Eur J Plast Surg (2002) 25:305–308
DOI 10.1007/s00238-002-0408-2

ORIGINAL PAPER

V. Vindigni · C. Pavan · M. Semenzin · S. Granà
F.M. Gambaro · M. Marini · F. Bassetto
F. Mazzoleni

The importance of recognizing body dysmorphic disorder in cosmetic surgery patients: do our patients need a preoperative psychiatric evaluation?

Received: 17 June 2002 / Accepted: 1 August 2002 / Published online: 13 September 2002

Abstract Body dysmorphic disorder (BDD) is classified in DSM IV as a somatoform disorder. The main features of this condition are a persistent preoccupation with a supposed physical defect or the presence of a slight imperfection in appearance. If a real defect should exist, the importance given to this in determining self-appreciation causes an important impairment in social, affective, or other functioning areas. This affection causes the patient to ask for multiple esthetic treatments. In most cases such interventions do not produce positive results in improving symptoms and may induce a chronic situation. The aim of this report is to aid in recognition of BDD in patients requesting esthetic improvements and to study psychopathological comorbidities. A counseling service was established, and 56 patients (11 men, 45 women) were seen. There were two specific interviews, one for personality, psychotic, and mood disorders and the other for the diagnosis of BDD (SCID II 2.0 and MINIPLUS 5.0). The findings in this study confirm those reported previously: BDD is more frequent in this selected population than in the general population (53.6%). There is a high prevalence of mood and anxiety disorders. Among personality disorders the most frequent are borderline and obsessive-compulsive types. We emphasize the importance of increasing the collaboration between the esthetic surgeon and the psychiatrist to determine the true motivation for surgical improvement and to avoid esthetic surgery on patients with psychiatrist disorders.

An invited commentary to this paper is available at: http://dx.doi.org./10.1007/s00238-002-0410-8

V. Vindigni (✉) · F. Bassetto · F. Mazzoleni
Department of Plastic and Reconstructive Surgery,
Padua University School of Medicine, Via Giustiniani no. 2,
35100 Padua, Italy
e-mail: vindvinc@katamail.com
Tel.: +39-049-8212701, Fax: +39-049-8213687

C. Pavan · M. Semenzin · S. Granà · F.M. Gambaro · M. Marini
Department of Neurological and Psychiatric Sciences,
Padua University School of Medicine, Via Giustiniani no. 2,
35100 Padua, Italy

Keywords Body dysmorphic disorder · Somatoform disorders · Mood and personality disorders · Presurgical counseling

Introduction

The desire to be good-looking is deeply rooted, as attested by history extending back centuries and by diverse cultures throughout the continents. In contemporary society one's physical appearance is of the essence in everyday life: those who are considered attractive are often held in higher esteem; they are the recipients of preferential treatment at a social level, including a better education, better job, and better chances of romantic attachments. Persons today increasingly feel an inner need for their appearance to reflect a certain esthetic model, as contemporary social customs attribute increasing importance to a person's looks in his or her daily interaction, both in the private and the professional sphere. The demand to improve one's features or to retain them in a youthful way in later life is constantly on the rise, as society has come to believe that improvement on nature is acceptable.

It is, however, important to understand that the dividing line between this common wish to improve one's looks and neurosis can sometimes become very fine. Extreme dissatisfaction with one's appearance may conceal psychopathological traits that are not always easy to recognize, and which if neglected may involve serious iatrogenic and medicolegal consequences. A plastic surgeon was recently accused of malpractice for not having taken into due consideration the psychiatric problems of his patient, who was judged to be incapable of giving her informed consent for the operation because she was diagnosed with body dysmorphic disorder (BDD) [4].

BDD appears in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV) among the somatoform disorders, its main clinical characteristics being an obsessive preoccupation with a supposed defect in the patient's appearance [2]. If a minor flaw is present, he

or she attributes far too much importance to it; this preoccupation is the cause of clinically significant unease or disability; it constitutes a handicap in the patient's behavior in social situations, at work or in other important areas of his or her life. This behavior cannot be attributed to any other mental disorder (such as the dissatisfaction with one's body shape and size in anorexia nervosa) [1, 6, 7]. Plastic surgery constitutes a privileged vantage point for the analysis of this disorder, as it is strategically situated with regard to the study of the body image in these patients. BDD is in fact a pathology that is often not presented to psychiatrists to observe because the patients, who do not understand the true nature of their problem, turn to dermatologists and above all to plastic surgeons. It must be stressed that such a patient may benefit from psychiatric treatment alone; an operation, even if perfectly performed, is incapable of resolving the psychological discomfort stemming from the supposed physical defect and leads, more often than not, to a lawsuit [11, 12, 13].

In collaboration with our colleagues at the University Clinic of Psychiatry in Padua, the sociodemographic characteristics, frequency, and comorbidity of BDD were studied patients who came to us between February 2001 and December 2001 seeking cosmetic surgery.

Materials and methods

All of the patients (n=65) aged of 15–66 years who attended our clinic for cosmetic procedures were asked to participate in the study, 56 agreed (45 women, 11 men; mean age 36±13 years, range 15–63). Of these, 32% (n=18) had a high school diploma, 32% (n=18) were married, and 56% (n=31) were regularly employed. The most frequently requested operation was septorhinoplasty (29%, n=16).

Our research protocol was structured as follows: At the first appointment the patient's informed consent was obtained regarding participation in the research program, acquisition of sociodemographic data, psychiatric evaluation. Psychiatric consultation consisted of the following: psychological screening with regard to patient's expectations and motivations in requesting the operation, psychiatric medical history, investigation of possible presence of BDD on the basis of DSM-IV diagnostic criteria, filling in of the Structured Clinical Interview for DSM-IV (SCID) II 2.0 questionnaire to evaluate possible comorbidity of personality disorders (DSM IV axis II classification), completion of the Mini-International Neuropsychiatric Interview Plus (MINIPLUS) to evaluate the presence of axis I disorders (in keeping with DSM IV) [14] (Italian version 5.0, D. Sheehan, J. Janvas, R. Barker, 1994). The Body Dysmorphic Disorder Examination was used to evaluate the gravity of the disorder in the patients who presented with it [3]. Patients with moderate to severe BDD were not scheduled for surgery but sent for psychiatric treatment. Patients with mild BDD were operated on after psychiatric go-ahead and followed postoperatively by the same specialist. The data collected was analyzed statistically by means of the χ^2 test.

Results

BDD was diagnosed in 53% (n=30) of the cases, involving 45% (n=5) of the men and 55% (n=25) of the women, with the following range of severity: 82% (4 men and 21 women) mild, 10% (1 man and 2 women) moderate, 8% (2 women) severe. Previous plastic surgery was reported by 27% (n=15), by 20% (n=1) of the men and 40% (n=10) of the women suffering from BDD. In 12.5% (n=7) there was a history of consulting psychiatric services, in 60% (n=3) of the men and 12% (n=3) of the women with BDD (χ^2=6.000, P<.06).

Table 1 The psychopathological comorbidities in patients affected by BDD (percentages)

	Men (n=5)	Women (n=25)
Axis I diagnosis		
Major depressive episode	0	24
Dysthymic disorder	60	8
Manic episode	0	12
Panic disorder	0	8
Agoraphobia	0	12
Social phobia	60	20
Obsessive compulsive disorder	0	0
Generalized anxiety disorder	20	20
Alcohol abuse	0	0
Substance abuse	40	0
Anorexia	0	0
Bulimia	0	12
Suicide risk	0	0
Somatization disorder	20	16
Antisocial disorder	20	0
Adjustment disorder	0	4
Posttraumatic stress disorder	40	8
Psychotic disorder	20	0
Axis II diagnosis		
Avoidant	0	12
Dependent	0	0
Obsessive-compulsive	0	24
Oppositive	0	16
Depressive	20	20
Paranoid	20	20
Schizotypic	0	8
Schizoid	0	12
Histrionic	0	4
Narcissistic	20	20
Borderline	40	28
Antisocial	20	0

The principal axis I psychopathological comorbidities in the patients affected by BDD were as follows (Table 1): as regards the men (n=5) 60% (n=3) dysthymia, 60% (n=3) social phobia, and 40% (n=2) posttraumatic stress disorder; as regards the women (n=25) 24% (n=6) major depressive episode, 20% (n=5) social phobia, and 20% (n=5) generalized anxiety disorder. The principal axis II psychopathological comorbidity in the patients suffering from BDD were as follows (Table 1): as regards the men (n=5) personality disorders 40% (n=2) borderline, 20% (n=1) narcissistic, and 20% (n=1) depressive; as regards the women (n=25) personality disorders 28% (n=7) borderline, 24% (n=6) obsessive-compulsive, and 20% (n=5) narcissistic.

Discussion

Is it necessary to obtain a psychiatric consultation for every patient seeking cosmetic surgery? Most certainly not, as the literature pertaining to this question attests

[5, 10, 11, 12, 13]. Severe BDD is in effect a disorder that can hardly be missed during a thorough presurgical [10]. It is a relatively rare disorder, the prevalence rate of which has been estimated by several studies to be around 0.1–1% in the general population, and higher in patients seeking cosmetic surgery (7%) [6, 7, 8]. Our discipline in fact constitutes a privileged vantage point, as it is excellently positioned for the study of the body image in these patients.

Patients suffering from the disorder have an extreme dissatisfaction with their appearance, as determined on the basis of the DSM IV diagnostic criteria [2]. Its cause is unknown, although sociocultural factors imposing an idealized, perfect body image are undoubtedly important. The esthetic models imposed by the mass media condition and influence the way in which one perceives and modifies one's own body [6]. BDD typically appears during adolescence or early adulthood and commonly coexists with other mental disorders: depression, social phobia, and obsessive-compulsive disorder [1, 6, 15]. In the affected women in our sample the most common disorder was major depression, followed by generalized anxiety and somatization. In the men, however, the prevailing disorder was dysthymia, followed by social phobia, substance use, and posttraumatic stress. Among those of both sexes having BDD the most frequently diagnosed disorder was borderline personality, the main features of which are characteristic emotional and affective instability and an altered perception of reality.

The patient's social life is often endangered because he or she experiences anxiety in the company of others, is afraid of being noticed for the supposed physical deformity, and believes that all of life's difficulties derive from this defect [15]. Symptoms often associated with the problem are fixed ideas or outright delirium (directed especially towards persons who notice the supposed flaw), obsessive checking of one's image in mirrors or obsessively trying to avoid any and all reflecting surfaces, and attempts to mask the supposed deformity with make-up, hairstyles, or clothing [6, 7]. In spite of the fact that patients generally focus on a specific anomaly, they may simultaneously find other defects, or their attention may shift in the course of time from one part of their body to another. This phenomenon, called substitution, may be seen in the fact that soon after the surgical procedure the patient begins to complain of some other defect [7, 8, 11]. In this case a completely useless operation is seen to have been performed, in the sense that not even the most perfect surgical outcome is capable of resolving the patient's psychiatric disorder, if such is present. If BDD goes untreated, it tends to become chronic: in the sample studied 26.8% of the patients had already undergone previous cosmetic procedures (20% of the men and 40% of the women).

The importance of entrusting these patients to the care of a psychiatrist is obvious; this specialist alone can initiate specific treatment, which is presently based on the use of selective serotonin reuptake inhibitors and cognitive-behavioral psychotherapy [6, 7].

While it is not always necessary to refer the patient for psychiatric consultation, it is undoubtedly of the essence that a plastic surgeon be adequately trained to understand the psychological implications associated with cosmetic surgery [9, 10]. We should all be professionally capable of conducting a brief psychological screening to investigate the motivations and expectations of our patients, their psychiatric condition and history, and their perception of their body image. Patients with a psychiatric history, if dissatisfied with their postoperative results, may exploit their psychiatric problems to sue the surgeon, claiming that their condition prevented them from clearly and completely understanding the modalities of the operation and its possible outcomes.

In conclusion, in the course of his or her career, a plastic surgeon should acquire the knowledge and expertise required to evaluate patients carefully, and be able, skillfully and rationally, to refuse the services requested in dubious cases, as discussed above. It must furthermore be remembered that emphasizing the psychological implications of cosmetic surgery also means making a significant contribution towards the survival of the profession of the plastic surgeon, in a society characterized by a continuous increase in the competition of nonspecialists in the cosmetic surgery field. In providing the patients with honest and thorough information as to the effects that the operation can have on their feelings of self-esteem and self-confidence, on the quality of their lives, and on their body image, while dealing with any psychological problems they may have, the surgeon probably also supplies them with the information that will be crucial in promoting the credibility and legitimacy of cosmetic surgery both now and in years to come.

Acknowledgements This research was presented at 13th Annual Meeting of European Association of Plastic Surgeon (EURAPS) in Crete, Greece, 30 May–1 June 2002.

References

1. Albertini RS, Phillips KA (1999) Thirty-three cases of body dysmorphic disorder in children and adolescents. J Am Acad Child Adolesc Psychiatry 38:453–459
2. American Psychiatric Association (1994) Diagnostic and statistical manual of mental disorders, 4th edn. American Psychiatric Association Washington
3. Conti L (2000) Repertorio delle scale di valutazione in psichiatria, vol III. SEE, Florence, pp 1723–1757
4. Kaplan R (2000) What should plastic surgeons do when crazy patients demand work? The New York Observer, 7 March 2000, p 1
5. Mühlbauer W, Holm C, Wood L (2001) The thersites complex in plastic surgical patients. Plast Reconstr Surg 107:319–326
6. Phillips KA (1996) The broken mirror. Understanding and treating body dysmorphic disorder. Oxford University Press, Oxford
7. Phillips KA, Crino RD (2001) Body dysmorphic disorder. Curr Opin Psychiatry 14:113–118
8. Phillips KA, McElroy SL, Keck PE, Pope HG, Hudson JI (1993) Body dysmorphic disorder: 30 cases of imagined ugliness. Am J Psychiatry 150:302–308
9. Rohrich RJ (1999) Streamlining cosmetic surgery patient selection. Just say no! Plast Reconstr Surg 104:220–221

10. Rohrich RJ (2000) The who, what, when, and why of cosmetic surgery: do our patients need a preoperative psychiatric evaluation? Plast Reconstr Surg 106:1605–1607
11. Sarwer DB, Wadden TA, Pertschuk MJ, Whitaker LA (1998) Body image dissatisfaction and body dysmorphic disorder in 100 cosmetic surgery patients. Plast Reconstr Surg 101:1644–1649
12. Sarwer DB, Wadden TA, Pertschuk MJ, Whitaker LA (1998) Psychological investigations in cosmetic surgery: a look back and a look ahead. Plast Reconstr Surg 101:1136–1142
13. Sarwer DB, Whitaker LA, Pertschuk MJ, Wadden TA (1998) Body image concerns of reconstructive surgery patients: an under recognized problem. Ann Plast Surg 40:403–407
14. Spitzer RL, Williams J, Gibbon M (1985) Structured clinical interview for DSM-III-R personality disorders (SCID-2:7/1/85). Biometric Research Department, New York State Institute
15. Walker P (1999) Everything you need to know about body dysmorphic disorder. Dealing with a disturbed body image. Rosen, New York