Approaches to the cosmetic patient with potential body dysmorphia

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CASE SCENARIO

A 45-year-old man presents to the office of Dr Filler requesting hyaluronic acid to augment his malar eminences. The patient states that he repeatedly compares his cheeks to those of his coworkers and celebrities. He often finds that he spends several hours daily applying self-tanner in attempts to camouflage perceived defects and improve his "sunken" appearance. As a result of his beliefs about his cheeks, he rarely leaves his home and has quit his job. He has seen multiple physicians previously for laser treatments, soft-tissue fillers, and botulinum toxin injections, with nearly universally unsatisfying results. When directly questioned about the appearance of his face, he points to his cheeks and says that "these gaping sinkholes are ruining my life." On examination, he is of normal body habitus. His malar eminences demonstrate mild age-appropriate atrophy. Dr Filler has treated numerous patients with similar requests and is confident that he can enhance the patient's anatomy with excellent cosmetic results.

Dr Filler should:

A. Proceed with the process of informed consent and treat the patient with hyaluronic acid as he would any of his other patients seeking a similar cosmetic procedure.

B. Not perform the procedure and, instead, explain to the patient that he suspects the patient has body dysmorphic disorder (BDD).

C. Set limits with the patient. Agree to perform this procedure only, and recommend that no further cosmetic procedures be performed.

D. Inform the patient that he cannot help him and provide a list of other local providers who might perform the requested procedure.

DISCUSSION

In the scenario above, a patient presents to Dr Filler with a request for an easy and fast procedure to treat subtle, age-appropriate atrophy. However, given the patient's behavior and clinical history, the situation is far more complex.

Given the patient's (1) preoccupation with a perceived physical defect, (2) impairment in social and occupational functioning, and (3) repetitive behaviors that he has enacted in response to his condition, Dr Filler should raise a concern that the patient may meet criteria for BDD.[1] The diagnostic criteria for BDD include the 3 aforementioned items as well as a prerequisite that the preoccupation in appearance not be better explained by an eating disorder or concerns with body fat or weight. Of note, the criteria of BDD have been revised with the update to *Diagnostic and Statistical Manual of*

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Mental Disorders, Fifth Edition[1] to include repetitive behaviors (eg, mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (eg, comparing one's appearance to that of others) in response to appearance concerns. Although some of the repetitive behaviors may be shared in patients meeting criteria for obsessive-compulsive disorder, the preoccupations and behaviors of patients with BDD focus only on appearance. Other clues to a possible diagnosis of BDD include the patient's normal clinical appearance, history of multiple cosmetic procedures, and dissatisfaction with his previous procedures and providers.

Informing a patient of a suspected diagnosis of BDD is essential. Such patients may be difficult to diagnose in the mental health professions. They often withhold their symptoms because of embarrassment or a belief that cosmetic concerns are not within the mental health practitioner's scope of practice.[2] Thus, dermatologists may be the practitioners most consulted by patients with BDD. However, patients with BDD often have significant psychological distress. They have high rates of depression and suicide, and are largely unsatisfied by the results of cosmetic procedures. Their dissatisfaction sometimes reaches such high levels that in rare cases patients have sued, stalked, or murdered their treating physicians.[3] Concomitantly, patients may, and often do, experience poor quality of life and psychosocial functioning. Impairment may range from minor avoidance of social situations to complete incapacitation, leaving some patients housebound and unable to work.

As important as screening for BDD is recognizing the cognitive deficits that may accompany this disorder. BDD has been associated with abnormalities in executive functioning and visual processing.[1] When presented with visual stimuli, afflicted patients tend to scrutinize details rather than see the larger picture. These details are often magnified or distorted. Clinically, BDD may present in a spectrum of phenotypes, ranging from patients with good insight into their illness and preoccupation with minor defects in appearance to those with frank delusional beliefs. This has profound implications for cosmetic treatment, as an attentive dermatologist may be able to reason with an insightful patient about how a given procedure is unlikely to afford a satisfactory cosmetic result. Conversely, evidence of psychotic thought processes should immediately abort the process of informed consent before the onset of a procedure. Often dermatologists encounter patients who appear on the spectrum of BDD. Such patients may screen positive to several of the criteria for BDD, but lead functional lives. Importantly, they may not have the clinical distress or impairment in social or occupational functioning necessary to make the diagnosis of BDD. Although the behavioral and perceptive changes in such troubling patients often approaches the diagnosis of BDD, to label such patients as having true BDD must be very carefully considered. Unless the diagnosis of BDD is clear, definitive diagnosis may be best left to mental health professionals or dermatologists with the time, specialization, and familiarity to treat BDD.

Although one must be mindful to respect patient autonomy, given the cognitive deficits that accompany many patients with BDD, a diagnosis of BDD is often prima facie evidence of inability to provide informed consent. And indeed, there is some legal precedent for the impact of BDD on the ability to provide informed consent. In the case of *Lynn G. v Hugo*, heard by the New York State Court of Appeals in 2001, a patient sued her plastic surgeon after she had received multiple elective procedures and over 50 clinical consultations. She asserted that BDD had invalidated her ability to provide informed consent.[4] Although the court ultimately found that there was insufficient evidence to establish a diagnosis of BDD in the plaintiff, this case suggested that physicians may be entering into uncertain medicolegal territory when performing cosmetic procedures on patients with potentially dysmorphic concerns.

Because of the high prevalence of BDD in dermatology patients, a short, patient-administered psychological screening tool may be considered as part of the intake process of cosmetic dermatology practices. The BDD Questionnaire—Dermatology Version is a short form that has been validated in cosmetic dermatology settings.[5] Questionnaires are patient-administered, can be quickly reviewed by the busy practitioner, and if necessary, followed up by additional questions. Alternatively, health care providers may use a similar practitioner-administered survey during patient evaluation and before initiation of informed consent. For patients who screen positive, one may proceed with follow-up questions, including questions about suicidality. If applicable, the treating dermatologist should consult with the patient's mental health provider. And if a patient meets criteria for BDD, one should not hesitate to both speak with the patient about concerns of a diagnosis of BDD and make appropriate referrals without fear of destabilizing the patient.[2] Patients should be informed that excellent, evidence-based treatment is available. Treatment typically involves psychotherapy ("talk therapy") with a licensed mental health provider and often,