupation with perceived appearance of defect**
- **Depressive symptoms**
- **Delusional thoughts and beliefs related to appearance**
- **Suicidal ideation**
- **Anxiety, panic attacks**
- **Chronic low self-esteem**
- **Self-consciousness in social situations; thinking that others notice and mock their perceived defect**
- **Feelings of shame**
- **Social and family withdrawal, social phobia, loneliness and self-imposed social isolation**
- **Overdependence on others such as a partner, friend or parents**
- **Inability to work or an inability to focus at work owing to preoccupation with appearance**
- **Decreased academic performance (problems maintaining grades, problems with school/ college attendance)**
- **Problems initiating and maintaining relationships (both intimate relationships and friendships)**
- **Alcohol and/or drug misuse (often an attempt to self-medicate)**

Treatment

The National Institute for Health and Care Excellence (NICE) guidelines on BDD recommend two treatments:

- Cognitive Behaviour Therapy (CBT) and;
- serotonergic anti-depressant medications.

CBT is a form of psychotherapy that emphasises the importance of underlying thoughts in determining how we feel and act. Through working with a CBT therapist, someone with BDD can uncover thought/behaviour patterns that make anxiety, self-criticism and social withdrawal worse. CBT is also used in the treatment of body image issues to reduce repetitive behaviours, (such as mirror checking and excessive grooming).

Medicated treatment is with anti-depressants which are strongly "serotonergic". The dose may need to be in the high range and taken daily for at least 12 weeks to determine its effectiveness. The medication may provide either a total cure or no benefit at all. If the drug is effective then a person will need to remain on it for at least a year, often longer, as discontinuing the medication may lead to high rate of relapse. It is not known how the medication 'works', but it may do so in the absence of depression. Such a drug may be used either alone or in combination with Cognitive Behaviour Therapy.

Assessment

Recognition of the condition may be achieved with proper screening with validated questionnaires. There are a number of questionnaires available from various organisations, such as:

1. The Cosmetic Procedure Screening Questionnaire (COPS)
2. The Body Dysmorphic Disorder Questionnaire (BDDQ)
3. The Yale Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder, (BDD-YBOCS)
4. Body Dysmorphic Disorder, NICE Guidance
5. The Bader-Kiosses Defective Genitalia Appearance Questionnaire (BK-DGAQ #20)

The BK-DGAQ asks specific questions related to the participant's genitals rather than body image more generally.

It is currently being developed at the University of Oxford in collaboration with ESAG. A small sample study has already been conducted and currently a larger scale study is on its way. The initial aim was to validate the BK-DGAQ, in the hopes that it could be used as a screening tool for BDD in women seeking labiaplasty. The BK-DGAQ #20 results are represented by the total score, with a maximum of 80 possible. Higher scores on this questionnaire represent a higher likelihood of BDD and a greater dissatisfaction with genitalia. The initial results indicate that the BK-DGAQ #20 seems to demonstrate good internal consistency and be an appropriate tool for demonstrating perceptions and feelings towards genitalia.

In the control group, the BK-DGAQ #20 was found to correlate with the COPS and the BDDQ. This indicates that the BK-DGAQ #20 is measuring perceptions towards genitalia and correlates with measures of body dysmorphia, perhaps demonstrating its clinical use as a screening tool.

To express your interest in the BK-DGAQ#20, please contact Dr A. Bader: doctorbader@gmail.com. Anyone interested in participating on the CPD-accredited ESAG course, please contact info@esag.org for more information and dates.

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Referral

Referral to a mental healthcare specialist may be necessary in the management of BDD. The role of a dermatologist, surgeon or aesthetic

practitioner is to prepare the patient for potential psychological help. Without necessary preparation, the patient will usually refuse to seek psychiatric treatment and may continue their journey with other cosmetic doctors.

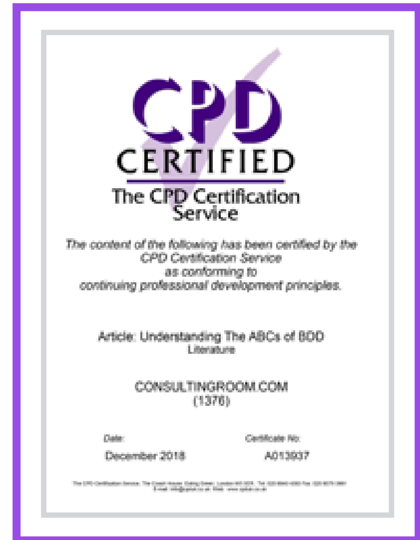
Discussing the distress caused by their concerns may help patients to understand the need for mental health referral. The patient should be informed that this is a recognised problem and there is successful treatment, however some may not be ready during the first consultation to accept that idea.

Do not force them, just allow them enough time; keep a good professional relationship and ask if they would like to come again. Referral to a local psychologist may be easily accepted by the patient as they may feel more comfortable as many patients may not want other people to know that they need psychological help.

Conclusion

Based on my personal experience treating patients with BDD, the majority may be driven by media pressure in a 'celebrity' culture, together with greater availability and popularity of cosmetic procedures.

Early recognition of BDD may help to prevent progress of the disease, to improve quality of life of the patient and of their family, and may even help to save the life of the patient as well as the reputation and well-being of the practitioner. When referring to a therapist, it is important to locate one with CBT training who has experience not only treating patients with BDD but also with eating disorders, OCD, and depression. Furthermore, collaboration between the psychologist and the aesthetic practitioner is essential.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References

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To download a CPD Reflective Learning Form, produced in association with the British Association of Cosmetic Nurses (BACN) & the British College of Aesthetic Medicine (BCAM), please use the QR code or visit bit.ly/CR-CPD in your web browser.

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